Kirkley Mill Surgery

Quality Report

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Date of inspection visit: 1 June 2017
Date of publication: 20/07/2017

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

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 1 June 2017. Overall the practice is rated as inadequate. Our key findings across all the areas we inspected were as follows:

- There was a system in place for the recording and reporting of significant events. However, learning from significant events was not always shared with staff.
- There was no effective system in place for receiving, sharing and actioning patient safety alerts.
- Policies and procedures for safeguarding children and vulnerable adults were in place, and staff were aware of these. Not all staff had received safeguarding training appropriate to their role, and not all GPs had the correct permissions in place on the computer system to ensure they were aware of patients with current safeguarding needs.
- Health and safety risks to patients and staff were assessed and monitored, however there was no evidence that fire drills had been undertaken.
- We found the practice was clean and tidy and procedures were in place for infection prevention and control. However, the infection control lead had not completed any specific training to undertake this role. The record of staff hepatitis B immunity was incomplete and the lock on one of the external clinical waste bins was broken.
- We reviewed patients who were prescribed high risk medicines. They had not all been reviewed in a timely manner before their medicines had been reissued.
- There was no effective system in place for dealing with clinical pathology results in a timely manner and the practice did not use an agreed and consistent coding system for patient's medical records.
- Clinical staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment to patients; however evidence based guidance was not always being followed.
- The arrangements for triaging requests for home visits were undertaken by non-clinical staff, without written guidance or clinical oversight.

Summary of findings

- There was limited evidence of quality improvement including clinical audit.
- The practice did not hold regular multi disciplinary meetings and did not ensure that relevant information was shared with other services. The practice planned to hold multi disciplinary meetings, however these had not commenced at the time of the inspection.
- Some areas of the practice performance were insufficiently understood and supported to ensure safe and effective care and treatment for patients.
- A process was in place for receiving, investigating and responding to complaints. Information on how to escalate a complaint was not provided to complainants in response letters; however the practice had included this in their new information leaflet, which was being printed. Improvements were made to the quality of the service provided as a result of complaints and concerns; however actions taken were not shared with all staff to encourage learning.
- A healthy lifestyle behavioural coach worked at the practice and feedback from patients on this service was very positive.
- Most patients reported being treated with compassion, dignity and respect and involved in decisions about their care and treatment. Patients were able to make an appointment with a GP although there was not always continuity of care.
- The results from the national GP patient survey showed the practice was generally performing below CCG and national averages. The practice did not have a Patient Participation Group (PPG).
- We found there was a lack of overall clinical leadership and oversight at the practice.

The areas where the provider must make improvement:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider should make improvement are:

- Offer health reviews to patients with a learning disability.
- Ensure that information about the complaints policy is available for patients and includes information about how to take action if a complainant is dissatisfied with the response.
- Continue with plans to start a Patient Participation Group in order to obtain patient feedback and engagement with the practice and act on this feedback to improve patient satisfaction.

Since our inspection Great Yarmouth and Waveney Clinical Commissioning Group (CCG) and East Coast Community Healthcare Community interest Company (ECCH) have taken significant action in response to our findings. We have been provided with evidence to demonstrate that immediate actions have been undertaken and assurance from the CCG that all identified actions will be completed to minimise the risk to patients.

I am placing this service 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 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.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services.

- There was a system in place for reporting and recording significant events, however the learning from significant events was not shared to minimise the risk of reoccurrence.
- We were told that patient safety alerts were logged, shared and searches were completed. However, we could not be assured this process was effective as we conducted a small number of searches and found 36 patients who were on combinations of medicines identified in Medicines and Healthcare Products Regulatory Agency (MHRA) alerts who had not been reviewed.
- Patients on high risk medicines were identified but they were not all monitored appropriately before medicines were reissued.
- When things went wrong patients received reasonable support, detailed information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had some systems, processes and practices in place to keep patients safe and safeguarded from abuse. However not all locum GPs had been set up to be able to view the safeguarding records in the patients medical records and not all staff had received safeguarding training appropriate to their role.
- We found the practice was clean and tidy and procedures were in place for infection prevention and control. However, the identified lead for infection control had not received specific training to undertake this role. The record of staff hepatitis B immunity was incomplete and the responsibility for cleaning spilt body fluids was unclear. The lock on one of the external clinical waste bins was broken.
- Health and safety risks to patients and staff were assessed and managed. However fire drills had not been carried out.
- Clinical risks to patients were not always assessed and well managed. For example clinical letters and pathology results were not all reviewed in a timely manner and the practice did not use an agreed and consistent coding system for patients' medical records.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services.

Summary of findings

- Data from the Quality and Outcomes Framework (QOF) showed varied results. Some patient outcomes were in line with the Clinical Commissioning Group (CCG) and England averages. However other outcomes were below these averages. The exception reporting rate was above the CCG and England average in all of the clinical domains, apart from heart failure. 2016/2017 unverified data from the practice showed that performance in some areas had significantly deteriorated, however the exception reporting had improved. The practice had reviewed their QOF performance and had identified actions to understand and improve their data.
- Clinical staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment to patients. However patients' needs were not always assessed in a timely manner or by an appropriate clinician and the practice did not monitor that National Institute of Clinical Excellence (NICE) guidelines were always implemented.
- The practice had 84 patients on the learning disability register. Six of these patients have had a health review since April 2016.
- There was limited evidence of quality improvement including clinical audit. The practice could not evidence any completed single cycle or clinical audits that had been re-run to monitor and improve outcomes for patients.
- The practice did not hold regular multi disciplinary meetings and effective processes were not in place to ensure that any relevant information was shared with other services.
- There was evidence of appraisals for staff.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services.

