

Care Quality Commission

Inspection Evidence Table

Martlesham Heath Surgery (1-5652858053)

Inspection date: 13 January 2020.

Date of data download: 17 December 2019

Overall rating: Good

The practice was previously rated as requires improvement overall. Improvements had been made to the systems and oversight of training, medicines monitoring, referrals and actions from safety alerts. There was effective oversight of the dispensary with standard operating procedures which we saw were up to date and signed, completed competency assessments for dispensing staff and documented checks of the expiry dates of medicines. The practice had improved their governance processes to ensure appropriate and timely recruitment checks, health and safety checks were completed and staff were aware of their responsibilities.

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

Safe

Rating: Good

The practice was previously rated as inadequate for providing safe services because:

- Disclosure and barring service checks had not been completed for one clinician before they started to work unsupervised with patients and ongoing checks of professional registration were not undertaken.
- Patients prescribed medicines which required additional monitoring before being reissued, were not always monitored appropriately and blood monitoring results undertaken in secondary care were not always reviewed before prescriptions were reissued.
- The system to ensure that safety alerts were actioned, and patients reviewed, if appropriate, was not always effective.
- There was not an effective failsafe system in place for cervical screening. Two-week wait referrals for suspected cancer were documented, but there was no system to check that appointments had been made.
- Dispensing Standard Operating Procedures (SOPs) 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.
- Training deemed mandatory had not been completed by all practice staff.

At this inspection we saw improvements had been made and the practice is now rated as good for providing safe services.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	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.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y 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.	Y 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 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>¹ The practice used a computer software package to support improved documentation and oversight of recruitment checks and the completion of staff training. Staff were sent reminders for when future training was due, so this could be completed in a timely way. All staff had completed safeguarding children and adults training. Non-clinical and dispensing staff had all completed safeguarding children training to level one. In line with updated national guidance, staff who have contact (however minimal) with children and young people, parents and carers or adults who may pose a risk to children should be trained to level two. The practice advised staff who met these criteria would work towards achieving level two.</p> <p>² All staff had received a Disclosure and Barring Service (DBS) check and these had been documented in the new computer software package. We reviewed the records of a new staff member and a DBS check had been completed prior to commencement of employment.</p>	

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.	Y ¹
Explanation of any answers and additional evidence:	

¹ The practice used a computer software package to support improved documentation and oversight of ongoing checks of professional registration. Checks of staff professional registration were made on employment and these were reviewed on an annual basis. Reminders had been set up for the annual checks to be completed. This included checks for regular locum staff.

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 14/3/2019.	Y
There was a record of equipment calibration. Date of last calibration: 14/3/2019.	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: 9/1/2020.	Y
There was a log of fire drills. Date of last drill: 8/7/ 2019.	Y ¹
There was a record of fire alarm checks. Date of last check: 9/1/2020.	Y
There was a record of fire training for staff. Date of last training: Various dates.	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 21/5/2019.	Y
Actions from fire risk assessment were identified and completed.	Y ²
Explanation of any answers and additional evidence: ¹ The practice had acted on the recommendations from the fire risk assessment and had undertaken a fire drill in July 2019. A written review of the fire drill was available and actions to improve were highlighted and had been acted on. ² Actions from the fire risk assessment had been reviewed and monitored to completion. Fire extinguisher training for staff had been completed and monthly checks of the fire extinguishers, emergency lighting and fire drills had been established and documented.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 21/5/2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 21/5/2019	Y ¹

Explanation of any answers and additional evidence:

¹ Actions from the health and safety risk assessments had been completed. For example, quarterly health and safety audits had been established; the most recent audit had been completed on 8 January 2020. The five-year fixed wiring check had been completed on 18 July 2019. A legionella water test had been undertaken by an external company on 9 December 2019. A schedule of water testing was in place, which included hot and cold water temperatures. Systems were in place to document these checks, which had been completed. A Legionella risk assessment had been booked for 21 January 2020. The practice used a computer software package to support improved documentation and oversight for safety systems. Actions were allocated to staff who received reminders when checks were due to be completed. Staff were confident and knowledgeable in undertaking these roles.

