

# The Chesterfield Drive Practice

## Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

## Ratings

Overall rating for this service	Good	
Are services safe?	Good	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive to people's needs?	Good	
Are services well-led?	Good	

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Chesterfield Drive Surgery on 21 January 2016. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows;

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, and addressed. Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice:

- One of the GPs worked as a MacMillan GP for the area and as such shared in depth knowledge of cancer care. The practice treated all new patients with cancer diagnoses as significant events.

The areas where the provider should make improvement are:

- Ensure that the practice's computer system indicates links to the next of kin of children that are deemed vulnerable.
- Improve ease of access to policies and procedures for staff.

# Summary of findings

- Ensure annual reviews for learning disability, mental health and dementia patients are undertaken in a timely way.

**Professor Steve Field (CBE FRCP FFPH FRCGP)**  
Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as good for providing safe services.

- There were effective systems in place for reporting and recording adverse incidents and significant events, which included patients with new cancer diagnoses. Lessons were shared to make sure action was taken to improve safety in the practice.
- When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Good



### Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average for the locality and compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.

Good



### Are services caring?

The practice is rated as good for providing caring services.

- Data from the National GP Patient Survey showed patients rated the practice generally higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.

Good



# Summary of findings

- We saw staff treated patients with kindness and respect. Although improvements could be made around patient confidentiality at the front desk the practice had taken steps to improve it in other ways.

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.
- Patients said there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was regularly reviewed, audited and shared with staff and other stakeholders.

Good



## Are services well-led?

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to this.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern its activity but staff access to these needed improvement. There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for recognizing notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The patient participation group was active, and held regular meetings which were attended by the practice.
- There was a strong focus on continuous learning and improvement at all levels.

Good



# Summary of findings

## The six population groups and what we found

We always inspect the quality of care for these six population groups.

### Older people

The practice is rated as good for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people.
- The practice was responsive to the needs of older people and offered home visits and urgent appointments for those with enhanced needs.
- The practice worked with multi-disciplinary teams when providing care for older people, if required.
- There was a programme of visits to local care homes.

Good



### People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

- Clinical staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- One of the GPs was a MacMillan GP for the area; as a result the practice undertook thorough reviews of patients with a new cancer diagnosis.
- Quality Outcome Framework performance for a variety of long term conditions was equal or better compared to the CCG and national average.
- Longer appointments and home visits were available when needed.
- Long term condition clinics were held during which care plans could be modified in light of discussion with the patient.

Good



### Families, children and young people

The practice is rated as good for the care of families, children and young people.

- There were systems in place 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 A&E attendances.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

Good



# Summary of findings

- The practice had a comprehensive cervical screening programme. The practice's percentage of patients receiving the intervention according to 2014-2015 data was 93.4%, which was above the England average of 81.8%. Patients who didn't attend their appointment were followed up with letters and via the telephone.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives and health visitors.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 91.1% to 96.9% compared to the local average of 94.8% to 97.7%, and for five year olds from 94.3% to 99.6% compared to the local average of 92.6% to 97.2%.
- A family planning clinic was held weekly, during which a GP and three other clinicians could fit contraceptive coils and implants.

## **Working age people (including those recently retired and students)**

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Extended hours appointments were available one evening during the week and on Saturdays.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

Good



## **People whose circumstances may make them vulnerable**

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for patients requiring this.
- The practice carried out annual health checks for people with a learning disability and 65 out of 119 of these patients had received a review since April 2015.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people.

Good



# Summary of findings

- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. However, the records for children with safeguarding concerns were not always linked with their next of kin.

## **People experiencing poor mental health (including people with dementia)**

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.
- The practice had 112 registered patients with dementia of which 50 had received an annual review since April 2015. 50 of 145 patients with mental health problems had a care review recorded since April 2015.
- The practice carried out advance care planning for patients with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. A mental health link worker visited the practice regularly.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Good



# Summary of findings

## What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was performing generally in line with the national and Clinical Commissioning Group (CCG) averages. There were 309 surveys sent out and 103 responses which was a response rate of 33%.