- Data from the national GP patient survey, published in July 2016, showed patients rated the practice below other practices both locally and nationally for all aspects of care.
- The majority of patients we spoke with and received comments from reported that they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. However two patients commented negatively about the poor bedside manner of one member of staff.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Summary of findings

- The practice had identified 76 patients as carers (1.2% of the practice list). An advisor came to the practice twice a week to signpost patients to other services and organisations, which included support for carers.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services.

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Patients were able to make an appointment with a GP, with urgent appointments available the same day, although there was not always continuity of care. Home visits were available, however requests for home visits were not prioritised or reviewed by a clinician and there was no policy or guidance available for non-clinical staff on how to respond to these requests.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. However information about how to escalate a complaint was not provided to complainants. The practice had already identified this and included this in their new patient compliment, query or complaint information leaflet, which was being printed. Improvements were made to the quality of the service provided as a result of complaints and concerns, although actions taken were not shared with all staff to encourage learning.

Are services well-led?

Inadequate

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

- ECCH had a clear vision and set of values, however not all staff were clear about the vision and their responsibilities in relation to it.
- There was a lack of clinical leadership and oversight at the practice.
- Governance arrangements at the practice were insufficient to ensure safe and effective care.
- The practice had a number of policies and procedures to govern activity. However, practice level policies were not in place for clinical coding, summarising and responding to home visit requests.
- The practice had recently re-established staff team meetings as these had not been held for approximately one year. Nurse meetings, which included the healthy lifestyle behavioural

coach, had also been recently implemented and we saw some minutes of these. There was scope for the minutes of meetings to be improved for the practice to be assured of shared learning and that identified actions had been completed.

- The practice sought feedback from staff and patients in relation to complaints, which it acted on. The results from the national GP patient survey showed the practice was generally performing below the local CCG and national averages. The practice did not have a Patient Participation Group (PPG) however they planned to start a PPG in order to obtain patient feedback and engagement with the practice.

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

Inadequate

The practice is rated as inadequate overall, inadequate for providing safe, effective and well led services and requires improvement for providing caring and responsive services. The concerns which led to these ratings apply to everyone using the practice including this group.

- The practice offered personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs. However requests for home visits were not always reviewed by a clinician.
- GPs and the emergency care practitioner provided alternate weekly home visits to patients living in the one care home covered by the practice.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people, including rheumatoid arthritis, dementia and heart failure were above the local and national averages. However the exception reporting rate for rheumatoid arthritis and dementia was above the local and national rate. 2016/2017 unverified data from the practice showed that performance had reduced significantly for rheumatoid arthritis, and had been maintained in the other areas.

People with long term conditions

Inadequate

The practice is rated as inadequate overall, inadequate for providing safe, effective and well led services and requires improvement for providing caring and responsive services. The concerns which led to these ratings apply to everyone using the practice including this group.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified.
- A diabetes specialist nurse undertook monthly clinics for those patients with more complex diabetes.
- The practice used the information collected for the Quality and Outcomes Framework (QOF) to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). Data from 2015/2016 showed that performance for diabetes related indicators was

Summary of findings

90%, which was the same as the local and national average. Exception reporting for diabetes related indicators was 33% which was above the local average of 17% and the England average of 12% (exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). 2016/2017 unverified data from the practice (which excluded any exceptions) showed the practice performance had reduced to 59% for diabetes related indicators.

- Longer appointments and home visits were available when needed. However we found that requests for home visits were not always reviewed by a clinician.

Families, children and young people

Inadequate

The practice is rated as inadequate overall, inadequate for providing safe, effective and well led services and requires improvement for providing caring and responsive services. The concerns which led to these ratings apply to everyone using the practice including this group.

- Immunisation rates were in line with the Clinical Commissioning group (CCG) and England averages for all standard childhood immunisations. The practice planned to hold drop in clinics for childhood immunisations in order to further increase uptake.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice offered a full range of family planning services and chlamydia screening.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice planned to offer evening appointments to increase the uptake of cervical screening as well as well woman clinics.
- A midwife held a clinic at the practice on a weekly basis.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate overall, inadequate for providing safe, effective and well led services and requires improvement for providing caring and responsive services. The concerns which led to these ratings apply to everyone using the practice including this group.

- Appointments were available between 8am and 5.55pm.

Summary of findings

- Pre bookable telephone consultations were not available, however patients could phone on the day and a GP would phone them back. Appointments could be booked online. The practice offered online prescription ordering and access to the patient's own medical record.
- The percentage of women aged 25-64 whose notes recorded that a cervical screening test had been performed in the preceding five years was 64%, which was below the CCG average of 75% and the England average of 76%. The practice were planning to trial later evening appointments for cervical screening in order to improve uptake.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate overall, inadequate for providing safe, effective and well led services and requires improvement for providing caring and responsive services. The concerns which led to these ratings apply to everyone using the practice including this group.