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.	Y ²
Infection prevention and control audits were carried out. Date of last infection prevention and control audit:15/10/2019.	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y ³
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 The practice had an identified lead and deputy lead for infection prevention and control, who had recently taken over this role. An infection control risk assessment had been undertaken on 15 October 2019. The practice had an infection control policy and a range of related policies, for example environmental cleanliness, which had been established by the new lead for infection control. These were available for staff.

² The practice used a computer software package to support improved documentation and oversight of the completion of staff training. Staff were sent reminders for when future training was due, so this could be completed in a timely way. All staff had completed infection prevention and control training.

³ The practice had an overarching infection prevention and control action plan and most actions had been completed; longer term actions had been identified and were kept under review. Due to the recent changes with the infection control lead, the newly implemented cleaning checks and schedules had commenced in January 2020. A schedule of other infection control audits was in place, which included a weekly environmental cleanliness audit. Identified actions from this audit, undertaken on 6 January 2020 had been acted on.

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
<p>Explanation of any answers and additional evidence:</p> <p>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.</p>	

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
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.	Y ¹
There was a documented approach to the management of test results and this was managed in a timely manner.	Y ²
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y ³
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 The practice had written a protocol for the management and follow up of patients who had a two-week wait referral. A task was set up when the referral was sent, to check the patient had been seen and to contact the patient if they had not been seen. A search was undertaken weekly to check that patients who had been referred had been seen. Appropriate action was taken for patients who had not been seen. We reviewed one patient and this approach was evidenced.</p> <p>² The practice had written a cervical smear results audit process. A search was undertaken once a</p>	

month to check results had been received for all cervical smears taken and results were documented and acted on where appropriate.

³ Twenty records had been sampled and reviewed by a GP, for both November and December 2019, to audit clinical correspondence had been actioned in line with the relevant protocol and coded appropriately. This was confirmed in both audits. This audit was planned monthly.

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	1.05	0.94	0.87	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). (01/10/2018 to 30/09/2019) (NHSBSA)	7.6%	8.4%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2019 to 30/09/2019) (NHSBSA)	8.03	6.10	5.60	Significant Variation (negative)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	1.32	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 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	N/A

Medicines management	Y/N/Partial
supervision or peer review.	
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.	Y ²
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.	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 ³
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 ⁴
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 Improvements had been made and the dispensary had been fitted with a keypad so that access was limited only to authorised staff.</p> <p>² The practice had made improvements and had a documented and agreed high risk medication monitoring audit process. We reviewed 21 patients who were prescribed medicines which required additional monitoring before being reissued. All of these patients had appropriate blood monitoring undertaken and the results reviewed, before medicines had been reissued. Blood monitoring results undertaken in secondary care were reviewed by the practice before prescriptions were reissued.</p> <p>³ 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. They were working towards prescribing this for three to five days in line with evidence based practice and advised they continued to work with the Clinical Commissioning Group. 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> <p>⁴ The practice held emergency medicines. Although they did not stock all emergency medicines and</p>	

Medicines management	Y/N/Partial
had risk assessed this decision, this had not been documented. The practice submitted a written risk assessment following the inspection.	

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 which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Y ¹
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Y 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.	Y 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.	Y 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 The GP dispensary lead had reviewed the Dispensing Standard Operating Procedures (SOPs) and the dispensers had signed each one to confirm they had read and understood them.</p> <p>² Competency assessments were in place for each dispenser and each dispenser had been assessed by a pharmacist and signed off by the lead GP for the dispensary. One of the dispensers had recently attended prescribing training.</p> <p>³ An electronic system had been established which listed all medicines in stock and their expiry date. The system prompted staff daily, to advise which medicines were approaching their expiry date. We checked a sample of medicines and found they were in date.</p> <p>⁴ The SOPs included error management, significant events and near misses. Near misses were recorded and regularly overseen by the GP dispensary lead.</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
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:	14
Number of events that required action:	14
Explanation of any answers and additional evidence: The practice had documented significant events, which related to other services and had raised these appropriately.	

