Kirkley Mill Surgery

Quality Report

Clifton Road,
Lowestoft,
Suffolk,
NR33 0HF
Tel: 01502 532599
Website: http://www.kirkleymillsurgery.co.uk

Date of inspection visit: 17 January 2018
Date of publication: 02/03/2018

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	Not sufficient evidence to rate
Are services safe?	Inadequate
Are services effective?	Not sufficient evidence to rate
Are services caring?	Not sufficient evidence to rate
Are services responsive to people's needs?	Not sufficient evidence to rate
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Kirkley Mill Surgery on 17 January 2018. The surgery was inspected under the previous provider, East Coast Community Healthcare Community Interest Company (ECCH) on 6 June 2017 and rated as inadequate overall, inadequate for providing safe, effective and well led services and requires improvement for providing caring and responsive services and was placed in special measures. The current provider, Suffolk GP Federation became the provider with the support of the Clinical Commissioning Group on 1 November 2017.

We have inspected, but not rated, some key questions because we did not have sufficient evidence to rate. This was because the service had recently been reconfigured and the historical data related to the previous provider.

The key questions are rated as:

Are services safe? – inadequate.

Are services effective? – not sufficient evidence to rate.

Are services caring? – not sufficient evidence to rate.

Are services responsive? – not sufficient evidence to rate.

Are services well-led? - good.

As part of our inspection process, we also look at the quality of care for specific population groups. We have inspected, but not rated population groups, because we did not have sufficient evidence to rate. This was because the service had recently been reconfigured and the historical data related to the previous provider.

Older People – not sufficient evidence to rate.

People with long-term conditions – not sufficient evidence to rate.

Families, children and young people – not sufficient evidence to rate.

Working age people (including those recently retired and students – not sufficient evidence to rate.

People whose circumstances may make them vulnerable – not sufficient evidence to rate.

People experiencing poor mental health (including people with dementia) - not sufficient evidence to rate.

At this inspection we found:

- Suffolk GP Federation became the provider on 1 November 2017. The management team had developed an action plan based on the identified risks, once they had taken over the management of the practice. The Director of Primary Care and Practice Services Director from Suffolk GP Federation were undertaking the practice management role jointly. Clinical governance was overseen by the Medical Director of Suffolk GP Federation and the practice had appointed a clinical lead GP in January 2018 who was based at the practice.

Summary of findings

- Practice staff we spoke with told us that improvements had been made and they felt positive about the future of the practice since Suffolk GP Federation had taken over the management of the practice. They understood that further improvements were required and a plan was in place to continue to address these.
- The practice had an effective system for managing significant events. When they did happen, the practice learned from them, improved their processes and shared the learning with other GP practices.
- An effective process was in place for acting on patient safety and medicine alerts.
- The practice had a plan in place to improve identified safety risks; for example, improved monitoring of patients prescribed high risk medicines, completion of summarising, health and safety risk assessments, infection control and training deemed mandatory by the practice. Not all patients prescribed high risk medicines had been reviewed appropriately before their medicines were re issued. The practice agreed to review the patients identified.
- The practice performance in relation to the Quality and Outcomes Framework (QOF) 2016/2017 was significantly lower when compared to the local Clinical Commissioning Group (CCG) and national averages. The practice was aware of this and shared their performance data for 2017/2018 (unverified) and their plans to continue to improve the coding of patients and their QOF achievement.
- The practice had commenced a programme of quality improvement and had completed eight single cycle audits, although we identified four patients where risks had not been follow up on. The practice agreed to review the patients identified.
- Staff had not all received training deemed mandatory by the practice, for example safeguarding children and vulnerable adults, infection control, basic life support and anaphylaxis and fire safety. The practice had established a training matrix, which included locum GPs and had started to identify where the gaps in staff training were. They were planning face to face training for staff to ensure all staff were up to date. The practice was aware of the need to update the locum information pack.
- Staff involved and treated people with compassion, kindness, dignity and respect. All of the patients and patient representatives we spoke with and received comments from gave positive responses in this area. Information from the July 2017 national GP patient survey showed the practice was below average for its satisfaction scores on consultations with GPs.
- Patients we spoke with found the appointment system easy to use and reported that they were generally able to access care at the right time, although two patients felt continuity of GPs could be improved. The practice was auditing the appointment system.
- Policies and procedures were in place, however staff were not always confident in how to access them and which policies to follow, as some of the policies from the previous provider were still available.
- Staff we spoke with said they felt supported by the new management team, were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure care and treatment is provided in a safe way to patients.