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. The practice were planning to undertake work with the local learning disability team to corroborate their register.
- The practice had 84 patients on the learning disability register. Six of these patients have had a health review since April 2016.
- The practice supported vulnerable patients through a number of local schemes, including for example 'Lowestoft Rising', where the lead nurse provided health expertise at a monthly meeting. The lead nurse supported an access clinic for homeless people and encouraged them to register at the practice. They also supported patients as part of a detox programme, provided by the East Coast Recovery.
- A healthy lifestyles behavioural coach was available at the practice and offered appointments on a range of areas which included healthy eating, exercise and smoking cessation. Feedback from patients on this service was very positive.
- An advisor, trained by the Citizens Advice Bureau, attended the surgery twice a week for patients to drop in and obtain information on self help groups and other support organisations based on the patients' need. Advisors also attended the practice every day if appointments had been booked in advance, to support and signpost patients other services, including for example, wellbeing, housing and debt support services.

Summary of findings

- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. However not all staff had received safeguarding training appropriate to their role.
- The practice's computer system alerted practice staff if a patient was also a carer. The practice had identified 76 patients as carers (1.2% of the practice list).

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate overall, inadequate for providing safe, effective and well led services and requires improvement for providing caring and responsive services. The concerns which led to these ratings apply to everyone using the practice including this group.

- The 2015/2016 Quality and Outcomes Framework (QOF) data showed that 50% of patients diagnosed with dementia had their care reviewed in a face to face meeting which was 24% lower than the CCG average and 28% lower than the England average (QOF is a system intended to improve the quality of general practice and reward good practice). Unverified 2016/2017 data provided by the practice showed that performance had improved to 57%.
- 45% of patients experiencing poor mental health had a comprehensive care plan, which was lower than the CCG average of 67% and the England average of 78%. Unverified 2016/2017 data provided by the practice showed that performance had fallen to 34%.
- The practice had information available for patients experiencing poor mental health about how to access various support groups and voluntary organisations. Information was also available on the practice's website.
- Patients were able to self refer to a service called 'Solutions' which was a social prescribing scheme, offered by the practice to provide patients with non-medical support in the community.
- A mental health nurse had recently been employed by the provider ECCH, to offer face to face appointments for signposting to other services, at least once a week.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice was generally performing below the local CCG and national averages. 260 survey forms were distributed and 99 were returned. This represented a 38% response rate.

- 58% of patients found it easy to get through to this practice by phone compared to the CCG average of 81% and the national average of 73%.
- 70% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 87% and the national average of 85%.
- 65% of patients described the overall experience of this GP practice as good compared to the CCG average of 89% and the national average of 85%.
- 49% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 82% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 13 comment cards which were all positive about the standard of the care received and the friendliness of the staff. A number of patients named specific staff members for being particularly helpful, knowledgeable and kind.

We spoke with representatives from one care home where residents were registered at the practice. They advised that a clinician from the practice visited every week, and when they requested a home visit, and that patients were involved in decisions about their care and treatment.

We spoke with three patients during the inspection. Two patients said that they were able to get through on the phone to make an appointment and another patient said this was difficult, but if they requested an appointment they would be seen. Two patients commented negatively about the poor bedside manner of one of the staff members, but that they were treated with dignity and their privacy was maintained by the staff. Two patients said they would recommend the practice. The practice engaged with the Friends and Family Test. The most recent data submitted, which was published in December 2016, showed that from 19 responses, 79% of patients would recommend the practice.

Areas for improvement

Action the service MUST take to improve

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Action the service SHOULD take to improve

- Offer health reviews to patients with a learning disability.
- Ensure that information about the complaints policy is available for patients and includes information about how to take action if a complainant is dissatisfied with the response.
- Continue with plans to start a PPG in order to obtain patient feedback and engagement with the practice and act on this feedback to improve patient satisfaction.

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 practice manager specialist adviser.

Background to Kirkley Mill Surgery

East Coast Community Healthcare Community Interest Company (ECCH) became the provider for the practice in April 2016, and holds an Alternative Primary Medical Service (APMS) contract with the local CCG. ECCH is a provider of over 30 community services, which includes four GP practices and has been established for five years.

The practice area covers most of the town of Lowestoft and the surrounding villages and offers health care services to approximately 6285 patients. In March 2017, the practice had registered approximately 2,000 patients from the closure of a nearby practice. Kirkley Mill Surgery is located in a purpose built health centre and has consultation space for GPs and nursing team members, including a healthy lifestyles behavioural coach. It is in the Great Yarmouth and Waveney Clinical Commissioning Group (CCG) area and 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.

The practice employs two regular locum GPs, both of whom are male, and additional locum GP cover to provide the equivalent cover of two full time GPs. If a patient requested to see a female GP, they were offered an appointment with a female nurse initially. There is a full time nurse manager, a full time and part time nurse, a part time health care assistant and a full time healthy lifestyle behavioural coach. The practice also had an emergency care practitioner (a registered paramedic) who worked two days a week. The practice had recently recruited a nurse practitioner; however they had not yet accepted the post. At the time of our inspection, the practice was relying on locum GPs due to difficulties in recruiting permanent GPs in the area. There was a practice manager who had been in post for three months and was supported by a team of administration and reception staff.

