Cutlers Hill Surgery

Quality Report

Bungay Road,
Halesworth,
Suffolk,
IP19 8HP
Tel: 01986 874 618
Website: www.cutlershillsurgery.co.uk

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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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Cutlers Hill Surgery has a practice population of approximately 10300 patients. The surgery offers a medicine dispensing service for patients who lived in excess of one mile of a pharmacy.

We carried out a comprehensive inspection at Cutlers Hill Surgery on 9 October 2014 to explore the standards of care and treatments that patients received.

We have rated each section of our findings for each key area. The overall rating was requires improvement. This was because some improvements were needed for safety and well led in respect of management of and dispensing medicines to patients. Other aspects of the service were rated as good for effective, caring and responsive for the population it served.

Our key findings were as follows:

- We found that patients were treated with respect and their privacy was maintained. Patients informed us they were satisfied with the care they received. The patients we spoke with told us they were able to make informed decisions about their care and that they felt in control.
- We found that the practice was clean. Patients we spoke with were always satisfied with the standards of hygiene at the practice.
- There was a higher than average older population of 3257 patients. Of those 172 were housebound or lived in a care home. This resulted in a high number of regular home visits needed by GPs and practice nurses to cope with patient's needs.
- To cope with higher demands for appointments on Mondays and following bank holidays two GPs were on call to assist with patients in receiving same day appointments. Patients told us they could see a doctor when they needed to.
- Systems were in place for identifying patients who were at risk and those who had complex needs. Care was provided using a multidisciplinary approach.

Summary of findings

However, there were also areas of practice where the provider needs to make improvements.

In addition the provider should:

- Serious dispensing errors should be reported to the practice manager and lead GP and treated as significant events.
- Risk assessments should be carried out for the remote collection point for dispensed medicines to ensure a safe system was in place.
- The practice manager assured us they would make improvements to ensure safe storage of medicines and checks of controlled drugs carried out more regularly.
- There was scope to improve the governance of dispensary staff by introducing additional accountability from the management team and to improve channels of communication and review of staffing levels.
- Patients should be informed of who their named GP is.

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?

Requires improvement

Care was tailored to individuals' needs and circumstances. There was a process and policy in place for safeguarding children and vulnerable adults from abuse. The recruitment processes ensured patients were protected against care being provided by inappropriate staff. Systems were in place to ensure the premises and medical equipment were safe for use. There were enough staff to keep people safe.

Patients were not fully protected against the risks associated with management of medicines for storage, use and handling of medicines.

Are services effective?

Good

The practice staff had procedures in place to deliver care and treatment to patients in line with best practice. Practice staff carried out clinical audits and as a result made changes where necessary to promote effective care for patients. There was evidence of multidisciplinary meetings and joint working in delivery of effective and up to date patient care. Systems were in place for regular reviews of patients who had long term conditions and housebound patients.

Are services caring?

Good

All the patients we spoke with during our inspection told us they were satisfied with the service they received from the practice staff. The majority of comments made by patients on the comment cards we received were complimentary. We observed staff interacting with patients in a caring, supportive and respectful way. Consideration had been given to ensuring patient confidentiality.

Are services responsive to people's needs?

Good

The practice demonstrated how they listened to and responded to their patient group. We saw that efforts had been made to reach out to each population group to ensure they received appropriate care and treatments. There was a system in place which supported patients to raise a complaint. Complaints received were recorded, investigated and responded to in a timely way. The layout of the premises supported access for patients who had restricted mobility.

Are services well-led?

Requires improvement

Analysis of incidents and complaints were completed in order to minimise the risk of further occurrences.

Summary of findings

Staff performance monitoring was in place for practice staff but was not robust enough in respect of dispensing staff. The lead GP for medicines management was not meeting with and adequately monitoring dispensing staff practices. The practice manager should familiarise themselves with the dispensary service that patients received.