- 96% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 90% and a national average of 85%.
- 99% say the last appointment they got was convenient compared with a CCG average of 94% and a national average of 92%.

- 86% describe their experience of making an appointment as good compared with a CCG average of 79% and a national average of 73%.
- 54% feel they don't normally have to wait too long to be seen compared with a CCG average of 61% and a national average of 58%.
- 32% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 60% and a national average of 60%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. Despite having left comment cards and a box for patients to deposit these in we received no completed cards.

## Areas for improvement

### Action the service SHOULD take to improve

- Ensure that the practice's computer system indicates links to the next of kin of children that are deemed vulnerable.

- Improve ease of access to policies and procedures for staff.
- Ensure annual reviews for learning disability, mental health and dementia patients are undertaken in a timely way.

## Outstanding practice

- One of the GPs worked as a MacMillan GP for the area and as such shared in depth knowledge of cancer care. The practice treated all new patients with cancer diagnoses as significant events.

# The Chesterfield Drive Practice

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

A CQC lead inspector. The team included a GP specialist advisor and a practice manager specialist advisor.

## Background to The Chesterfield Drive Practice

The Chesterfield Drive Surgery is situated in Ipswich, Suffolk. The practice has a branch surgery in Landseer Road in Ipswich. The practice provides services for approximately 14700 patients. The practice holds a Personal Medical Services (PMS) contract.

According to Public Health England information, the patient population has a higher number of patients aged 0 to 19 compared to the practice average across England. It has slightly lower proportions of patients aged 35 to 39 and 45 to 59 compared to the average across England. The number of female patients over 85 years of age is above average. Other age groups are in line with the practice average across England. Income deprivation affecting children is in line with the practice average across England, income deprivation affecting older people is slightly below the practice average across England and the overall deprivation across the practice population is slightly above the practice average across England.

The practice has four GP partners, three male and one female and three salaried GPs. One of the partners is retiring in September 2016. There are four nurse practitioners (of which one is still in training), one clinical

practitioner, four practice nurses, three health care assistants and one phlebotomist. The practice also employs a practice manager, office manager and an office team consisting of 18 personnel in varying roles to support the practice.

The practice offers on site physiotherapy, minor surgery and mental health link worker clinics; midwives hold clinics weekly at both locations.

The practice is a training practice with one active registrar GP and hosts medical students. The practice also partakes in research with the Primary Care Research Network.

There is a pharmacy housed in the same premises but this operates as a separate entity.

The practice's opening times at the time of the inspection were from 08:00 to 18.30 Monday to Friday at both locations. Extended opening hours were from 18:30 to 20:00 on Wednesday at the Chesterfield Drive location and on Saturday the practice operated extended hours between 08:00 and 11:00, three weekends out of four at the Chesterfield Drive location, and one weekend out of four at the Landseer Road location.

Appointments with clinicians could be booked twelve weeks in advance. During out-of-hours appointments were available with GP+ (an Ipswich GP based out-of-hours provider) between 18:30 and 21:00 on weekdays and between 09:00 and 21:00 during weekends. During the remaining out-of-hours times GP services were provided by CareUK.

# Detailed findings

## Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 21 January 2016. During our visit we:

Spoke with a range of staff (including GPs, nurses, reception, administration and managerial staff) and spoke with patients who used the service.

Reviewed an anonymised sample of the personal care or treatment records of patients. To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

# Are services safe?

## Our findings

### Safe track record and learning

There was an open, transparent approach and a system in place for reporting and recording significant events. Staff told us they would inform the practice manager of any incidents and an incident form was available on the practice's computer system or in paper form. When relevant, complaints received by the practice were automatically treated as a significant event. Records and discussions with GPs identified that there was consistency in how significant events were recorded, analysed, reflected on and actions taken to improve the quality and safety of the service provided.