The practice is open between 8am and 6.30pm Monday to Friday. GP appointments are generally available between 8am and 5.50pm, although the times of clinical sessions vary day to day.

When the practice is closed Integrated Care 24 provide the out of hours service, patients are asked to call the NHS111 service to access this service, or to dial 999 in the event of a life threatening emergency.

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. The inspection was

planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 1 June 2017. During our visit we:

- Spoke with a range of staff (GPs, practice nurses, reception and administration) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and family members.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Spoke with representatives from one care home where residents were registered at the practice.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

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

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

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

Inadequate

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager or lead nurse of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- The practice took necessary action immediately following a significant event, however the learning identified was not shared with staff to minimise the risk of reoccurrence and there was no analysis of the significant events every year in order to identify trends.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, detailed information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.

We reviewed safety records, incident reports and patient safety alerts. The practice manager received the alerts and shared them within the practice; however no one was identified to receive the alerts when the practice manager was not available. We were told that patient safety alerts were logged, shared and searches were documented as completed. However, we reviewed five Medicines and Healthcare Products Regulatory Agency (MHRA) alerts and found that 36 patients were prescribed combinations of medicines in three of the five MHRA alerts where this was not advised, and no action had been taken by the practice to review this. Since our inspection East Coast Community Healthcare Community interest Company (ECCH) and the CCG have taken action in response to these findings.

Overview of safety systems and processes

- The practice had some arrangements in place to keep patients safe and to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead nurse for safeguarding and a safeguarding lead and team employed by ECCH. The ECCH safeguarding lead and the practice safeguarding lead attended safeguarding meetings when possible and provided reports where necessary for other agencies. Not all locum GPs had been set up to be able to view the safeguarding records in the patients' medical records. Staff demonstrated they understood their responsibilities and 81% of clinical and non-clinical staff had received training on safeguarding children and vulnerable adults relevant to their role. Most nurses and GPs were trained to child and adult safeguarding level three; however one of the GPs had not attended level three safeguarding training.
- A notice in the consultation rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The lead nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with evidence based practice, however they had not undertaken any training specific to this lead role. There was an infection control protocol in place and staff had received up to date training. We were told that annual infection control audits were undertaken and viewed the last audit from July 2016. We saw evidence that action was taken to address any improvements identified as a result. The practice scored 92% for this infection control audit. We were told that clinical staff were responsible for cleaning spilt body fluids, however the hepatitis B status of all clinical staff was not known. There were some records for hepatitis B immunity for non-clinical staff, but these were incomplete. Bodily fluid spillage kits were available in the practice. There was a sharps injury policy and procedure available. Clinical waste was stored and disposed of in line with guidance; however we noticed that the lock on one of the external clinical waste bins had broken. The lead nurse advised that they would take action to resolve this.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice did

not always keep patients safe (including obtaining, recording, prescribing, handling, storing, security and disposal). Although processes were in place for handling repeat prescriptions, which included the review of high risk medicines, we found these were not effective. We reviewed the records of patients prescribed four different high risk medicines. We found 33 patients who were prescribed an Angiotensin-converting-enzyme (ACE) inhibitor (a medicine for the treatment of hypertension and congestive heart failure), who had not been monitored appropriately for over three years. We found 13 patients who were prescribed warfarin (a medicine used to thin the blood) and who had not had appropriate monitoring in the past 12 weeks. Since our inspection ECCH and the CCG have taken action in response to these findings. We checked medicines stored in one of the GP visiting bags and found that they were in date. Weekly checks were completed and documented to ensure the medicines were available for use and is date. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The practice carried out regular medicines audits, to check if prescribing was in line with evidence based guidelines for safe prescribing, for example antibiotic use. However there was limited evidence of actions to address the identified areas for improvement.

- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

- The practice did not use an agreed and consistent coding system for patient's medical records. We observed informal discussion between non-clinical staff about how they would code a patient in response to patient correspondence that had been received. There was no policy, clinical guidance or clinical oversight for this. Since our inspection ECCH and the CCG have taken action in response to these findings.
- The practice did not have any trained staff who undertook summarising at the practice. Summarising is undertaken to produce an accurate summary of the patient's medical record. The practice had registered approximately 2,000 patients from the closure of another practice in March 2017. Although the GP from the practice which had closed was working as a locum GP at Kirkley Mill Surgery, there was no plan in place for how the practice were going to summarise the records of these patients. The practice did not know how many of their records had been summarised.
- There was no effective system in place for dealing with clinical pathology letters and tasks. We viewed one GP pathology inbox. This was not being cleared at the end of each day. Abnormal results had been received and had not been reviewed by a GP three days after receipt. We also saw that approximately 300 clinical letters, which had been received up to 15 days prior to the inspection, had not been reviewed. Since our inspection ECCH and the CCG have taken action in response to these findings.
- There were procedures in place for monitoring and managing health and safety risks to patient and staff safety. There was a health and safety policy available and a health and safety risk assessments had been undertaken. The practice had up to date fire risk assessment which had been completed in May 2017. Recommendations had been made which the practice were planning to implement. The practice manager was not aware if any fire drills had been undertaken. All the electrical equipment had been checked in September 2016 to ensure the equipment was safe to use. Clinical equipment was checked to ensure it was working properly in May 2017. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and legionella (legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- The practice had experienced a high turnover of staff, had considered the skill mix of staff for the practice and were in the process of recruiting to staff vacancies. This work was kept under review.