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

Requires improvement

The practice had a higher than average number of older patients. This impacted on the number of home visits that GP's needed to do. A practice nurse carried out home visits to conduct regular health checks of patients who had chronic diseases. We found these were well organised to ensure patients received care when they needed it. All patients aged over the age of 75 years have been informed of their named and accountable GP.

We found that some improvements were needed in respect of safe and well led arrangements for the dispensing of medicines to patients.

People with long term conditions

Requires improvement

The practice staff held a register of patients who had long term conditions. These patients were supported through multidisciplinary meetings to ensure any changes in needs were identified and acted on. The administration team organised clinical reviews. The necessary tests and investigations required were organised beforehand to ensure all information was to hand for the reviews. Patient's reviews were held at any time during the week rather than through dedicated clinics to assist patients in accessing the practice when it suited them. A practice nurse was attending specialist training in diabetes to supplement care carried out by the GPs.

We found that some improvements were needed in respect of safe and well led arrangements for the dispensing of medicines to patients.

Families, children and young people

Requires improvement

Practice staff worked with local health visitors in offering a full health surveillance programme for children. Six week post natal mother and baby checks were carried out by the GPs. Children were offered childhood immunisations. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk.

We found that some improvements were needed in respect of safe and well led arrangements for the dispensing of medicines to patients.

Summary of findings

Working age people (including those recently retired and students)

Requires improvement

Practice staff offered patients telephone consultation appointments. Patients told these were particularly useful for those who worked away from home, for routine queries and advice about urgent medical attention. The practice also had extended opening hours to provide easier access for patients who work during the day. The extended hours included, 6:30pm until 7pm Monday to Thursday and two GPs held a clinic at 8:30am until 11:30am one Saturday each month. Patients who were not registered at the practice such as, tourists would be seen as temporary patients.

We found that some improvements were needed in respect of safe and well led arrangements for the dispensing of medicines to patients.

People whose circumstances may make them vulnerable

Requires improvement

The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. These patients were offered an annual health check. This provided staff with an opportunity to gain an insight into the type and levels of support provided by other agencies. Such information assisted practice staff in determining if there were any health or social aspects that were not being met. If these patients failed to attend for their appointments a practice nurse told us they would contact them by telephone and if necessary their relatives on a 'need to know' basis to protect the patients confidentiality. Practice nurses visited housebound patients and carried out regular reviews.

We found that some improvements were needed in respect of safe and well led arrangements for the dispensing of medicines to patients.

People experiencing poor mental health (including people with dementia)

Requires improvement

Patients who presented with anxiety and depression were assessed and managed in line with the National Institute for Care Excellence (NICE) guidelines. The practice worked in conjunction with the local mental health team. Patients had open access to and were able to self-refer to the mental health team. Practice staff could refer patients to a private counsellor. This service was funded by the local Clinical Commissioning Group (CCG). Patients who had significant mental health conditions were offered annual health checks.

We found that some improvements were needed in respect of safe and well led arrangements for the dispensing of medicines to patients.

Summary of findings

What people who use the service say

During the inspection we spoke with 12 patients. They were all complimentary about the services they had received and told us they could make appointments when they needed them. They informed us they were happy with the care and treatments they received from GPs and nurses. Those who had referrals told us they had been able to choose which hospital they wished to go to. Patients advised us the GPs explained their health needs so that they understood. They told us reception staff were polite and helpful.

One patient told us they would like the practice to open on Saturdays. They confirmed they were not aware the practice opened Saturday mornings once a month.

Prior to the inspection we provided the practice with a box and comment cards inviting patients to tell us about their care. We received eight cards. Seven cards provided positive comments with the exception of three who did not know who their named GP was.

One card gave negative comments about their ability to get an appointment and failure of staff to inform them of the need to fast before a blood test could be taken.

We spoke with three members of the Patient Reference Group (PRG). PRG's are an effective way for patients and surgery staff to work together to improve services and promote quality care. They were very positive about the standards of care they received as patients. They told us the management team liaised with the group to look at ways to further develop and improve the services provided to patients.