The areas where the provider **should** make improvements are:

- Continue to increase the uptake of annual health checks for patients with a learning disability.
- Formally review the work undertaken by advanced nurse practitioners to obtain assurance of the quality of their work.
- Continue with plans to have Suffolk GP Federation policies and procedures in place and easily accessible for all staff.

This service was placed in special measures in June 2017. Suffolk GP Federation became the provider on 1 November 2017. We have inspected, but not rated, some key questions because we did not have sufficient evidence to rate. The practice will remain in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of

Summary of findings

preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

Special measures will give people who use the service the reassurance that the care they get should improve.

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

Kirkley Mill Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and included a GP specialist adviser and a practice manager specialist advisor.

Background to Kirkley Mill Surgery

- The name of the registered provider is Suffolk GP Federation. The practice address is Clifton Road, Lowestoft, Suffolk, NR33 0HF.
- Suffolk GP Federation became the provider with the support of the commissioners on 1 November 2017.
- The practice is registered to provide diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury.
- The practice has an alternative primary medical services (APMS) contract with the Great Yarmouth and Waveney Clinical Commissioning Group (CCG).
- There are approximately 6,350 patients registered at the practice.
- The practice website is http://www.kirkleymillsurgery.co.uk
- The practice is based on the ground floor and first floor of a building which is shared with another provider. There is lift access to the first floor. The management, clinical, reception and administration staff are based in different areas of the building.
- The practice has five GP locum staff (four male and one female) and one salaried GP (male). The salaried GP is the clinical lead and commenced in post in January 2018. The nursing team includes one advanced nurse practitioner (female) and two locum advanced nurse practitioners (male), one mental health nurse, two practice nurses, one healthcare assistant and one behavioural lifestyle coach. The Director of Primary Care and Practice Services Director from Suffolk GP Federation are currently undertaking the practice management role jointly. There is a team of ten reception and administration staff and a practice administrator.
- The practice serves patients living in one of the most deprived wards in Lowestoft. The overall deprivation decile is one, which indicates areas with the most deprivation. The practice demography is broadly similar to the CCG and England average. However, there are more male patients aged 25 to 34, 40 to 44 and 50 to 59 than the CCG and England average. There are less female patients aged 5 to 15 and aged 30 to 59. Male and female life expectancy in this area is lower than the England average at 76 years for men and 81 years for women.

Inadequate

Are services safe?

Our findings

We rated the practice, and all of the population groups, as inadequate for providing safe services. The practice was rated as inadequate for providing safe services because:

- We found that two patients prescribed high risk medicines were not reviewed appropriately before these were re issued. We identified 23 patients who were prescribed an angiotensin-converting-enzyme (ACE) inhibitor and who had not received appropriate blood monitoring. A significant number of patient's notes had not been summarised. Work had started but needed to continue to ensure that patients were coded appropriately. Clinical staff had not all completed basic life support and anaphylaxis, safeguarding and infection control training appropriate to their role.

Safety systems and processes

The practice had some systems to keep people safe and safeguarded from abuse; however these needed to be embedded into practice.

- The practice had safety policies which were regularly reviewed and available to staff. Staff received safety information for the practice as part of their induction. The practice had systems to safeguard children and vulnerable adults from abuse and was working with the safeguarding team to further improve these systems. Safeguarding children and safeguarding vulnerable adult policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. There was a lead and deputy lead member of staff for safeguarding.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment Disclosure and Barring Service (DBS) (DBS
- Staff had not all received up-to-date safeguarding training appropriate to their role and deemed mandatory by the practice. Two clinical staff had not received safeguarding children training to the appropriate level and one clinical and one non-clinical staff member had not received safeguarding adults training. The practice was aware of this and training had been booked. Staff we spoke with knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check before they were able to chaperone.
- There was a system to manage infection prevention and control. There was a lead nurse for infection control, who had undertaken infection control training and were aware of sources of information and support. An external infection control audit was completed in January 2018 and we saw evidence that some of the identified actions had been completed. For example, needle stick injury posters had been displayed in clinical rooms. The practice was aware of the hepatitis B immunity of clinical staff who were responsible for the cleaning of spilt body fluids. Five clinical staff had not received infection control training. The practice was aware of this although training had not been booked. Cleaning schedules were in the process of being agreed with the cleaning company. The practice planned to establish internal infection control audits.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. This included the purchase of new equipment for locums.
- There were systems for safely managing healthcare waste within the practice. We noted that two clinical waste storage bins were still not lockable, which was raised with the previous provider at the 6 June 2017 inspection. We raised this with the current provider who immediately contacted the organisation responsible and we were advised that these would be replaced at the next collection.