The practice recorded significant events and adverse incidents. The latter included incidents related to clinical, prescribing, communication and confidentiality matters amongst a variety of topics. The significant events comprised of new cancer diagnoses, patients sectioned under the Mental Health Act and medication errors amongst others. One of the GP partners worked with a local cancer care organisation and took a special interest in cancer related care and diagnosis. They considered it useful for review and learning purposes to record new cancer diagnoses as significant events. The practice carried out an analysis of the significant events and adverse incidents during monthly risk management meetings and on an annual basis for which we saw evidence. During 2014 there were 49 significant events and 54 adverse incidents recorded. For 2015 there were 72 significant events and 35 adverse incidents recorded. If a significant event or adverse incident was urgent it was dealt with on the day. Outcomes and learning from significant events and adverse incidents were shared with staff via a monthly bulletin or via meetings.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance and alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). The information was monitored by a dedicated member of staff and electronically shared with other staff. Any actions required as a result were researched by a designated staff member and brought to the attention of the relevant clinician to ensure this was dealt with. Clinicians we spoke with confirmed this took place and worked well.

### Overview of safety systems and processes

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

- Arrangements to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Safeguarding children and vulnerable adults' policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare, as did specific guides available in all clinical rooms. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. However, we found that the practice's computer system did not indicate links to the next of kin of children that were deemed vulnerable.
- There were notices displayed in the waiting room advising patients that chaperones were available if required. Staff acting as chaperones had received a Disclosure and Barring Service check (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Recruitment checks were carried out and staff files we reviewed showed that appropriate recruitment checks had been undertaken prior to staff's employment. For example, references, qualifications, registration with the appropriate professional body and the checks through the Disclosure and Barring Service.
- Arrangements were in place for planning and monitoring the number of staff and skill mix of staff needed to meet patients' needs. There was a rota system in place for the different staffing groups to ensure that enough staff were on duty. Staff in the different teams were able to cover each other's roles and there were designated leads for clinical areas such as chronic obstructive pulmonary disease and asthma, cancer and diabetes as well as for general work areas, such as infection prevention and control, health and safety, first aid and information governance.
- Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments and there were sufficient stocks of

## Are services safe?

equipment and single-use items required for a variety of interventions. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was calibrated to ensure it was working properly.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available and this was on display in a staff area. The practice had a variety of risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, infection control, asbestos and legionella. The latter two were specified for the different locations of the practice and we saw that improvements had taken place as a result, for example plumbing work had been undertaken. The practice had made use of an external organisation for health and safety guidance and advice.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The nurse practitioner was the infection prevention and control (IPC) clinical lead who liaised with the local IPC teams to keep up to date with best practice. There was an IPC protocol in place and staff had received up to date training. Needle stick protocols were displayed in consultation and treatment rooms, guiding staff to what action to take in the case of injury. We saw evidence that annual IPC audits were historically undertaken and actions had been taken to address any improvements identified as a result, for example the installation of wrist/elbow operated taps. We saw that the practice was in the process of installing hard flooring throughout the premises, of which the majority had been done. No clinical rooms had carpets fitted in them.

- The arrangements for managing medicines, including emergency drugs and vaccinations, kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of the local CCG pharmacy team to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there was a system in place to monitor and track their use.

### **Arrangements to deal with emergencies and major incidents**

Staff identified and responded to changing risks to patients who used the practice through the safe management of medical emergencies. Staff received up to date annual basic life support training. Emergency medicines were available and staff we spoke with knew of their location. All the medicines we checked were in date and fit for use. The practice had an automated external defibrillator and oxygen with masks for use on the premises in an emergency situation. Panic buttons were present on the computers and at front reception in case of an emergency. We saw that patients in the waiting room were monitored by staff for deteriorating health and wellbeing.

The practice had up to date fire risk assessments and a business continuity plan in place for major incidents such as power failure or building damage. The plan included up to date emergency contact numbers for utilities and practice staff and several copies were held off site.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all GPs were kept up to date via meetings. Other clinical staff were kept informed through informal meetings which were not recorded. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs.

### Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF - is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. In 2014/2015 the practice achieved 96.1% of the total number of points available, which was above the national average of 93.5% and the local average of 94.1%. The practice reported 10.8% exception reporting (above CCG and national average). Data from 2014/2015 showed:

- Performance for asthma, atrial fibrillation, cancer, chronic obstructive pulmonary disease, dementia, depression, epilepsy, heart failure, hypertension, learning disability, osteoporosis: secondary prevention of fragility fractures, palliative care, rheumatoid arthritis and stroke and transient ischaemic attack were better or the same in comparison to the CCG and national averages with the practice achieving 100% across each indicator.
- Performance for chronic kidney disease related indicators was higher compared to the CCG and lower compared to the national average. With the practice achieving 93.8%, this was 0.5 percentage points above the CCG average and 1.0 percentage points below the national average.

- Performance for diabetes related indicators was lower compared to the CCG and national average. With the practice achieving 88.4%, this was 2.0 percentage points below the CCG average and 0.8 percentage points below the national average.
- Performance for mental health related indicators was 84.6% which was 6.4 percentage points below the CCG average and 8.2 percentage points below the national average.
- Performance for peripheral arterial disease related indicators was lower compared to the CCG and national average. With the practice achieving 83.3%, this was 11.8 percentage points below the CCG average and 13.4 percentage points below the national average.
- Performance for secondary prevention of coronary heart disease related indicators was lower compared to the CCG and national average. With the practice achieving 93.3%, this was 0.4 percentage points below the CCG average and 1.7 percentage points below the national average.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved in improving care and treatment and people's outcomes. We saw evidence of 13 audits that the practice had undertaken. We saw evidence of completed audit cycles in seven of those where the improvements found were implemented and monitored. Findings were used by the practice to improve services. We discussed a number of clinical audits with the lead GP on the day of the inspection. For example, an audit on the prescribing of Quinine (medication used to treat night time leg cramp) following an update in prescribing from the MHRA.

This audit was undertaken in September 2015 and repeated in January 2016. At the first audit 92 patients were identified as having been prescribed Quinine. Of which nine had either decided not to take the medication or had only taken it for a few months and then stopped. It was still on their repeat prescription. The practice had considered this a safety issue. A letter was written to all patients explaining the concerns and that the medication would be stopped, advising them that withdrawal issues should be discussed with a GP. The reasons behind the decision were also discussed with prescribing clerks so that they would be able to explain it to patients.

# Are services effective?

## (for example, treatment is effective)

Clinicians were informed through the mentoring system and a written prescribing update was sent round electronically and as a paper copy to each GP.

On re-audit in January 2016 the number of patients with Quinine on their repeat prescription had reduced to seven patients and no new patients had started on Quinine. Six of these patients had been seen by a GP and had safety concerns documented and accepted. One patient appeared to not have been included in the initial audit for unknown reasons.

Amongst other audits, adherence to cancer pathways was being audited. All patients with a new cancer diagnosis were discussed at monthly risk management meetings. These were also recorded as significant event to ensure a robust review approach was taken. The practice's rationale for doing this was that if cancer referrals were reviewed in a systematic way then learning could be shared and improvements could be made. With one of the GPs active as a MacMillan GP for the area, outcomes were shared through that pathway.

### Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

The practice had an induction programme for newly appointed members of staff that covered topics such as health and safety, confidentiality and practice procedures.

The learning needs of staff were identified through a system of meetings and reviews of practice development needs. Further staff support included ongoing support during sessions, one-to-one meetings, clinical facilitation and support for the revalidation of doctors and nurses. Staff had appraisals and records showed that staff had either received, or planned to receive an appraisal within a 12 month period. Staff told us they felt well supported by the practice.

Staff had opportunities on a daily basis to raise concerns, clinical and non-clinical during discussion at coffee break times.

Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. Staff had access to, and made use of, e-learning training modules, in-house and external training. Staff received training that included safeguarding and basic life support amongst others. We saw that information governance and

fire safety training was overdue for some members of staff but the practice manager informed us this was planned in the near future. Staff we spoke with said they had been provided with additional training they had shown an interest in and were either able to undertake training during work hours or had their training costs covered.

### Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care plans, medical records, investigations and test results. Information such as NHS patient information leaflets were also available.

The practice shared relevant information with other services in a timely way, for example; when referring patients to other services. Staff worked together and with other health and social care services, to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated. For example, the practice's GPs undertook peer reviews of patient referrals. In addition, monthly palliative care meetings were held and unplanned admissions were discussed on a monthly basis.