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

Top and bottom	Specific action taken
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.
A fridge used for the storage of temperature sensitive medicines temporarily exceeded the recommended maximum storage temperature due to a power cut.	Data logger reviewed, and appropriate people contacted for further advice. Policy for vaccine ordering and maintaining the vaccine cold chain updated with link to fact sheets to informing patients of the use of vaccines off licence and reassuring them of vaccine safety.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y ¹
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: ¹ The practice had a protocol for safety alerts which detailed the process for how a range of safety alerts would be managed and responded to by the practice. We saw written copies of alerts and actions taken had been recorded both on these and on an electronic spreadsheet. We reviewed seven recent alerts, and these had been acted on appropriately. The practice also received monthly medicines management quality and safety audits from Suffolk Primary Care (SPC). SPC is a group of 13 practices who had formed a partnership and worked together to deliver primary care across Suffolk.	

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.	Y 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 now a process to ensure that two-week wait referrals for patients with suspected cancer were sent from the practice to the hospital and 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) (01/10/2018 to 30/09/2019) (NHSBSA)	1.10	0.62	0.74	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.

- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

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 were offered 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 social 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 (01/04/2018 to 31/03/2019) (QOF)	81.2%	83.5%	79.3%	No statistical variation
Exception rate (number of exceptions).	3.0% (8)	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)	67.1%	80.1%	78.1%	Tending towards variation (negative)
Exception rate (number of exceptions).	3.7% (10)	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	87.2%	83.0%	81.3%	No statistical variation

12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) (QOF)				
Exception rate (number of exceptions).	12.7% (34)	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)	79.9%	78.1%	75.9%	No statistical variation
Exception rate (number of exceptions).	3.7% (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) (QOF)	90.1%	92.1%	89.6%	No statistical variation
Exception rate (number of exceptions).	13.8% (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) (QOF)	84.7%	85.4%	83.0%	No statistical variation
Exception rate (number of exceptions).	2.7% (27)	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) (QOF)	98.3%	92.6%	91.1%	Variation (positive)
Exception rate (number of exceptions).	5.7% (7)	5.5%	5.9%	N/A

Families, children and young people

Population group rating: Good

Findings

- The practice had met the World Health Organisation (WHO) based national target of 95% (the recommended standard for achieving herd immunity) for all four childhood immunisation uptake indicators. 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), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	49	50	98.0%	Met 95% WHO based target
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)	47	49	95.9%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	47	49	95.9%	Met 95% WHO based target
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)	48	49	98.0%	Met 95% WHO based target

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 79%, which was below the 80% coverage target for the national screening programme. The practice was 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 159 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). (31/03/2019 to 30/06/2019) (Public Health England)	78.7%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	78.9%	75.0%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	68.0%	61.5%	58.0%	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. (01/04/2018 to 31/03/2019) (PHE)	67.4%	61.7%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	55.8%	57.7%	53.8%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- 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 who were eligible for a health review and had completed three reviews of patients with a learning disability in the previous 12 months. The practice had two patients booked for a review and planned to invite the remaining patients before the end of March 2020.
- 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 who was available at the practice every week to see patients who had a pre-booked appointment.
- 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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	100.0%	92.6%	89.4%	Variation (positive)
Exception rate (number of exceptions).	0.0% (0)	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) <small>(QOF)</small>	94.3%	93.1%	90.2%	No statistical variation
Exception rate (number of exceptions).	2.8% (1)	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) <small>(QOF)</small>	78.1%	84.0%	83.6%	No statistical variation
Exception rate (number of exceptions).	11.1% (8)	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)	547.0	548.3	539.2