Risks to patients

There were some systems to assess, monitor and manage risks to patient safety. The practice had identified and was in the process of implementing and reviewing systems to assess, monitor and manage risks to patient safety.

- A home visit policy was in place which staff implemented. Requests for home visits were triaged by a clinician and guidance was in place for staff to follow to ensure patients at risk were identified and referred to a clinician appropriately. The practice had undertaken two home visit audits and continued to review and

improve the arrangements. Currently home visit requests were triaged by the duty GP and allocated to another GP to visit. This ensured that the duty GP was available at the practice.

- The practice was continuing to enhance their system for dealing with clinical pathology letters and tasks. These were checked at the end of the day by the clinical lead GP and the Director of Primary Care to ensure that these had all been actioned. At the time of the inspection there were no pathology letters or tasks outstanding.
- GPs were responsible for deciding the appropriate coding for patients. Read code training had been organised for staff for 25 January 2018. Work was planned to improve the consistency of codes used and Suffolk GP Federation coding protocol was going to be introduced, once the training had been completed.
- Some actions had been undertaken in relation to summarising patient's notes. Approximately 3,000 patients had transferred from another practice in April 2017 and their notes still required summarising when Suffolk GP Federation became the provider of the practice. The practice had increased the hours of the summariser and had advertised a fixed term vacancy for an additional summariser. At the time of the inspection, the practice had summarised 144 of these patients' notes since becoming the provider of the practice.
- The practice had completed two appointment access audits in November and December 2017 to assess the number and mix of clinical staff needed. They planned to complete this again in January 2018 before any adjustments were made to staffing.
- There was an induction system for staff, which included temporary staff. This was standardised for all staff and had been delivered when Suffolk GP Federation became the provider. Information folders were available for locum staff; however these were incomplete and not up to date. The practice was aware of this and had plans to review the induction process for locums at the practice.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was made available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Appropriate and safe use of medicines

The practice had some systems for appropriate and safe handling of medicines.

- We reviewed a sample of the care records of patients prescribed high risk medicines such as methotrexate, warfarin and lithium. These medicines required regular monitoring. Appropriate monitoring was in place for most patients we reviewed. However we identified two patients, one prescribed warfarin, and one prescribed lithium, who were overdue their blood monitoring. We raised this with the provider, who advised they would ensure these identified patients were reviewed as a priority.
- We identified 23 patients who were prescribed an angiotensin-converting-enzyme (ACE) inhibitor and who had not received appropriate blood monitoring.
- The systems for managing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance.

Track record on safety

Suffolk GP Federation had been managing the practice since 1 November 2017 so evidence was not available to demonstrate their track record. Some systems were in place which enabled the practice to monitor and review activity; however other systems needed to be embedded.

- The practice had met with the health and safety lead from the National Health Property Services, who manage the building where the practice is based. Checks were being undertaken by an external company, which included for example, legionella (Legionella is a term for a particular bacterium which can contaminate

water systems in buildings). During a recent check, legionella was found to be in one of the taps in another part of the building. The practice took appropriate action in response to this.

- The fire risk assessment for the building was completed in May 2017. The practice advised that regular tests on fire alarms and emergency lighting were undertaken by an external company. The practice was not sure how many staff had completed fire safety training so were arranging for this training to be delivered to all staff. A fire evacuation had not been organised, however the need for this had been identified.
- The practice had not undertaken a health and safety risk assessment for their staff. They were aware of the need to do this.
- The practice monitored and reviewed activity and escalated risks to the integrated governance meetings. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. The practice had recorded five significant events since 1 November 2017.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons identified themes and took action to improve safety in the practice and in the other services which they provided where appropriate. For example following a breach of patient confidentiality, information governance restrictions were established on the patient computer system; these were shared and implemented in the other practices managed by Suffolk GP Federation.
- The practice learned from external safety events and patient safety alerts. There was a system for recording and acting on new patient safety alerts, which the practice had established since managing the practice.

Not sufficient evidence to rate

Are services effective?

(for example, treatment is effective)

Our findings

We have inspected, but not rated whether services were effective, because we did not have sufficient evidence to rate. This was because the service had recently been reconfigured and the historical data related to the previous provider.

