Kirkley Mill Surgery

Inspection report

Kirkley Mill Surgery,
Clifton Road,
Lowestoft.
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Date of inspection visit: 23/08/2018
Date of publication: 08/10/2018

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 location	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Overall summary

This practice is rated as requires improvement overall. (Previous rating published 2 March 2018 – not sufficient evidence to rate.)

The key questions at this inspection are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at Kirkley Mill Surgery on 23 August 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 undertook an announced comprehensive inspection on 17 January 2018. The practice was rated as inadequate for safe and good for well led. We were unable to rate some key questions because we did not have sufficient evidence. This was because the service had recently been reconfigured and the historical data related to the previous provider. The practice remained in special measures. This inspection was to follow up on breaches of regulation and to provide a rating for the practice.

At this inspection we found:

- Since the Suffolk GP Federation took responsibility for the practice, a number of changes had been made, however work was needed to ensure that systems and processes in place, were fully implemented. Clinical leadership at the practice had improved with a permanent GP clinical based at the practice and a primary care medical director, who also provided clinical leadership.
- Significant improvements had been made in relation to patients prescribed high risk medicines, the management of pathology results and the clinical management of home visit requests.
- Appropriate recruitment arrangements were in place; however, one clinical staff member was still awaiting a Disclosure and Barring Service Check (DBS) and worked unsupervised with patients. The practice was aware of this and following our inspection, evidence of a DBS check for this member of staff was provided.
- The practice had some systems to manage risk so that safety incidents were less likely to happen. Medicines and Health Care Regulatory Authority (MHRA) safety alerts were being logged and acted upon. However, we identified one alert from October 2017, which remained relevant and had not been acted upon. This was before the provider took over responsibility for the practice. The provider agreed to review these patients and include the alert in their review plan. Reception staff were aware of guidance for recognising the deteriorating patient, but specific guidance, for example for sepsis was not in place.
- A range of risk assessments and audits were completed to ensure safety. However, there was no health and safety or premises risk assessment; following our inspection a health and safety risk assessment was undertaken. Not all appropriate emergency medicines were available and no risk assessment had been undertaken.
- Effective systems had been established for the assessment and management of infection prevention and control.
- Improvements were evident for the number of patients whose notes had been summarised and the coding of patients, although work was still needed in these areas to ensure safe and effective care. For example, approximately 1,000 patients' notes still needed to be summarised.
- We found two Patient Group Directions which had not been authorised. Action was taken immediately to authorise these.
- All staff had received mandatory training appropriate to their role and a management tool had been established to record and monitor this.
- The practice recognised that their Quality and Outcome framework overall achievement for 2017 to 2018 was similar to, and their exception reporting higher than the 2016 to 2017 data that related to the previous provider. Improvements had been recently implemented but the success of these had not been evidenced at the time of our inspection.

Overall summary

- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect. All the patients and patient representatives we spoke with and received comments from gave positive responses in this area.
- Patients found the appointment system easy to use and reported that they could access care when they needed it. Continuity of care had improved with the reduction of the number of locum GPs from five (January 2018) to two at the time of the inspection.
- On the day of the inspection, managerial staff at the practice were not able to access the electronic system where significant events and complaints were logged. Staff we spoke with were not all aware of the outcomes of significant events. The systems in place for significant events and complaints were not effectively embedded at a practice level.
- Work had been undertaken to ensure that only Suffolk GP Federation policies and procedures were in place. Staff were confident in how to access and follow them.
- There was a focus on continuous learning and improvement at all levels of the organisation.

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.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

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

- Continue to increase the uptake of annual health checks for patients with a learning disability.
- Improve the system so that all Patient Group Directions are authorised.

I am taking this service out of special measures. This recognises the significant improvements made to the quality of care provided by this service.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

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

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector**.** The team included a GP specialist adviser and a practice manager adviser.

Background to Kirkley Mill Surgery

- The name of the registered provider is Suffolk GP Federation.
- 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 one GP locum staff (male) and two salaried GP (one male and one female). One of the salaried GPs is the clinical lead and commenced in post in January 2018. The nursing team includes a lead nurse who is an advanced nurse practitioner (female) and two locum advanced nurse practitioners (one male and one female), one mental health nurse, three practice nurses (two of whom are locums), two healthcare assistants 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 twelve 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.
- The OOH provider is IC24.

Requires improvement

Are services safe?

At our previous inspection published on 2 March 2018, we rated the practice as inadequate for providing safe services. This was because the arrangements for the completion of mandatory training by staff, including clinical staff, the summarising and coding of patients' notes and the reviewing of patients prescribed medicines which required additional monitoring, were not adequate.