Arrangements to deal with emergencies and major incidents

Risks relating to emergencies were assessed and well managed.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.

Inadequate

Are services safe?

- All staff received annual basic life support training and there were emergency medicines available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and copies were kept off site.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and generally delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) evidence based guidelines. We completed four searches to check whether NICE guidance was being followed. This was being followed in three of the searches we undertook. We identified one search where nine patients with gestational diabetes had not been reviewed in accordance with NICE guidance.

- The practice had systems in place to keep all clinical staff up to date and staff we spoke with also used their own methods to keep updated. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice did not monitor that NICE guidelines were followed in practice. The practice had identified the need to improve in this area and were in the process of implementing clinical templates to help ensure that care and treatment followed evidence based guidelines. This had not been completed at the time of our inspection.

Management, monitoring and improving outcomes for people

The practice did not have an effective system in place in order to code patients and to ensure effective recall for the monitoring of patients' health needs. The practice performance data for patient outcomes had declined and the exception reporting was above average. Patients were not getting the care that they were entitled to receive.

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results from 2015/2016 showed the practice achieved 94% of the total number of points available. The overall exception reporting rate was 25% which was 11% above the CCG average and 15% above the national average (exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

2016/2017 unverified data from the practice, showed the practice achieved 77% of the total number of points available and had a 17% exception reporting rate. The practice had a QOF action/improvement plan for 2017/2018 which identified actions for improvement which mainly focused around validating the register and improved coding. The practice were unable to explain why the exception reporting was so high, however they planned to audit the use of exception reporting in some domains. Training had been arranged for staff in June 2017; this had not been undertaken at the time of our inspection.

Data from 2015/16 showed:

- Performance for diabetes related indicators was 90%, which was the same as the Clinical Commissioning Group (CCG) and England average. The exception reporting rate was 33%, which was higher than the CCG exception reporting rate of 17% and the England exception reporting rate of 12%. 2016/2017 unverified data from the practice (which excluded any exceptions) showed the practice performance was 59% and had significantly deteriorated in this area.
- The prevalence of mental health was 2%, which was higher than the CCG and England average of 1%. Performance for mental health related indicators was 81%, which was 9% below the CCG average and 12% below the England average. The exception reporting rate was 18% which was lower than the CCG average of 19% and England average of 11%. 2016/2017 unverified data from the practice (which excluded any exceptions) showed the practice performance was 47% and had significantly deteriorated in this area.
- Performance for dementia related indicators was 100% which was 5% above the CCG average and 8% above the England average. The exception reporting rate was 38% which was higher than the CCG average of 14% and the England average of 13%. 2016/2017 unverified data from the practice (which excluded any exceptions) showed the practice performance was 100% and had been maintained in this area.
- Performance for rheumatoid arthritis was 100%, which was 8% above the CCG average and 4% above the England average. The exception reporting rate was 36% which was above the CCG average of 10% and the England average of 8%. 2016/2017 unverified data from the practice (which excluded any exceptions) showed the practice performance was 17% and had significantly reduced in this area.

Inadequate

Are services effective?

(for example, treatment is effective)

- Performance for hypertension related indicators was 78%, which was 18% below the CCG average and 19% below the England average. The exception reporting rate was 7% which was the same as the CCG average and above the England average of 4%. 2016/2017 unverified data from the practice (which excluded any exceptions) showed the practice performance was 65% and had reduced in this area.

There was limited evidence of quality improvement including clinical audit.

- The practice could not evidence any completed single cycle or clinical audits that had been re-run to monitor and improve outcomes for patients.
- We reviewed one audit of antibiotic prescribing compliance with the Great Yarmouth and Waveney CCG prescribing formulary from April 2016 to January 2017. The conclusion of the audit was that 'Generally, prescribing by the regular prescribing team adheres to formulary, unfortunately most non-compliant prescribing is by locums who we have very little control over'. An action to educate GPs and nurse practitioners had been identified, however there was no evidence of this action being completed.
- The provider, ECCH, had a QOF improvement action plan which identified a number of actions to improve patients' outcomes. Staff we spoke with confirmed that some of these actions had been discussed, although there was limited evidence of completion and improvement in relation to outcomes for patients.

Effective staffing

- The provider had a corporate induction programme for all newly appointed staff, including locum GPs. Existing staff were in the process of completing the induction programme. Additional mandatory training was identified for new staff, according to staff role and included areas such as safeguarding, infection control, fire safety, assessing and managing risk, health and safety, moving and handling and information governance. We reviewed four staff files which included one recent new member of staff and saw evidence that staff had received mandatory training according to their role.
- There was evidence that staff attended role-specific training and received updates. For example, for those reviewing patients with long-term conditions. This included support from staff at the practice and attendance at meetings and courses.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at health professional meetings.
- Staff appraisals were comprehensive and included, for example, a reflective review, talent mapping, agreed objectives and quarterly reviews. We reviewed three staff files and found evidence that appraisals had been undertaken.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was not always available to relevant staff in a timely and accessible way through the practice's patient record system.