Overall QOF score (as a percentage of maximum)	97.9%	98.1%	96.4%
Overall QOF exception reporting (all domains)	4.1%	5.2%	5.9%

	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> <ul style="list-style-type: none"> • The practice had completed an audit in December 2017 and repeated the cycle annually, to ensure that patients who were prescribed a specific medicine had the correct shared care arrangement plan in their records. In 2017, 94% of patients had the correct paperwork in place. In 2018, this was in place for 88% of patients and in 2019, 93% of patients had this in place. Actions were taken to ensure the appropriate shared care agreement was in place for all patients. • 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, in line with evidence-based guidance. We saw that 100% of patients had received this in 2017, 100% in 2018. In the 2019 audit, 95% had received a review. One newly registered patient had not received a review; following the audit they were contacted and referred for specialist review. • 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. 	

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 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.	Y ²
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical	Y ³

supervision and revalidation. They were supported to meet the requirements of professional revalidation.	
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 ⁴
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
¹ Staff were up to date with childhood immunisation training. ² The practice provided evidence that one of the health care assistants had completed the care certificate in September 2016 and the other health care assistant had completed the diploma in clinical healthcare support in March 2018. ³ The management team had restructured how annual appraisals were undertaken, so that these were devolved within the practice. All staff had received an appraisal. The practice used a computer software package to support improved documentation and oversight of the completion of appraisals. ⁴ 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. Documented review of the work of nursing staff was completed on a monthly basis and areas for improvement were shared as appropriate. Assessment of the competency of dispensing staff had been undertaken.	

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) <small>(QOF)</small>	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	Y

own health.	
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>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 blood pressure monitoring machine in the waiting room; 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.</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)	94.3%	95.8%	95.0%	No statistical variation
Exception rate (number of exceptions).	1.2% (20)	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.	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.	24
Number of CQC comments received which were positive about the service.	20
Number of comments cards received which were mixed about the service.	4
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Patient interviews.	Patients were treated with kindness and practice staff were caring.
Feedback from CQC comment cards.	Patients reported that staff were helpful, caring and professional.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
6155.0	245	126	51.4%	2.05%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2019 to 31/03/2019)	85.7%	89.9%	88.9%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very	79.9%	88.7%	87.4%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
good at treating them with care and concern (01/01/2019 to 31/03/2019)				
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	97.4%	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)	84.1%	86.3%	82.9%	No statistical variation

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

Any additional evidence	
The National GP patient survey.	The practice had reviewed the results from the 2019 survey and had worked with the practice and patient group (PPG) to complete a practice survey to obtain feedback from patients who had recently used the practice, so feedback was based on current appointments and experiences.
Practice survey.	The PPG undertook a patient survey, which used a subset of questions from the national GP patient survey. Data from the practice survey is not directly comparable as it used a different methodology from the national survey. However, the data provided encouraging feedback to the provider. The practice told us that 72 responses were received between July and September 2019, from questionnaires available in the practice waiting room. From 69 responses, 94% of patients reported the healthcare professional was good at listening, from 67 responses, 97% of patients reported the health care professional was good at treating them with care and concern 98% of patients (65 respondents) had confidence and trust in the healthcare professional and 97% of patients (64) responses described the overall experience as good.
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. We reviewed the most recent ten responses on the Healthwatch Suffolk website; four were positive, in relation to clinical care and six were mixed in relation to access to appointments and waiting time following arrival for an appointment. At the time of the inspection, the practice had a four out of five star rating, based on 52 reviews.

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
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, felt listened to and were not rushed during their appointments.

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)	93.5%	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
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, feedback and suggestions.	