Effective needs assessment, care and treatment

- The practice had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians generally assessed needs and delivered care and treatment in line with current legislation, standards and guidance. However, we identified three patients who were prescribed combinations of medicines which did not follow evidence based guidelines. The practice advised that they would review these patients urgently. Following the inspection the practice confirmed that these patients had been reviewed and a system was in place to identify other patients who may be affected.
- Patients received a full assessment of their needs. This included their clinical needs and their mental and physical wellbeing.
- The practice's rate for hypnotic prescribing and antibacterial prescribing was below the CCG and national averages. The practice's rate for prescribing broad spectrum antibiotics was above the CCG and national averages. In December 2017, the practice had audited their antibiotic prescribing for the previous three months. Their prescribing of broad spectrum antibiotics was 6.8%, which was an improvement, as it was previously 7.3%. They planned to continue auditing this every three months.
- We saw no evidence of discrimination when making care and treatment decisions in the records we viewed.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse. Two of the five patients we spoke with felt this had happened in relation to their needs; the other three patients stated that this did not happen.

Older people:

- Nationally reported Quality and Outcomes Framework (QOF) data showed that outcomes for patients for conditions commonly found in older people, including dementia, osteoporosis and heart failure were in line with the local and national averages. The outcomes for patients with rheumatoid arthritis were below local and national averages. The practice achieved 17% for patients with rheumatoid arthritis compared with the CCG average of 74% and the national average of 96%. 2017/2018 unverified data showed the practice had achieved 57% so far.
- There was some high exception reporting in some of the sub indicators for dementia and heart failure; For example, 73% of patients with dementia had their care plan reviewed in a face to face meeting compared to the CCG average of 80% and the national average of 84%. The exception reporting was 37% compared with the CCG average of 9% and the national average of 7%.
- There was some low exception reporting for the sub indicators for heart failure and osteoporosis; for example, 100% of patients with heart failure were treated with two appropriate medicines, compared with the CCG and national average of 99%. The exception reporting was 0%, compared with the CCG average of 18% and the national average of 15%.
- GPs and nursing staff provided home visits to patients who lived in the one care home covered by the practice. Feedback we received was positive in relation to the responsiveness of staff to urgent visit requests and the care and treatment received.
- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- GPs followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra or changed needs. A pharmacist reviewed their medicines.

People with long-term conditions:

- Nationally reported data showed that outcomes for patients with long term conditions, including asthma and atrial fibrillation were in line with the local and national averages. The outcomes for patients with diabetes, chronic obstructive pulmonary disease (COPD) and hypertension were below local and national averages. The practice achieved 59% for diabetes, compared with the CCG average of 77% and the national average of 91%.They achieved 47% for COPD, compared with the CCG average of 80% and the national average of 96%. For hypertension, they achieved 65% compared with the CCG average of 81% and the national average

Not sufficient evidence to rate

Are services effective?

(for example, treatment is effective)

of 97%. 2017/2018 unverified data showed the practice had achieved 31% for diabetes, 39% for COPD and 57% for hypertension so far. The practice had established a process to identify patients who were due for review and had scheduled additional nursing staff in January and February to start to address the lower than average achievement.

- There was some high exception reporting in some of the sub indicators for asthma, COPD and diabetes; for example, 77% of patients with asthma, on the register had had a review in the preceding 12 months compared to the CCG average of 75% and the national average of 76%. The exception reporting was 38% compared with the CCG average of 15% and the national average of 8%. The exception reporting was system generated based on diagnosis date and patient registration date and not due to patient dissent.
- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. They were recalled in their month of birth. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of people with long term conditions had received specific training.
- 91% of patients with long term conditions, who were recorded as current smokers had received discussion and advice about smoking cessation. This was in line with the CCG average of 94% and national average of 95%.
- Families, children and young people:
- The practice was establishing systems to identify and follow up children living in disadvantaged circumstances and who were at risk. Work was planned with other health and social care services to ensure that the data was current and accurate.
- We saw positive examples of joint working with other professionals, including health visitors and social workers.
- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above. For example, rates for the vaccines given to two year olds ranged from 94% to 96% and for five year olds from 90% to 97%. Appropriate follow up of children who did not attend for their immunisations were in place, although this was based on custom and practice. A policy was not in place to support this process. We raised this with the practice who agreed to write a policy.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 56%, which was below the 80% coverage target for the national screening programme. 2017/2018 unverified data showed some improvement. Appropriate follow up of patients who did not attend for their cervical screening appointment was in place. The practice sent a third reminder on pink paper to encourage attendance. A written policy was not in place to support this process.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks which included new patient checks and NHS checks for patients aged 40 to 74. 532 health checks had been offered in the previous 12 months and 89 had been completed. A further 821 were eligible and plans were in place to invite them. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- Annual health assessments for people with a learning disability were undertaken by the practice nurse and healthy lifestyle behaviour coach, who had attended additional training to undertake this work. The practice nurse and healthy lifestyle behaviour coach visited patients with a learning disability who lived in a care home to increase the uptake of these reviews. The practice had 82 patients on the learning disabilities register; 47 of these patients had received a health review in the previous 12 months.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