Areas for improvement

Action the service SHOULD take to improve

- Serious dispensing errors should be reported to the practice manager and lead GP and treated as significant events.
- Risk assessments should be carried out for the remote collection point for dispensed medicines to ensure a safe system was in place.
- The practice manager assured us they would make improvements to ensure safe storage of medicines and checks of controlled drugs carried out more regularly.
- There was scope to improve the governance of dispensary staff by introducing additional accountability from the management team and to improve channels of communication and review staffing levels.
- Both the nurse practitioner and the practice manager acknowledged there should have been a formal system in place to regularly check the levels of hygiene within the practice.
- The practice manager told us they would introduce a system to inform patients of who their named GP is.

Cutlers Hill Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a CQC pharmacist, a GP and a Specialist Advisor who had experience in practice management.

Background to Cutlers Hill Surgery

Cutlers Hill Surgery serves approximately 10330 patients. The service dispenses medicines to patients who lived in excess of one mile of a pharmacy.

At the time of our inspection there were eight GP partners at the practice, some of these worked on a part time basis. There were three female doctors. The partners provided 46 sessions per week. The timings of the sessions varied between 1 hour 45 minutes to 3 hours 30 minutes. Cutlers Hill Surgery is a training practice for a maximum of two trainee GPs. There was a full time nurse practitioner and seven practice nurses who worked varying numbers of hours that equated to 5.09 whole time equivalents (based on 37 hours per week). The dispensary manager was responsible for the team of nine dispensary staff who equated to 6.56 whole time equivalents. The practice manager was supported by a part time assistant. There was a reception manager and a total of 17 reception, administration and secretaries who worked varying hours.

The phlebotomy service was available 8:30am until 12pm Monday to Friday at the local hospital. There were no phlebotomy services at the practice. The surgery offered minor injuries facilities to reduce the number of patients who may have considered visiting the hospital Accident and Emergency department. Minor surgery was offered to patients. Patients with long term conditions were reviewed regularly through the normal clinic sessions. Health screening appointments were offered to all adult patients.

Patients were able to access the out of hour's services when the surgery was closed. Information received from these services by practice were followed up, where necessary.

Why we carried out this inspection

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. This 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.

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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.

Detailed findings

How we carried out this inspection

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 are provided for specific groups of people and what good care looks 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)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

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 9 October 2014. During our visit we spoke with a range of staff. They included three GPs, the nurse practitioner, a practice nurse, the dispensary manager, the practice manager, the reception manager, one administrator and two reception staff. We spoke briefly with two district nurses and a health care assistant who were visiting the practice. We also spoke with patients 12 who used the service and three patients who were members of the Patient Reference Group (PRG) who acted as patient advocates in driving improvements. We observed how people were being cared and how staff interacted with them and reviewed personal care or treatment records of patients. We reviewed eight comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice was able to demonstrate it had a good track record for safety. Practice staff used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents and national patient safety alerts. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We reviewed safety records and incident reports and saw how the practice manager recorded incidents and ensured they were investigated. The partners held an annual meeting to review the practice's safety record over the previous year and to check that the actions taken had been effective.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff recorded incidents when they occurred. The practice manager formally recorded the incidents ready for investigations to be carried out. For example, a requested blood test that had not been done for a patient in a care home. As a result the system for blood tests of people living in care homes was changed to prevent a recurrence.

There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. The practice staff had notified the Clinical Commissioning Group (CCG) of individual events. The CCG have a role in monitoring the standards of the services provided by practices.

We were given some sample significant event audits. These clearly stated the investigations carried out, the resultant actions and which staff the information had been cascaded to. The records we saw told us they had been completed in a comprehensive and timely manner.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies.

The practice had a dedicated GP appointed as the lead in safeguarding for vulnerable adults and children who had been trained and demonstrated they had the necessary skills to identify abuse and take appropriate action. All staff we spoke with were aware who to speak with if they had a safeguarding concern. We saw a poster in the waiting area advising patients of the contact details of safeguarding agencies if they had concerns about their safety.