- The practice did not have a consistent approach to the coding of patients. We observed informal discussion between non-clinical staff about how they would code a patient in response to patient correspondence that had been received. There were no guidelines in place for the effective clinical coding of patients and there was no clinical oversight of the coding used by non-clinical staff. Since our inspection ECCH and the CCG have taken action in response to these findings.
- The practice did not undertake regular multidisciplinary meetings. We viewed the minutes of the most recent meeting which was held in January 2017; however, where patients had been discussed and reviewed, this had not been recorded in their medical records. The practice did not have a clear process for sharing information with the out of hours service, particularly for patients with palliative care needs. The practice were planning to hold another multi disciplinary meeting in June 2017, however we were told this was dependent on a room being available.

Inadequate

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

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

Supporting patients to live healthier lives

The practice promoted and encouraged self care and information was available on the practice's website for common ailments which could be self managed. The practice identified patients who may be in need of extra support. This included patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, exercise, smoking and alcohol. A healthy lifestyles behavioural coach was available at the practice and offered appointments on a range of areas which included healthy eating, exercise and smoking cessation. Feedback from patients on this service was very positive. The lead nurse supported an access clinic for homeless people and encouraged them to register at the practice. The lead nurse also supported patients as part of a detox programme, provided by the East Coast Recovery Service, where they registered temporarily at the practice whilst undergoing the detox programme. A mental health nurse had recently been employed by the provider ECCH, to offer face to face appointments for signposting to other services, at least once a week.

The practice's uptake for the cervical screening programme was 76% which was below the CCG average of 83% and the national average of 81%. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice was aware of the lower uptake and was planning to offer evening appointments to try to improve uptake. Well woman clinics were also being planned during evening appointments.

The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

- 51% of patients aged 60 to 69 had been screened for bowel cancer in the last 30 months compared to the CCG average of 60% and an England average of 59%.
- 69% of females aged 50 to 70 had been screened for breast cancer in the last 36 months compared to the CCG average of 72% and an England average of 73%.

Childhood immunisation rates for the vaccinations given were comparable to CCG and England averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 79% to 98%, which was comparable to the CCG range of 76% to 95% and the national range of 21% to 96%. Vaccinations given to five year olds ranged from 71% to 94% which was comparable to the CCG range of 70% to 97% and the national range of 16% to 94%. Missed appointments were followed up by a phone call to encourage rebooking. The practice were planning to trial a drop in baby immunisation clinic to increase uptake and reduce the number of missed appointments.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. These were undertaken by the health coach and the nursing staff. Appropriate follow-ups for the outcomes of health assessments and checks were made by a GP, where abnormalities or risk factors were identified. The practice used simple pictorial information leaflets to explain breast and cervical screening and testicular checks. The practice had 84 patients on the learning disability register. Six of these patients had received a health review since April 2016. The practice was planning to improve accessible information to undertake health checks for people with a learning disability.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were polite and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- A notice was placed at the reception desk to ask patients to stand back from the reception desk to try to maximise confidentiality.

We spoke with representatives from one care home who advised that patients were treated with care and their privacy and dignity as maintained. Two of the three patients we spoke with commented negatively about the poor bedside manner of one of the staff members, but that they were treated with dignity, and their privacy was maintained by the staff. All of the 13 patient Care Quality Commission comment cards we received were positive about the service experienced. They highlighted that staff were helpful, knowledgeable and friendly.

Results from the national GP patient survey, published in July 2016, showed the practice was below local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 78% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 73% of patients said the GP gave them enough time compared to the CCG average of 89% and the national average of 87%.
- 86% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 72% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and the national average of 85%.
- 87% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 94% and the national average of 91%.
- 84% of patients said they found the receptionists at the practice helpful compared to the CCG average of 90% and the national average of 87%.

The practice were aware of this data but did not have an action plan to address it in place at the time of our inspection.

Care planning and involvement in decisions about care and treatment

Two of the three patients we spoke with told us they felt involved in decision making about the care and treatment they received. They told us they felt listened to and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. All the patient feedback from the comment cards we received was positive in relation to their involvement in decisions about their care and treatment.

Results from the national GP patient survey, published in July 2016, showed results were below the local and national averages for how patients responded to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 76% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and the national average of 86%.
- 65% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 82%.
- 75% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 90% and the national average of 85%.

The practice were aware of this data but did not have an action plan to address it in place at the time of our inspection.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. We saw information was available on the practice's

website information was available in the practice information leaflet informing patients this service was available. The practice website provided the facility to translate the information pages into over 100 different languages.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Patient information leaflets and information about support groups was also available on the practice website.

An advisor attended the surgery twice a week for patients to drop in and obtain information on self help groups and other support organisations based on the patients' need. The Citizens Advice Bureau attended the practice every day if appointments had been booked in advance, to support and signpost patients other services, including for example, wellbeing, housing and debt support services.

The practice's computer system alerted GPs if a patient was also a carer and identified 76 patients as carers (1.2% of the practice list). Information for carers was available from the advisor who attended the surgery twice a week. Written information was available on the practice's website, to direct carers to the various avenues of support available to them.

If families had suffered bereavement, one of the practice nurses contacted them and offered support if required.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice were aware of the needs of its local population and some services were offered in response to the identified needs.