The practice provided clinics supported by other health care professionals, for example a physiotherapist held clinic at the practice for patients with musculo-skeletal problems. This allowed patients that required this type of consultation to access the appropriate care immediately but it also provided relief on the workload of GPs and nurses.

### Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of their capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear, the GP or nurse assessed the patient's

# Are services effective?

(for example, treatment is effective)

capacity and, where appropriate, recorded the outcome of the assessment. We saw evidence of consent documented for patients who had had an intrauterine contraceptive device fitted.

## Supporting patients to live healthier lives

Patients who might be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers and those at risk of developing a long-term condition. Patients were then signposted to the relevant service. For example, in addition to multi-disciplinary team meetings where specific needs were discussed, the practice also met with the MacMillan palliative care team every two months.

- The practice had a comprehensive cervical screening programme. The practice's percentage of patients receiving the intervention according to 2014-2015 data was 93.4%, which was above the England average of 81.8%. Patients that had not attended for a screening appointment were followed up with letters and via the telephone.

- Flu vaccination rates for September 2013 up to, and including January 2014, for the over 65s were 76.4% compared to the national average of 73.2%; and at risk groups 47.5% compared to the national average of 48.4%.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 91.1% to 96.9% compared to the local average of 94.8% to 97.7% and for five year olds from 94.3% to 99.6% compared to the local average of 92.6% to 97.2%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Where abnormalities or risk factors were identified, the practice informed us that follow-ups on the outcomes of health assessments and checks were made. 239 patients had received their health check during the period April 2015 to December 2015. The practice's target was to undertake 454 by April 2016.

Smoking cessation services were also offered, 192 patients had taken up this advice out of 2649 patients deemed eligible.

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and helpful to patients, both attending at the reception desk and on the telephone. We saw that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private but we saw that this was not implemented effectively at the front desk. Patients waiting in the queue could overhear conversation at the front desk and there was no effective queuing system to aid confidentiality. However, reception staff could offer patients a private room to discuss their needs when patients wanted to discuss sensitive issues or appeared distressed. The practice's telephone calls were answered in an office that was located away from patient areas and calls could not be overheard. The practice had installed an air-conditioning system so that during warm weather staff didn't have to open the windows and potentially compromise confidentiality.

Despite having left comment cards and a box for patients to deposit these in we received no completed cards from patients.

Results from the national GP patient survey showed patients were happy with how they were treated. The practice performed above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 95% said the GP was good at listening to them compared to the CCG average of 90% and national average of 87%.
- 92% said the GP gave them enough time compared to the CCG average of 89% and national average of 87%.
- 98% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%.
- 92% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 85%.

- 96% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 90%.
- 99% said the nurse gave them enough time compared to the CCG average of 94% and national average of 92%.
- 87% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and national average of 87%.

### Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were above the local and national averages, for example:

- 90% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 86%.
- 91% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and national average of 81%.

### Patient and carer support to cope emotionally with care and treatment

Information in the patient waiting rooms told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all people who were carers, 199 patients on the practice list had been identified as carers and were being supported, for example, by offering them health checks, extended appointments if required and referral for organisations such as social services for support. 143 patients were identified as being cared for. Written information was available for carers to ensure they understood the various avenues of support available in the practice's waiting room and on their website.

## Are services caring?

Staff told us that if patients had suffered bereavement, their usual GP contacted them either via letter, in person or

via the phone. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area. The practice held information about the prevalence of specific diseases. This information was reflected in the services provided through means of screening programmes, vaccination programmes and family planning.

Services were planned and delivered to take into account the needs of different patient groups and to help ensure flexibility, choice and continuity of care.