A chaperone policy was in place and visible in the waiting areas. Chaperoning was provided by clinical staff. We spoke with the nurse practitioner who demonstrated they would carry out the role appropriately.

Medicines Management

We found that improvements were needed in respect of medicines management. Repeat prescriptions could be requested by telephone, by post or by leaving the repeat request tear off slip at the practice. There was a delivery service for patients who did not need to pay for their prescriptions. The patients' leaflet stated that it took three working days for medicines to be ready for collection. Some of the patients we spoke with told us there was sometimes a delay in getting their prescriptions. The Patient Reference Group (PRG) members we spoke with made a similar comment.

The dispensary manager had recorded nine dispensing errors since August 2013. We were told these were discussed within the department only. To prevent further errors from occurring a system had been introduced, the system of a second dispenser checking the medicines had been increased to a third member of staff. Although appropriate action had been taken to prevent recurrences the dispensary manager had not reported these to the practice manager or the lead GP. This meant they had not been recorded as or investigated as significant events or disseminated to other staff.

At the time of the inspection we found no evidence to confirm that audits in relation to medicine management practices or meeting deadlines for dispensing had been

carried out. This was confirmed when we spoke with GPs. The dispensary manager told us staff had annual appraisals but they did not include checks on staff competencies.

Access to the dispensary was by a coded lock. Staff told us the code had not been changed for two years. Cleaning staff used the code to gain access and were not supervised by dispensary staff even though they were present for the first hour that cleaning staff were on the premises. The key to the controlled drug (CD) cabinet was not kept in a secure place. CDs are medicines which are subject to extra controls as there is a potential for them to be misused or obtained illegally causing potential harm. Checks on the CDs were spasmodic but the numbers corresponded with the recordings that staff had made. We found they had been checked 27 May 2015 then not until 29 September 2014. This meant there could be a delay in identifying discrepancies. We found that the temperature of the fridge in the treatment room was recorded daily and it was kept at a safe temperature that complied with manufacturer's instructions to ensure medicines remained safe for use. However, the fridge and the door to the room were not locked. Blank prescription forms for the computers were not kept secure and all staff had access to them.

The practice manager had been in post for 18 months. They told us they had not had any previous experience of dispensing practices and was unsure about this area of management. No clinical audits had been carried on the dispensing aspect of the service. Dispensary staff were invited to attend the monthly practice meetings but they told us they did not always attend due to their workload.

The opening times of the dispensary were 9am until 7pm Monday to Friday. There was a delivery service for patients who did not need to pay for their prescriptions. The practice had a higher than average older population who would require a higher volume of medicines. The dispensary manager told us that when staff were absent due to holidays or sick leave no additional staff were scheduled to work to cover the gaps. A third dispenser checked medicines before they were collected by the patient. These factors put additional pressure on the dispensary staff to meet targets. No dispensary staffing analysis had been carried out to demonstrate there were adequate staff to meet patient demands.

For ease of access the dispensary staff operated a remote collection point. The practice manager confirmed that no risk assessments had been carried out to ensure that collections from this point were safe.

The medicines and equipment for use in an emergency were regularly checked and the findings recorded to ensure they were fit for use. GPs bags were taken to the dispensary for staff to check their contents. Dispensary staff were in the process of developing individual lists to check against the expiry dates of the medicines.

Cleanliness & Infection Control

We saw that all areas of the practice were visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We were shown the cleaning schedule for staff to follow and recordings that had been made where actions were needed by the cleaning staff.

The practice had a lead for infection control who had received appropriate training for this role. All other staff had received training in infection control. We saw evidence that the local Clinical Commissioning Group had carried out an infection control audit every two years. Where actions had been identified they had been addressed. We enquired about the arrangements in between the CCG audits. Both the nurse practitioner and the practice manager acknowledged there should have been a formal system in place to regularly check the levels of hygiene within the practice.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff confirmed there were always good stocks of PPE within the practice. There was also a policy for needle stick injury.