- The practice used a text message appointment reminder service for those patients who had given their mobile telephone numbers.
- The practice offered longer appointments and appointments at quieter times for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. However requests for home visits were not always reviewed by a clinician. Since our inspection East Coast Community Healthcare Community interest Company (ECCH) and the CCG have taken action in response to this finding.
- GPs and the emergency care practitioner undertook alternate weekly visits to one residential home to assess, monitor and review patients who were residents.
- The practice offered support to patients by advising them to inform the practice if they had any specific accessibility needs. Patients were asked to advise the practice if they had difficulty reading correspondence sent by the practice, if they needed someone to support them at their appointments, if they needed information in a different format, if they needed support to be able to lip read, used a hearing aid or communication tool, or if they needed an interpreter. Translation services were available.
- Alerts were recorded on the patient's record to ensure staff were aware of any particular needs. This included, for example where a patient was not able to read so was contacted by telephone to share information.
- Consultation rooms were on the ground and first floor and were easily accessible by a lift.
- The practice website had the facility to translate each page into over 100 different languages and the web pages were designed so the style, size and colour of the font and background colour of the page could be changed to improve the accessibility of the information.
- The provider, ECCH, had recently appointed a business lead for primary care with responsibility for implementing actions plans for all ECCH GP practices on new ways of working and new models of care. For example, working with the practice to identify how time can be released for clinical staff by developing the skills of the administration team.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.

Access to the service

The practice was open between 8am and 6.30pm on Monday to Friday. GP appointments were generally available between 8am and 5.55pm; however clinic times varied on each day of the week. Appointments could be booked in person, by telephone and online. Pre bookable telephone consultations were not available, however patients could phone on the day and a GP would phone them back. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent on the day appointments were also available for people that needed them. The practice offered online prescription ordering and access to the patient's own medical record.

Results from the national GP patient survey, published in July 2016, showed that patient's satisfaction with how they could access care and treatment was below local and national averages.

- 68% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and the national average of 76%.
- 58% of patients said they could get through easily to the practice by phone compared to the CCG average of 81% and the national average of 73%.

The practice were aware of this data but did not have an action plan in place to address it at the time of our inspection.

We spoke with three patients during the inspection. Two patients said that they were able to get through on the phone to make an appointment and another patient said this was difficult, but if they requested an appointment they would be seen. Patients we spoke to and patients' views from comments cards we received showed that they were able to make an appointment with a GP, with urgent appointments available the same day, although there was not always continuity of care due to the use of locum GPs.

The practice did not have a safe system in place to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. We saw two

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

examples where requests for home visits were scheduled for the next working day by a non-clinical member of staff and there was no clinical oversight or review of this. There was no policy or guidance in place for responding to requests for home visits and therefore clinical and non-clinical staff were not aware of their responsibilities when managing requests. Since our inspection ECCH and the CCG have taken action in response to these findings.

Listening and learning from concerns and complaints

There was a system in place for receiving, investigating and responding to complaints. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs. There was a designated person responsible who handled all complaints in the practice. Improvements were made to the quality of the service provided as a result of complaints and concerns.

We saw that information was available to help patients understand the complaints system on the practice's website and in the practice's information leaflet. Compliments, questions, concerns and complaints forms were available at the practice for patients to take without having to ask for one. Patients could also send complaints to the patient liaison manager at ECCH. Reception staff were aware of the complaints system and were able to act appropriately to a patient complaint.

We looked at documentation relating to three complaints received in the previous year and found they had been fully investigated and responded to in a timely and empathetic manner. Information on how to escalate a complaint was not provided in response letters to complainants. However ECCH had included information about escalating complaints in their new patient compliment, query or complaint information leaflet, which was currently being printed. Lessons were learnt from individual concerns and complaints. There was no system for sharing the learning from complaints with the entire staff team to encourage learning and development. Analysis of themes was undertaken and collected for all ECCH services and reported to the integrated governance committee. These were published on the ECCH website for Kirkley Mill Surgery.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

There was limited evidence of the service being operated in accordance with their vision, which was to 'be a ground-breaking, forward thinking community focused social enterprise with a reputation for excellence and quality in improving health and wellbeing'. East Coast Community Healthcare Community interest Company (ECCH) had agreed values which had been developed by their staff which covered the areas of attitude, behaviour, competence and delivery. Practice staff we spoke with were not all aware of ECCH's vision and values.

Governance arrangements

The practice level governance was not adequate.

- There was a lack of clinical leadership at the practice which had not been addressed. We found that non-clinical staff were working outside of their scope of competence. For example, non-clinical staff had triaged requests for home visits; there was no policy or guidance in place and there was no clinical oversight of these decisions. Since our inspection ECCH and the CCG have taken action in response to these findings.
- There was a governance process for policies to be ratified by ECCH before implementation within the practice. We saw a number of policies were available and implemented. This included, for example, a health and safety policy and safeguarding policies and procedures. However there were no agreed policies in place for clinical coding, summarising, or responding to requests for home visits. Since our inspection ECCH and the CCG have taken action in response to these findings.
- There was limited evidence of quality improvement including clinical audit. The practice could not evidence any completed single cycle or clinical audits that had been re-run to monitor and improve outcomes for patients.
- Arrangements for monitoring and ensuring that patients received safe and effective care were not in place. For example, abnormal pathology results had been received and had not been reviewed by a GP three days after receipt. We also saw that approximately 300 clinical letters which had been received up to 15 days previously had not been reviewed. Since our inspection ECCH and the CCG have taken action in response to these findings.
- The practice had not ensured that staff were assessing patient needs or providing care and treatment in line with evidence based guidelines.
- The practice held a risk register; however we found clinical risks during our inspection which had not been identified by the practice or ECCH.
- The ECCH board were aware of concerns about the poor bedside manner of one of the staff members and we were informed that this was being addressed.