Not sufficient evidence to rate

Are services effective?

(for example, treatment is effective)

People experiencing poor mental health (including people with dementia):

- 73% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months. This compared to the CCG average of 80% and the national average of 84%. The exception reporting was 37% compared with the CCG average of 9% and the national average of 7%.
- 32% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was significantly below the CCG average of 89% and the national average of 90%. 2017/2018 unverified data showed the practice had achieved 79% so far.
- 71% of patients who experienced poor mental health had received discussion and advice about alcohol consumption, which was below the CCG average of 88% and the national average of 91%.
- The practice had employed a mental health nurse, since they became the provider for the practice. The mental health nurse was a non-medical prescriber and worked four days a week. They provided assessment and treatment for patients with mental health needs. The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health. The nurse attended multi-disciplinary team meetings as appropriate.

Monitoring care and treatment

The practice had developed a programme of quality improvement activity and implemented a plan to routinely review the effectiveness and appropriateness of the care provided. Since November 2017, when Suffolk GP Federation became the provider, they had completed eight single cycle audits. These included for example, referrals, palliative care, antibiotic prescribing and home visits. These were planned to be repeated every three months. One of the clinical audits we looked at reviewed two week referrals for suspected cancer. We identified that one patient was recorded as not having attended, but there was no action taken in response to this. The practice advised that they would review this patient urgently. Following the inspection the practice confirmed that this patient had attended.

A further ten clinical audits had been identified, for example, infection control, scanning, accident and emergency reductions and contraceptive reviews. The plan to drive improvement through clinical audit needed to be embedded and the changes monitored. Where appropriate, clinicians took part in local and national improvement initiatives.

The most recent published Quality Outcome Framework (QOF) results were 77% of the total number of points available compared with the clinical commissioning group (CCG) average of 81% and national average of 95%. The overall exception reporting rate was 17% compared with the CCG average of 13% and the national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.) The practice was aware of this information and had prioritised work to improve patient coding initially. 2017/2018 unverified data showed that the practice had achieved 59% so far.

Effective staffing

- The majority of staff at the practice received induction training on 1 November 2017, when Suffolk GP Federation became the provider. Suffolk GP Federation was in the process of reviewing the training needs of all the staff in order that they could provide protected time and training to meet the identified needs appropriately. Up to date records of skills, qualifications and training were being established. We checked the records of staff whose role included immunisation and taking samples for the cervical screening programme and saw they had received specific training and could demonstrate how they stayed up to date.
- Staff were encouraged and given opportunities to develop. For example the lead nurse for infection control was planning to attend infection control meetings. Relevant staff had been booked onto a non-medical prescriber study day. Evidence was limited due to the short time Suffolk GP Federation had been responsible for the practice.
- Staff from Suffolk GP Federation had undertaken a one to one meeting with all staff members in the week before they became the provider. In order to support and develop staff, an appraisal meeting has been scheduled for March/April 2018 to review their work and agree a personal development plan.

Not sufficient evidence to rate

Are services effective?

(for example, treatment is effective)

- The practice did not have a system to ensure the competence of all staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing. However, this was in place for the mental health nurse, who had monthly supervision with a Psychiatrist at Norfolk and Suffolk Foundation Trust. Outcomes from supervision were shared with the clinical lead.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff supported patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives and patients at risk of developing a long-term condition.
- The practice employed a healthy lifestyle behaviour coach, who supported patients to improve their health, by support and advice, for example in relation to healthy eating, smoking cessation, lifestyle advice and alcohol addiction. Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns.
- 66% of females between the ages of 50 and 70 had been screened for breast cancer in the preceding 36 months, compared to the CCG average of 77% and national average of 73%.
- 49% of patients aged between the ages of 60 and 74 had been screened for bowel cancer in the preceding 30 months. This was below the CCG average of 61% and national average of 59%.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and told us they recorded a patient's mental capacity to make a decision.
- Clinical staff we spoke with were not able to find any policies on consent, although they said they would seek advice from a GP if they had any concerns.