Carers	Narrative
Percentage and number of carers identified.	The practice had 110 patients who were registered as carers. This was approximately 2% of the practice population.
How the practice supported 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

(including young carers).	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. A representative from Suffolk Family carers was available in the practice on a monthly basis.
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 ¹
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>¹ 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 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> <p>The practice had worked with the local integrated neighbourhood team to develop information and raise awareness on services which were accessed via self-referral, for example physiotherapy. They had also developed a patient centred care map which detailed different community care options available to patients.</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
6155.0	245.0	126.0	51.4%	2.05%

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)	95.1%	95.1%	94.5%	No statistical variation

Older people

Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- Flu vaccinations were given to patients who were housebound.
- There was regular liaison between 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 were offered an annual review to check their health and medicines needs were being appropriately met.
- Patients with multiple conditions were reviewed at one appointment, where appropriate and consultation times were flexible to meet each patient's specific needs.
- A diabetes specialist nurse held a clinic at the practice every two to three months 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. GP reviewed all A&E discharge letters for all children who attended with an 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 consultations were also available.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including 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, carers for these patients 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 (01/01/2019 to 31/03/2019)	86.6%	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)	75.5%	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)	71.4%	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)	82.5%	80.0%	73.6%	No statistical 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 the same day, and most patients were satisfied with the waiting time for a non-urgent appointment. Two patients found it difficult to get through to the practice by telephone.
Practice survey.	The 'practice and patient group' (PPG) undertook a patient survey, which used a subset of questions from the national GP patient survey, so that results could be compared. A total of 72 responses were received between July and September 2019, from questionnaires available in the practice waiting room. The provider reported that 90% of patients (71 respondents) found it easy to get through to the practice by telephone, 97% of patients (64 respondents) described the overall experience as good, 88% of patients (72 respondents) were satisfied with the GP

	practice opening times and 96% (70 respondents) were satisfied with the type of appointment they were offered.
Comments on Healthwatch Suffolk website.	Healthwatch had published 52 comments received since May 2015 and based on these reviews the practice had a four out of five-star rating. We reviewed the most recent ten comments which had been received since July 2019. All responses were positive in relation to the clinical care and ease of getting an appointment. Four responses were mixed, which included wait following arrival for an appointment.

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.	13
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 ¹
There was evidence that complaints were used to drive continuous improvement.	Y ²
<p>Explanation of any answers and additional evidence:</p> <p>¹ Complaints information was available on the practice's website and on the patient feedback information board in the waiting room.</p> <p>² The practice had improved the documentation of the identification of learning from complaints. The practice was still 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
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 empathetic for how the patient felt. Practice to be more apologetic in complaint responses.
Poor fit of the 24-hour blood pressure monitor equipment.	The practice now only uses the new 24-hour blood pressure monitor.

Well-led

Rating: Good

The practice was previously rated as requires improvement for providing well led services because:

- The governance systems for recording the oversight of staff training was not always effective.
- The clinical governance systems to ensure that patients prescribed medicines which required a higher level of monitoring were appropriately monitored and safety alerts were actioned, were not always effective.
- Staff were not always clear about their roles and responsibilities, which had led to some delays in establishing effective monitoring systems.
- There was not effective oversight of the dispensary service.

At this inspection we found improvements had been made and the practice is now rated as good for providing well led services.

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 ¹
They had identified the actions necessary to address these challenges.	Y ²
Staff reported that leaders were visible and approachable.	Y ³
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: ¹ The practice had overcome previous experiences of 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 both financial and workload pressures for the leadership team to resolve. 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. ² The practice was part of Suffolk Primary Care, a group of 13 Suffolk GP practices, who worked together and shared resources to ensure patients received high quality healthcare. ³ The clinical team met informally for coffee every morning and discussed any practice or patient concerns.	

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 ¹
There was a realistic strategy to achieve their priorities.	Y ²
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: ¹ The practice's philosophy and practice charter were displayed on the practice website. ² The practice had a five year business plan, which identified current and potential issues and possible 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.	

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

Source	Feedback
Staff interviews.	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.