Leadership and culture

ECCH had an organisational structure, which detailed the reporting relationships from frontline staff to the ECCH executive. However there was a lack of clinical leadership and oversight at the practice level. There was no guidance in place and clinical oversight for the work that was being undertaken. For example, there was no agreed system in place for the coding of patient's medical needs and we observed informal discussion between non-clinical staff about how they would code a patient in response to patient correspondence that had been received. We also saw two examples when home visit requests were scheduled for the next day by a non-clinical member of staff. There was no clinical guidance or clinical oversight for this. Since our inspection ECCH and the CCG have taken action in response to these findings.

ECCH had identified potential and actual challenges to service provision at the practice, and had taken limited actions which had resulted in a positive impact for patients. For example, the difficulty in recruiting GPs and the need to offer alternative provision to meet health care need had resulted in a paramedic being recently recruited to undertake some urgent care work. ECCH had recently appointed a business lead for primary care with responsibility for implementing actions plans for all ECCH GP practices on new ways of working and new models of care.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The practice had systems in place to ensure that when things went wrong with care and treatment, they gave affected people reasonable support, detailed information and a verbal and written apology.

Are services well-led?

Inadequate

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

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

The practice encouraged feedback from patients, the public and staff. It sought patients' feedback through surveys, comments cards and complaints received. We noted that the rooms in the practice had been named following a patient complaint. The practice was aware of data from the national GP survey; however there was no action plan in place to drive improvement in this patient feedback.

The practice did not have a Patient Participation Group (PPG) however they planned to start a PPG in order to obtain patient feedback and engagement with the practice. Information was available on the practice's website which invited patients to join. The practice engaged with the Friends and Family Test. The most recent data submitted, which was published in December 2016, showed that from 19 responses, 79% of patients would recommend the practice.

The practice had gathered feedback from staff through discussion, appraisals and had recently introduced staff meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and the practice manager. The practice had introduced a staff feedback board where notes of thanks and positive feedback could be left.

Continuous improvement

There was evidence that ECCH did support learning and improvement, for example some nursing staff had been supported to visit another Primary Medical Service practice to obtain ideas for increasing and implementing nurse led initiatives with the practice. However there were examples of where areas for improvement and learning had not been undertaken, such as improving antibiotic prescribing with GP locums.

ECCH had recently appointed a business lead for primary care with responsibility for implementing actions plans for all ECCH GP practices on new ways of working and new models of care. For example, working with the practice to identify how time can be released for the clinical staff by developing the skills of the administration team.

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 **There was no proper and safe management of medicines. In particular:** • The process for ensuring that MHRA alerts were actioned for patients affected was not adequate. We found patients who were on combinations of medicines identified in patient safety alerts, who had not been reviewed. • We reviewed patients who were prescribed high risk medicines. Patients who were prescribed two of the high risk medicines had not all been reviewed in a timely manner before their medicines had been reissued. **Not all of the people providing care and treatment had the qualifications, competence, skills and experience to do so safely. In particular:** • The arrangements for triaging urgent requests for home visits were not safe as these were undertaken by a non-clinical member of staff and without written guidance or clinical oversight. **There was additional evidence that safe care and treatment was not being provided. In particular:** • There was not an effective system in place for dealing with clinical pathology letters and tasks. **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. The infection control lead had not undertaken additional training specific to their role. The record of staff hepatitis B immunity was incomplete. We were told that clinical staff were responsible for cleaning spilt body fluids, however the Hepatitis B status of clinical staff was not**

This section is primarily information for the provider

Requirement notices

known and there were some records for Hepatitis B immunity for non-clinical staff, but these were incomplete. The lock was broken on one of the external clinical waste bins.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:** • There was not an effective process in place to ensure that the learning from significant events was shared with staff as appropriate. • Some areas of the practice performance were insufficiently supported to ensure safe and effective care and treatment for patients. For example, data from the quality and outcome framework was significantly lower than the CCG and national averages in some areas and the exception reporting was significantly higher than the CCG and national averages in many areas. 2016/2017 unverified data from the practice showed that performance in some areas had significantly reduced. **There were no systems or processes that enabled the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each patient. In particular:** • The practice did not use an agreed and consistent coding system for patients' medical records. An accurate, complete and contemporaneous record was not maintained for every patient. • The practice did not hold regular multi disciplinary meetings and effective processes were not in place to ensure that any relevant information was shared with the appropriate clinical staff. For example information for patients with palliative care needs with the OOH service and ensuring that safeguarding registers were corroborated.

This section is primarily information for the provider

Requirement notices

- Not all staff had received safeguarding training at an appropriate level to their role and not all GPs had the correct permissions in place on the computer system to ensure they were aware of patients with current safeguarding needs.

There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

- The practice could not evidence any completed single cycle or clinical audits that had been re-run to monitor and improve outcomes for patients.