Not sufficient evidence to rate

Are services caring?

Our findings

We have inspected, but not rated whether services were caring, because we did not have sufficient evidence to rate. This was because the service had recently been reconfigured and the historical data related to the previous provider.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural and social needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- In relation to being treated with kindness and respect, all of the 24 patient Care Quality Commission comment cards we received were positive about the service experienced. This is in line with the feedback we received from patients we spoke with.

Results from the July 2017 national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 297 surveys were sent out and 108 were returned. This represented a 36% completion rate. The practice was below average for its satisfaction scores on consultations with GPs and comparable to the CCG and national averages for nurses. For example:

- 78% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 79% of patients who responded said the GP gave them enough time compared with the CCG average of 88% and the national average of 86%.
- 84% of patients who responded said they had confidence and trust in the last GP they saw compared with the CCG average of 96% and the national average of 95%.
- 77% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared with the CCG average of 87% and the national average of 86%.
- 88% of patients who responded said the nurse was good at listening to them compared with the CCG average of 93% and the national average of 91%.
- 92% of patients who responded said the nurse gave them enough time compared with the CCG average of 94% and the national average of 92%.
- 97% of patients who responded said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 94% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared with the CCG average of 92% and the national average of 91%.
- 88% of patients who responded said they found the receptionists at the practice helpful compared with the CCG average of 88% and the national average of 87%.

The practice was aware of this data and had a plan to improve the satisfaction scores.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard:

- Interpretation services were available for patients who do not have English as a first language.
- Staff communicated with people in a way that they could understand, for example, easy to read information was used to invite patients with a learning disability to an annual review.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice identified patients who were carers, through asking patients who were registering at the practice. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 85 patients as carers (1.3% of the practice list). Staff we spoke with told us they would signpost to the Solutions service who could support patients who were carers. Solutions was a service based at the practice two days a week, which signposted and supported patients to access appropriate support services.

Not sufficient evidence to rate

Are services caring?

In the event of a bereavement staff we spoke with said they would signpost patients to bereavement services or to the Solutions service.

Results from the national GP patient survey were in line with or below local and national averages in relation to patients' involvement in planning and making decisions about their care and treatment.

- 80% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 89% and the national average of 86%.
- 67% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and the national average of 82%.
- 93% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 92% and the national average of 90%.
- 89% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 88% and the national average of 85%.

In relation to being involved in decision about their care and treatment, all of the 24 patient Care Quality Commission comment cards we received were positive about the service experienced. Two of the five patients we spoke with said they were not supported to understand their care and treatment options and four of the five patients we spoke with told us they were not involved in planning their own care and treatment.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- The practice complied with the Data Protection Act 1998.

Not sufficient evidence to rate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We have inspected, but not rated whether services were responsive, because we did not have sufficient evidence to rate. This was because the service had recently been reconfigured and the historical data related to the previous provider.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences and tried to meet these where possible.

- The practice was aware of the needs of its population and planned to consider if improved services could be offered in response to those needs. For example online services such as repeat prescription requests, advanced booking of appointments and accessing medical records were available, although the practice planned to review whether other services could be offered.
- The facilities and premises were appropriate for the services delivered to patients.
- The practice made reasonable adjustments when people found it hard to access services. For example, the practice could be accessed by wheelchair, automatic doors were used at the entrance to the practice and a lift was available to enable patients to access the first floor.
- Care and treatment for patients approaching the end of life and those with mental health needs was coordinated with other services.
- A service called Solutions was based at the practice twice a week. They offered 45 minute appointments with patients who could self-refer, to sign post and support patients with a wide range of needs which included for example, social, housing and financial needs.

Older people:

- All patients had a named GP.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- GPs and clinical staff provided home visits to patients who lived in the one care home covered by the practice.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple long term conditions were reviewed at one appointment, where the nurse was skilled in these areas.
- A specialist diabetes team held a clinic at the practice every six weeks to review patients with complex diabetes.