We found that Legionella testing had been carried out and there was a system in place for regularly flushing infrequently used taps and shower heads.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations,

assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and appropriate recordings maintained.

Staffing & Recruitment

Senior staff based staffing requirements on the current demands of patient care. Regular consideration was given by checking whether enough GP sessions were available to meet patient demands. Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. Patients told us they did not have difficulties in obtaining appointments when they needed to.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there as an identified health and safety representative. All clinical rooms had been risk assessed to ensure they were safe for patients.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, practice staff monitored patients with long term conditions and took appropriate action when their needs changed.

Arrangements to deal with emergencies and major incidents

We saw the business continuity plan. The document detailed the actions that should be taken in the event of a major failure and contact details of emergency service who could provide assistance. Copies of the document were held off site by senior staff to ensure it was accessible at all times. The document covered eventualities such as loss of computer and essential utilities. The plan was clear in providing staff guidance about how they should respond. It included the contact details of services that may be able to help at short notice.

A fire risk assessment had been undertaken that included actions required for maintaining fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Risks assessments associated with the premises had been carried out.

The patient leaflet and the telephone when the practice was closed gave information about how to access urgent medical treatment when the surgery was closed.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

We saw no evidence of discrimination when making care and treatment decisions. Our interviews with the GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

The GPs told us they led in specialist clinical areas such as chronic heart disease, epilepsy and palliative care, diabetes, family planning and prescribing. This allowed staff to focus on specific conditions and follow best practice guidelines. The practice employed a nurse co-ordinator who liaises with patients when they were discharged from hospital to help in arranging their care and medication needs. The nurse also supported patients with complex needs and those who received palliative care.

Management, monitoring and improving outcomes for people

The Quality and Outcomes Framework (QOF) is a voluntary performance monitoring tool linked to remuneration. It helps to further improve the quality of health care delivered by practice staff. We found that the latest results were slightly below, comparable and in some cases above the national average.

We saw evidence that clinical audits were carried out and where the results affected patient care this was acted upon. We were shown an ongoing audit that some practices were participating in as part of a CCG initiative. It concerned atrial fibrillation (irregular heart beat) and the potential effects that low dose aspirin had on those patients. The finding would be amalgamated with those of other practices to enable a decision to be made about how those patients should be cared for.

Other audits were carried out such as post complications from a specific contraceptive procedure. The results informed GPs where changes to their procedures may need to be acted upon. We saw that where changes to patient care had been made these were discussed during partners and clinical staff meetings to ensure all relevant staff were made aware of required changes to patient care. We were informed that a further audit would be carried out to review the success rate form the changes made.

Doctors in the practice undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and keep up to date. They also regularly did clinical audits on their results and used these as part of their learning.

Effective staffing

There was an on call GP every day who could be called on to assist with an unexpected high number of requests by patients to be seen on the day. On Mondays and following Bank Holidays there were two GP's on call to cope with excessive demands. This enabled GP's to carry out their home visits as required on the same day.

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending training courses considered essential by the practice such as annual basic life support. All GPs had completed their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

The practice manager showed us the dates when staff had completed their annual appraisal. We saw that some staff had not had their appraisal on time. The practice manager explained this had occurred prior to their appointment and they were working through to ensure that all staff received an appraisal. The appraisal forms informed us that staff identified learning needs from which action plans were documented. We saw that nurse's appraisals were carried

Good

Are services effective?

(for example, treatment is effective)

out by clinical staff so that their practices could be discussed and checked. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example specialist diabetes training for one of the practice nurses.

The dispensary manager had told us that the appraisals for dispensary staff did not include checks on staff's practices.

Working with colleagues and other services

The clinical staff told us there were good working relationships with community professionals. We spoke with two district nurses and a health care assistant. They told us it was 'easy' to speak with GPs and nurses. These staff regularly visited the practice and had a dedicated room with computer access.