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.	Y ¹
Staff were clear about their roles and responsibilities.	Y ²

There were appropriate governance arrangements with third parties.	Y ³
<p>Explanation of any answers and additional evidence:</p> <p>¹ Improvements had been made to governance structures and systems for the oversight of the dispensary service, completion of staff training, including dispensing competency checks, safety checks at recruitment and on an ongoing basis, infection control and health and safety and safe patient care.</p> <p>² The practice had an organisational chart which included the tasks each staff member was responsible for. Staff had received training and obtained advice and support in order to undertake their roles.</p> <p>³ The practice was engaged with the primary care network and integrated neighbourhood team to improve services locally.</p>	

Managing risks, issues and performance

The practice had clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y 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.	Y ²
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
<p>Explanation of any answers and additional evidence:</p> <p>¹ Improvements had been made and effective assurance systems were now in place for the dispensary. The SOPs included error management, significant events and near misses. Near misses were recorded and regularly overseen by the GP dispensary lead. There was a process to ensure that two-week wait referrals for patients with suspected cancer were sent from the practice to the hospital and to check that patients had received an appointment from the hospital. The practice had a cervical smear results audit process to check results had been received for all cervical smears taken and results were documented and acted on where appropriate.</p> <p>² The practice used a computer software package to support improved documentation and oversight of health and safety and staff checks and monitoring. This included for example, recruitment, checks of professional registration, immunisation and training. The practice had effective oversight of these areas.</p>	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Y

Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y ¹
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<p>Explanation of any answers and additional evidence:</p> <p>¹ The practice had effective oversight of completed training deemed mandatory by the practice. All staff had completed training appropriate to their role. The practice agreed to review the level of safeguarding children training undertaken.</p> <p>A range of governance meetings were held, for example leadership meetings, significant event meetings, clinical meetings and practice meetings. The documentation of identified learning from significant events and complaints had improved and meeting minutes were more detailed.</p>	

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 ¹
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y ²
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <p>¹ The practice manager had met with Healthwatch Suffolk and regular engagement was established, which included sharing feedback obtained from patients.</p> <p>² The practice had a whiteboard in the staff area where suggestions, comments and agenda items could be written for inclusion at practice meetings. This had been put in place following a staff suggestion.</p>	

Feedback from Patient Participation Group.

Feedback
<p>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 eight members who met face to face, every other month, or more frequently as required. The practice manager attended the meetings and the GP attended for part of most meetings. They also had a virtual patient group of six members, to gather the views of patients by email. They reported the practice was very open to suggestions and encouraged and listened to the views of patients. For example, the PPG had tested and recommended a new website supplier, which the practice had actioned; the front page of the PPG section of the practice website had been updated by the PPG. Members of the PPG supported at flu clinics and on their feedback, changes were made to invite patients to four sessions by surname in alphabetical order, to improve the flow of patients. 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 adjusting staff hours to start work before 8am so they could answer the telephones promptly at 8am. The PPG were currently working on a practice information leaflet for patients, which was due to be printed and available soon.</p>

Continuous improvement and innovation

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

	Y/N/Partial
There was a focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y

Examples of continuous learning and improvement

The PPG had been approved for funding from the clinical commissioning group 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, to be held by a sports physiotherapist and include for example exercise, diet and education advice for participants. The first programme had been completed with seven participants, the second programme was running at the time of the inspection and the third programme was due to begin in February 2020. The PPG was in the process of obtaining initial feedback from participants. They planned to obtain participant feedback six months after the programme too, to demonstrate the impact of the programme.

The practice was supported by a clinical pharmacist who was employed through the primary care network and was based at the practice one day every other week to help ensure safe and effective medicines management.

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

Patients were referred to a social prescribing service, where staff had a good knowledge of local support services and would directly support patients to access services. This ensured patients had easy access to other agencies who could support them.

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 practice's 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. 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.