Families, children and young people:

- The practice was establishing systems to identify and follow up children living in disadvantaged circumstances and who were at risk. Work was planned with other health and social care services to ensure that the data was current and accurate.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- We saw that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students):

- The needs of these populations had been identified and the practice were reviewing how they may be able to further adjust the services it offered to ensure these were accessible, flexible and offered continuity of care. Currently appointments were offered at the beginning or end of the day for patients who were unable to attend during normal working hours.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The practice offered online services such as repeat prescription requests, access to medical records and advanced booking of appointments as well as health promotion and screening that reflects the particular needs for this age group.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances which included those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.

Not sufficient evidence to rate

Are services responsive to people's needs?

(for example, to feedback?)

- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

People experiencing poor mental health (including people with dementia):

- The practice employed a mental health nurse who was a nonmedical prescriber, four days a week. They visited patients in their own home and at the local mental health team base to improve the uptake of health checks and reviews. They also provided face to face counselling at the practice.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- A shared care agreement with Norfolk and Suffolk Foundation Trust was in place for patients to be reviewed and prescribed treatment initiated in secondary care.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Three of the five patients we spoke with told us that waiting times and delays were not always managed well.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 national GP patient survey showed that patients' satisfaction with how they could access care and treatment was generally in line with local and national averages. 297 surveys were sent out and 108 were returned, which was a 36% response rate.

- 73% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 80% and the national average of 76%.
- 80% of patients who responded said they could get through easily to the practice by phone compared with the CCG average of 77% and the national average of 71%.
- 83% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 88% and the national average of 84%.
- 81% of patients who responded said their last appointment was convenient compared with the CCG average of 84% and the national average of 81%.
- 67% of patients who responded described their experience of making an appointment as good compared with the CCG average of 75% and the national average of 73%.
- 47% of patients who responded said they don't normally have to wait too long to be seen compared with the CCG and the national average of 58%.
- The practice had completed two appointment access audits in November and December 2017. In November 2,399 appointments were available; 998 with a GP, 686 with an advanced nurse practitioner (ANP) and 713 with a non-prescribing clinician. Of these appointments, 74 GP, 83 ANP and 134 non-prescribing clinician appointments had not been used. In December 2017, 1,941 appointments were offered which included 900 GP, 713 ANP and 328 non-prescribing clinician appointments. Of these appointments, 151 GP, 177 ANP and 49 non-prescribing clinician appointments had not been used. The audit was planned to run for another month before any adjustments to staffing were made.

Listening and learning from concerns and complaints

- Information about how to make a complaint or raise concerns was available and it was easy to do this. Staff told us they would treat patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice had not received any complaints since 1 November 2017, when they started providing the service at Kirkley Mill Surgery.
- The practice had a system in place to acknowledge, investigate, respond to and learn from individual and also from . This was managed by the Governance Manager at Suffolk GP Federation. We were not able to evidence that the practice acted as a result to improve

Not sufficient evidence to rate

Are services responsive to people's needs?

(for example, to feedback?)

the . However we saw that complaints were discussed at the primary care review meetings between the GP practices managed by the Suffolk GP Federation and a process was in place to share any learning.

Are services well-led?

Good

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

Our findings

We rated the practice as good for providing well led services.

Suffolk GP Federation has made progress in the short period of time since they became the provider on 1 November 2017. They were aware of the risks to patients and had prioritised and addressed some of these already. A clinical lead GP had been appointed in January 2018 who was based at the practice. Clinical governance was overseen by the Medical Director of Suffolk GP Federation. Practice staff we spoke with told us that improvements had been made and they felt positive about the future of the practice since Suffolk GP Federation had become the provider.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Staff told us that the felt the leadership at the practice had improved and would continue to improve with the appointment of the GP clinical lead.Leadership and clinical support was in place from Suffolk GP Federation to develop the practice and the new GP clinical lead. Suffolk GP Federation were keen to have the staff at the practice based in one area so that improvements could be made to team working.
- Suffolk GP Federation shared its values at the induction training, held with the new staff team on the first day they became the provider. Staff we spoke with had some awareness of the values.
- There was a practice action plan which identified the risk areas, issues and actions to address these. Outcomes were identified and actions and progress was monitored.
- The strategy was in line with health and social priorities across the region.

Vision and strategy

Suffolk GP Federation had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients. They were establishing new, and improving existing systems in place at Kirkley Mill Surgery to enable this for the patients registered at the practice.

- Suffolk GP Federation shared its values at the induction training, held with the new staff team on the first day they became the provider. Staff we spoke with had some awareness of the values.
- There was a practice action plan which identified the risk areas, issues and actions to address these. Outcomes were identified and actions and progress was monitored.
- The strategy was in line with health and social priorities across the region.