A multidisciplinary meeting was held each month. The district nurses told us they attended as well as occupational therapists, the community matron, Macmillan nurses and sometimes hospital consultants. The discussions included patients with long term conditions, housebound patients, palliative care and those considered to be at risk.

There was engagement with other health and social care providers to co-ordinate care and meet patient's needs.

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

For patients who had attended an out of hours service or following discharge from hospital we were told that the respective GP reviewed the information provided to them on a daily basis. A GP told us that if patient's required follow up they would send a request to the patient for them to make an appointment. If necessary a referral would be made to a hospital or physiotherapist.

Consent to care and treatment

We spoke with 12 patients and they all confirmed they felt in control of the care because they had been well informed about their illnesses and treatment options. We saw evidence that patients who had minor surgery at the practice had been properly informed of the risks and benefits of the procedure. We were told that consent forms were signed only after full explanations had been given to patients.

Clinicians were aware of the requirements within the Mental Capacity Act 2005. This was used for adults who lacked capacity to make informed decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity.

They also knew how to assess the competency of children and young people about their ability to make decisions about their own treatments. Clinical staff understood the key parts of legislation of the Children's and Families Act 2014 and were able to describe how they implemented it in their practice. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 years of age who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention

The nurse practitioner had introduced a monitoring system for identifying patients with obesity and how to promote a healthy lifestyle. Practice staff recorded the Body Mass Index (BMI) of all newly registered patients since August 2014. Patients with a BMI of 30+ would be added to the obesity register. This enabled staff to identify those who required support and advice in their weight reduction

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. We saw a variety a of health and welfare information displayed in the waiting areas informing patients about health promotion and prevention.

Practice staff encouraged female patients about the importance of regular cervical screening and leaflets were available in the waiting area for patients to take away with them.

The practice manager told us that all new patients were offered a health check and a review of any prescribed medicines they were taking. There was also opportunity to obtain patients medical histories and family histories. The

Good

Are services effective?

(for example, treatment is effective)

information would include social factors such as, type of employment, smoking and alcohol consumption. We were told that health advice and literature was given to patients as required.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We found that staff upheld and maintained the privacy and dignity of patients. A policy was available in respect of equality and diversity. We observed that when patients arrived staff greeted them in polite and helpful manner All of the 12 patients we spoke with told us staff were friendly and professional towards them. They told us the reception staff were courteous and helpful. Some comments made in the comment cards we received displayed their satisfaction with the way that reception staff greeted them.

Window blinds and privacy screens were in each consulting room. A nurse told us they were always used and the door closed before personal procedures were carried out. Patients we spoke with told us their privacy was always protected.

The practice had a chaperone policy on display in the waiting area and patients told us they were aware of their right to request a chaperone. Clinical staff only were used as chaperones for patients.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private.

The reception desk had a separate desk around a corner where staff could hold confidential conversations with patients. This prevented other patients overhearing potentially private conversations.

We saw that the National Patient Survey results from 2013 informed us that most patients were satisfied with the service they received. For example, 88.4 percent would recommend the practice to other people and patients overall experience was rated as 91.4 percent.

Care planning and involvement in decisions about care and treatment

Patients were given the time they needed and were encouraged to ask questions until they understood about their health status and the range of treatments available to them. The patients we spoke with told us they were able to make informed decisions about their care and they felt in control.

A practice nurse told us they explained tests and treatments to patients before carrying them out and ongoing information was provided during the procedures so that patients knew what to expect.

We saw the practice's consent policy and its guide to the Mental Capacity Act (MCA) 2005. These provided staff with guidance about decisions made in the best interests of patients who lacked capacity to make their own decisions.

We found that appropriate arrangements were in place for patients receiving end of life care, to ensure their wishes were respected. This included decisions about resuscitation and where they wished to die. The practice staff supported carers to care for their relatives receiving end of life care.