- Online appointment booking, prescription ordering and access to basic medical records were available for patients.
- There were longer appointments available for carers, patients with a learning disability or patients who needed a translation service; or for any other patient that required this.
- Home visits were available for older patients or patients who would benefit from these.
- Urgent access appointments were available for children.
- Telephone consultations were available for patients.
- Same day appointments were available but the practice also hosted a variety of clinics, for example for long term conditions, baby vaccination and family planning amongst others.
- There were disabled facilities available and there was level access for patients throughout the practice. The practice did have a first floor but this was for staff only.
- A hearing loop and translation services were available. Staff told us that translation services were available for patients who did not have English as a first language. The receptionist and the website informed patients this service was available. The practice's self-check in screen in reception displayed eight different languages.
- A private space was available for breast feeding mothers.
- Visits were undertaken at two local residential homes every week.
- One of the GPs also worked as a MacMillan GP for the area and as such shared in depth knowledge of cancer care. The practice treated all new cancer diagnoses as significant events.
- A mental health link worker visited the practice regularly.

- One of the GPs provided a minor injury clinic and another GP provided an intrauterine contraceptive device service.
- The practice provided care to a local fixed traveller's site, on site consultation was trialled to improve child vaccination in the community but this ceased following recognition that it wasn't successful.

### Access to the service

The practice's opening times at the time of the inspection were from 08:00 to 18.30 Monday to Friday at both locations. Extended opening hours were from 18:30 to 20:00 on Wednesday at the Chesterfield Drive location and on Saturday the practice operated extended hours between 08:00 and 11:00, three weekends out of four this was at the Chesterfield Drive location and one weekend out of four at the Landseer Road location.

Appointments with clinicians could be booked twelve weeks in advance. During out-of-hours appointments were available with GP+ (an Ipswich GP based out-of-hours provider) between 18:30 and 21:00 on weekdays and between 09:00 and 21:00 during weekends. During the remaining out-of-hours times GP services were provided by CareUK.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was above the local and national averages. For example:

- 85% of patients were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 74%.
- 95% patients said they could get through easily to the surgery by phone compared to the CCG average of 81% and national average of 73%.
- 86% patients described their experience of making an appointment as good compared to the CCG average of 79% and national average of 73%.
- 65% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 68% and national average of 65%.

### Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints' policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated

# Are services responsive to people's needs?

(for example, to feedback?)

responsible person who handled all complaints in the practice. A policy explained how patients could make a complaint and included the timescales for acknowledgement and completion. The process included an apology when appropriate and whether learning opportunities had been identified.

We reviewed an audit of complaints received in the last three years, this included 30 complaints in 2013, 27 in 2014 and 20 in 2015. The practice reviewed its complaints at monthly risk management meetings. The annual audit highlighted trends on categories of the complaints as well as what staff groups they related to. When we reviewed the complaints we noticed that there where appropriate complaints were raised as significant events. Records showed complaints had been dealt with in a timely way. If a

satisfactory outcome could not be achieved, information was provided to patients about other external organisations that could be contacted to escalate any issues.

We saw that information was available to help patients understand the complaints system for example information was available on the practice website and in the waiting room and complaint forms were available in the practice.

The practice had also analysed the compliments it received. This was also available in annual breakdown and showed that the practice had received 16 compliments in 2013, 14 in 2014 and 28 in 2015. The combined rise in compliments and reduction in complaints indicated the practice managed and understood this element of its operations well and was reactive to feedback.

# Are services well-led?

Good 

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

## Our findings

### Vision and strategy

The practice had a clear vision to 'care for patients by using high quality general practice services'. The practice aimed to achieve this through seven core principles it had set for itself. This included amongst others: 'putting the needs of patients at the centre of what they did', to 'respond to criticism and complaints promptly and thoroughly and to be prepared to accept when improvements are needed' and to 'develop new ways to serve patients'.

The practice had a robust strategy and supporting business plans which reflected the vision and values which were monitored.

The practice manager worked closely with two other practice managers of local GP practices. The purpose was to work together on financial, educational and managerial matters and to share learning and development.

### Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and rota planning and staff were aware of their own roles and responsibilities. Staff were multi-skilled and were able to cover each other's roles within their teams during leave or sickness. The nursing and office teams each had their own lead individual.
- The practice used clear methods of communication that involved the whole staff team and other healthcare professionals to disseminate best practice guidelines and other information. There was a schedule of meetings that were held in the practice, for example: monthly business/partners meetings, monthly risk assessment meetings (these included significant event/adverse incident reviews), clinical/educational meetings on a regular basis but also ad-hoc daily in coffee breaks during which patients and procedures were discussed to improve outcomes, monthly nurse team meetings and monthly office team meetings for both locations also took place. Written updates for GPs were distributed monthly.