Culture

There was a willingness for staff to improve the services provided at the practice. Staff we spoke with were positive about the changes that had occurred and those that were planned.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice planned to establish an operation group which was made up of representatives from each area of the practice. This was planned to encourage improved communication, understanding and ownership of issues and solutions between the teams within the practice. This is based on a successful model used in two other GP practices managed by the Suffolk GP Federation.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- Suffolk GP Federation was in the process of establishing systems to identify and monitor that staff had received training and support appropriate to their role. Staff had received a one to one support session and appraisal meetings had been set up in March and April 2018.

Are services well-led?

Good

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

- All staff were considered valued members of the practice team. Clinical staff were given protected time for professional development and evaluation of their clinical work.

Governance arrangements

Suffolk GP Federation had clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were established, however these needed to be embedded at the practice.
- The majority of staff told us they were clear on their roles and accountabilities, although there was limited clinical oversight to ensure staff were working within their competence and to agreed policies. Some processes did not follow an agreed written policy, for example responding to patients who did not attend for their appointment. The work undertaken by advanced nurse practitioners was not formally reviewed to obtain assurance of the quality of their work**.**
- A number of policies and procedures were in place and the practice had set up a separate folder on each computer where their policies were stored. However staff were not always confident in how to access them and which policies to follow, as some of the policies from the previous provider were still available. The practice had identified the need to ensure that policies were in place and easily accessible to staff.
- There were a number of staff with identified lead roles, for example safeguarding, infection control, and information governance. Staff we spoke with were aware of the staff members with these lead roles.

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

- There was an effective process to identify, understand, monitor and address current risks, which included risks to patient safety. A number of risks had been identified and an action plan was in place which was regularly monitored.
- Practice leaders had oversight of medicine and safety alerts, incidents, and complaints.
- A number of clinical audits had been completed and others had been identified. There was a schedule in place for when clinical audits would be repeated. Although some actions had been taken as a result of single cycle clinical audits, one audit identified a patient who did not attend a two week cancer referral appointment and this had not followed up. The practice agreed to action this.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any weaknesses.
- The practice submitted data or notifications to external organisations as required.
- There were effective arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, staff and external partners, to support high-quality sustainable services.

- A range of staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example Suffolk GP Federation engaged with the Clinical Commissioning Group, had met with each staff member individually in the week before they started managing the practice and during induction training on the first day. Staff and external partners we spoke with expressed positive views in relation to the engagement of Suffolk GP Federation.
- Suffolk GP Federation wrote a patient newsletter in November 2017, to inform patients about the change in the management of Kirkley Mill Surgery.
- Results from the Friends and Family test for the month of December 2017 showed of the five responses, four patients were extremely likely or likely to recommend

Are services well-led?

Good

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

the practice and one was unlikely to recommend the practice. The practice noted the comments that were fed back through this system and took action to address any issues raised.

- The practice was in the process of establishing a patient participation group to ensure that patient views and feedback was included in the future development of the practice.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

Suffolk GP Federation had systems and processes in place for learning, continuous improvement and innovation, these needed to be established and embedded at the practice.

- The practice made use of internal and external reviews. Learning was shared and used to make improvements.
- A service called Solutions was available in the practice two days a week. They offered 45 minute appointments with patients who could self-refer, to sign post and support patients with a wide range of needs which included for example, social, housing and financial needs. The practice funded this service one day a week.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • We identified two patients on high risk medicines who had not been reviewed appropriately before these were re issued. • We identified 23 patients prescribed an ACE inhibitor who had not been reviewed appropriately before these were re issued. • We identified four patients where identified risks had not been actioned. Three patients were prescribed combinations of medicines which were not in line with evidence based guidelines. One patient identified as not attending an appointment for a two week wait referral appointment for suspected cancer, had not been followed up. • Patients were not all coded appropriately or consistently. Staff had not received training on read coding and a policy was not in place, although these were planned. • We found a large number of patient notes that had not been summarised. • We found two members of clinical staff had not completed safeguarding children training appropriate to their role. Four clinical staff had not completed basic life support training and anaphylaxis training. • The practice did not meet the requirements as detailed in the Health and Social care Act 2008; Code of Practice for health and adult social care on the prevention and control of infections and related guidance. Five clinical staff had not received infection control training. Clinical waste was not stored securely.