Patient/carer support to cope emotionally with care and treatment

The practice was used as a venue for the Halesworth Dementia Support Group and Carers Support Group. These meetings included input from the Alzheimer's Society. The purpose of the group was to help and support carers of people who had dementia. The group had received a positive result from an independent review.

Practice staff notified district nurses when a patient died who they had been visiting. Information about those patients who had died were written on the practice's whiteboard that was not visible by patients. If relatives contacted the practice the reception staff would give them guidance about counselling services that were available and asked if they wished to have an appointment with a GP.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the local population and took appropriate steps to tailor the service to meet their needs. The practice had a significantly higher than average older population group on their list. We were shown the measures the provider had taken to target patients with diabetes and other long term conditions and their regular reviews. Patients were sent reminders to make an appointment for their reviews.

We found that patients with learning disabilities or mental health conditions were offered an annual health review. Patients aged 85 and over were also offered annual health checks. The practice nurses visited housebound patients in their homes to review their care needs and to offer flu vaccinations. Non-residents were seen as temporary patients. The patient information leaflet informed us that all adults were encouraged to have a health check.

There was an active Patient Reference Group (PRG) who interacted regularly with practice staff through the regular meetings they held. PRG's are an effective way for patients and surgeries to work together to improve services and promote quality care. The three members of the PRG we spoke with told us they were going to set up face to face group meetings. We evidenced that improvements had been made as a result of the last patient survey. The report was dated 2013 to 2014. The main area identified for improvements concerned the appointments and repeat prescriptions systems. Few patients were aware of the facility to make appointments and to request repeat prescriptions on line. The practice manager told us they were working on how patients could be informed of this facility.

Practice staff provided a service to three care homes. These homes received weekly visits by a GP and when they were requested to attend.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. People who were not registered at the practice and temporary to the area were seen and treated as temporary patients.

Cutlers Hill Surgery was purpose built. There was easy access for patients with restricted mobility. There were accessible toilet facilities and corridors were wide enough to accommodate wheelchairs. All consulting rooms were located on the ground floor.

When patients whose first language was not English requested an appointment reception staff automatically gave them a double appointment and arranged for a telephone interpreter service. This enabled effective communications and facilitated patients in understanding their health needs. There was also a hearing loop for use by patients who had difficulty hearing.

The practice had equality and diversity policy and staff were aware of it. Patients we spoke with did not express any concerns about their rights or how they were treated by staff.

Access to the service

Appointments were available each weekday mornings from 8am until 7pm Monday to Thursday inclusive and until 6:30pm Fridays. Reception staff told us children would always be seen on the day an appointment was requested.

Comprehensive information was available to patients about appointments on the practice website and in the practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy is in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who

Good

Are services responsive to people's needs?

(for example, to feedback?)

handled all complaints in the practice. The practice leaflet informed patients about how to make a complaint if they needed to and there were separate leaflets about complaints available at the reception desk.

The practice staff had a system in place for handling concerns and complaints. We were shown a summary of the complaints received during the last 12 months. We saw they had been investigated, responded to and there were instances where changes had been made to prevent recurrences. For example, a GP had initially been unable to make telephone contact with a patient discharged from hospital. The patient complained about lack of follow-up. The practice staff put a system in place to ensure all discharged patients received follow-up. Practice staff told us that the outcome and any lessons learnt following a complaint were disseminated to relevant staff and discussed during meetings.

Are services well-led?

Requires improvement

(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 vision to deliver high quality care and promote good outcomes for patients. It was evident that senior staff had continued to search for further areas of improvement on an ongoing basis. For example, the practice manager told us they were planning to carry out a review of the appointments system to ensure it was adequate in meeting patient's needs. The result of the Patient Reference Group (PRG) patient survey had highlighted that few patients were aware of the facility to book appointments on line. Actions to inform patients of this facility were in progress at the time of the inspection. The PRG work with staff in making improvements to the services and act as advocates for patients.