- The GPs were supported to address their professional development needs for revalidation.
- Staff were supported through a system of appraisals and continued professional development.
- From a review of records including action points from staff meetings, audits, complaints and significant event recording, we saw that information was reviewed to identify areas for improvements and to help ensure that patients received safe and appropriate care and treatments.
- The practice had a number of policies and procedures to govern activity, however when we reviewed the system to access these policies it proved to be difficult for staff to find the policy they were looking for. The practice manager was aware of this and explained they were in the process of developing a new approach to improve policy access.
- There were systems in place to monitor and improve quality and to identify and manage risk.
- GPs had undertaken clinical audits which were used to monitor quality, systems to identify where action should be taken and drive improvements.

### Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care.

The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness, dedication and honesty.

Staff told us that various regular team meetings were held. Staff explained that they had the opportunity to raise any issues at these meetings, were confident in doing so and felt supported if they did. Staff said they felt respected and valued by the partners in the practice.

The practice manager attended monthly practice management meetings with the CCG but also regularly met with practice managers of two other local GP practices. During these meetings best practices and learning points were shared to encourage business and practice development across the participating practices.

Three of the nurses were going through training and education to become a nurse practitioner. This training was supported by the practice and for one of the nurses it was

# Are services well-led?

Good 

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

funded by the practice. The others were funded through other sources, there was no expectation of staff to fund role related development themselves. A health care assistant active in the practice was supported through their asthma diploma to enable them to undertake more asthma related duties. Staff told us they were able to attend other training during work hours or their own time, if the training was mandatory they would be reimbursed for their time.

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

The practice encouraged and valued feedback from patients by proactively engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG), the NHS friends and family test and through surveys, compliments and complaints received. We spoke with one member of the PPG, which met face to face every two months. The PPG had eight to nine active members and PPG meetings were attended by the practice manager and a GP. The group was exploring intermediate meetings in addition to their on-going meeting programme to ensure more urgent matters could be addressed. The PPG informed us that the practice was open to suggestions from the group and had instigated changes such as the waiting room layout, a change of music in the waiting room and assisted with development of the information screen in the waiting room. The group had also attempted to resolve car parking shortages. The PPG told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. They said that patients were well and that their needs for care were met.

The practice, together with the PPG, had undertaken patient surveys. We were provided with evidence of a survey from October 2015. For this survey the PPG had questioned 80 patients during a flu clinic. The questions were devised by the PPG on areas that they considered needed patient feedback and focussed on the waiting area, services provided at the surgery and access to appointments.

The practice had introduced the NHS Friends and Family test (FFT) as another way for patients to let them know how well they were doing. For example, FFT data available to us showed that:

- In August 2015, from 21 responses, 100% recommended the practice compared to 88% nationally.
- In September 2015, from 15 responses, 93% recommended the practice compared to 89% nationally.
- In October 2015, from 13 responses, 92% recommended the practice compared to 90% nationally.

The practice provided newsletters for patients every two months, which were available in the practice, these included topics such as introduction of new staff, vaccination news and general practice news.

Staff told us the practice held an annual away day for GPs. These were utilised to combine work based discussions with leisure time. The practice had also gathered feedback from staff through staff training days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us that they felt generally well supported and that communication within the practice was good. One clinical member of staff told us they would benefit from more study time; another clinical member of staff informed us they were extremely happy with the available support from colleagues and direct access to GPs for advice and guidance.

## Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and took part in research with Primary Care Research Network.

The practice employed a clinical practitioner with a paramedic background who was able to provide home visits to patients. The patients that the practitioner saw were triaged by GPs to ensure suitability and were reviewed and discussed by the practitioner and a GP following consultation. If it was decided at triage or after consultation by the practitioner that if a patient had to be seen by a GP, this would be arranged.