We spoke with 11 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. They told us they were encouraged to make suggestions that led to improved systems and patient care.

Governance Arrangements

We found that arrangements were in place to ensure continuous improvement of the service and the standards of care. The practice manager had introduced new systems of working. For example, a computerised system for identifying patients who did not attend (DNA) their appointments and issuing of further invitations for them to attend. The practice policies and procedures were clear and accessible to staff.

We saw that regular practice meetings were held that enabled decisions to be made about issues affecting the general business of the practice. The minutes of the meetings were recorded and actions that arose from these meetings were clearly set out and reviewed to ensure required changes were made.

There was no clear structure to the governance arrangement of dispensary staff. A GP was the lead for the dispensary but they did not have regular one to one sessions with dispensary staff. The practice manager had been in post for 18 months and acknowledged they had not familiarised themselves with the operations of the dispensary or reviewed the staffing arrangements. There were obvious gaps in communications between the practice manager and the dispensary manager for reporting serious incidents. This shortfall failed to provide assurance to patients and the local clinical commissioning group (CCG) that the service was operating safely and effectively.

There were appropriate governance arrangements for other practice staff. There were clearly identified lead roles for areas such as safeguarding, complaints and incidents. The responsibilities were shared between doctors, nurses and the practice manager.

Leadership, openness and transparency

The feedback we received from patients was positive about the staff at the practice. They said that staff had a professional and respectful approach. Staff could meet with the practice manager whenever they wished. This supported staff to be able to discuss issues and raise concerns.

The practice manager and staff we spoke with articulated the values of the practice. All were confident and knowledgeable when discussing dignity, respect and equality. From speaking with the practice manager and other staff the importance of provision of quality care was evident. Staff members we spoke with described the culture of the organisation as supportive and open. There was no clear strategy in place for the safe management of dispensing of medicines.

Practice seeks and acts on feedback from users, public and staff

The practice had a patient reference group (PRG). The PRG was made up of practice staff and patients that were representative of the practice population. The main aim of the PRG was to ensure that patients were involved with decisions about the quality of the services provided by practice staff. We spoke with three members of the group and they told us they were planning to hold face to face meetings to strengthen the effectiveness of the PRG. The report from the last patient survey dated 2013 to 2014 informed us that patients were happy with the standard of the services they received. The report included direct comments that patients had made. This helped to inform staff of patient's opinions about their experiences. This and the actions identified from the overall results assisted staff in identifying where improvements could be made. For example, patient awareness that they could make on line appointment bookings.

Are services well-led?

Requires improvement

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

The staff we spoke with told us they felt able to express their views to the practice manager and that any suggestions they had for improving the service would be taken seriously.

The practice manager had introduced a schedule for staff appraisals. With the exception of dispensary staff there were effective arrangements in place to manage staff performance.

Management lead through learning & improvement

Staff told us that senior staff supported them to maintain their clinical professional development through training and mentoring. We looked at a range of staff files and saw that regular appraisals took place which included a personal development plan. We saw that the appraisals for dispensing staff did not include checks on their competencies. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice had completed reviews of significant events and other incidents and shared them with staff via meetings to ensure the practice improved outcomes for patients. For example, the GP felt that a blood test could have been carried out earlier to confirm the correct diagnosis, which was different from the diagnosis the hospital had given the patient. The case was discussed at the partner's weekly meeting. As a result the blood test would be carried out routinely to prevent delays in diagnoses.

Although appropriate action had been taken the dispensary manager had not shared serious dispensing errors with the practice manager or the lead GP. This meant they were not investigated as significant events.

The practice manager had systems in place to identify and manage the risks associated with the use of equipment and facilities. Although the premises were clean and tidy there was no auditing of the cleanliness of the environment to protect patients from the risk of infections.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Patients were not protected against the risks associated with the management of medicines because the provider did not have appropriate arrangements in place for the recording, handling, safe keeping and dispensing of medicines.