These arrangements had improved when we undertook a follow up inspection on 23 August 2018. The practice is now rated as requires improvement for providing safe services because:

- A significant number of patient's notes had been summarised since our last inspection although approximately 1,000 still needed to be summarised and action was needed to ensure that patients were coded appropriately.
- Reception staff were aware of guidance for recognising the deteriorating patient, but specific guidance, for example for sepsis was not in place.
- Appropriate emergency medicines were not all available and no risk assessment had been undertaken.
- There was no health and safety risk assessment. This was written and submitted following the inspection.

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their 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.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis. However, one clinician did not have a DBS check. The practice was aware of this and had recently applied for one. There was no risk assessment in place whilst this was being awaited. The provider agreed to complete a risk assessment. Following our inspection, evidence of a DBS check for this member of staff was provided.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were systems to assess, monitor and manage most risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role. An up to date, comprehensive locum pack was in place.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Staff were suitably trained in emergency procedures. Clinicians knew how to identify and manage patients with severe infections including sepsis. Reception staff were aware of guidance for recognising the deteriorating patient, but specific guidance, for example for sepsis was not in place. The practice had an adult and child oximeter to enable the assessment of patients with presumed sepsis. There was no baby/infant oximeter.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. Clinical staff told us that they handed over to the out of hours service, however, there was no documented evidence of this in the patient records that we viewed.

Requires improvement

Are services safe?

- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had systems for appropriate and safe handling of medicines; however, these were not always effective.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- We found two PGD's had not been authorised. Immediate action was undertaken to authorise these.
- We reviewed the stock of emergency medicines and found that not all emergency medicines were available. The provider agreed to review this and complete a risk assessment as appropriate.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and acted to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.
- Effective protocols and processes were in place to monitor and review patients prescribed high risk medicines.

Track record on safety

- A range of risk assessments and audits were completed to ensure safety. Identified actions were monitored. However, there was no health and safety or premises/ security risk assessment. The practice completed and submitted these following the inspection.
- The practice monitored and reviewed safety using information from a range of sources.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and were encouraged to report all incidents and near misses. Leaders and managers supported them when they did so.
- There were systems for reviewing and investigating when things went wrong. Lessons were learnt and themes were identified and shared at a corporate level, however the process for learning from significant events was not embedded at the practice level.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts. However, one alert from October 2017, which remained relevant to patients, had not been acted upon. This was before the provider took over responsibility for the practice. The provider agreed to review these patients and include the alert in their review plan.

Please refer to the evidence tables for further information.

Requires improvement

Are services effective?

At our previous inspection published on 2 March 2018, we were unable to rate the practice because we did not have sufficient evidence. This was because the service had recently been reconfigured and the historical data related to the previous provider.

We rated the practice as requires improvement for providing effective services overall and across all population groups, except for people experiencing poor mental health (including people with dementia) which we rated inadequate because:

- The quality and outcome framework data used in the evidence table relates to the previous provider. The provider took over the practice on 1 November 2017, and shared with us their unverified performance data for 2017 to 2018. This showed the practice's overall performance had remained the same, and the overall exception reporting had increased. This effected all the population groups.
- The achievement for people experiencing poor mental health (including people with dementia) remained poor and the exception reporting was high.
- The practice had completed 26 out of 88 health reviews in the previous 12 months for patients with a learning disability. The practice was aware of this and had set aside appointments for these reviews to be completed by two of the advanced nurse practitioners by the end of September 2018.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. The practice had recently introduced an electronic template system to ensure all monitoring was undertaken and information recorded correctly.
- We saw no evidence of discrimination when making care and treatment decisions.
- Patients were encouraged to use a blood pressure machine at the practice. Printed results were given to reception staff who logged these in the patient's record. The results were reviewed by a GP.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of their medicines.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Achievement in the quality and outcomes framework in conditions commonly found in older people had improved, however, they were still below the national average.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- Clinicians followed up patients who had received treatment in hospital or through out of hours services.
- The practice could demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes.
- Clinicians followed best practice guidance for patients who were newly diagnosed with long term conditions.
- The practice's unverified 2017 to 2018 quality and outcomes framework indicators, for long term conditions showed mixed achievement. There was some significant improvement, for example the achievement for the review of patients with COPD had increased from 38% to 71%; however, there was a significant reduction in the achievement for the review of patients with asthma, which had reduced from 77% to 45%. The exception reporting across most of the

long-term condition indicators had improved, in some cases significantly. For example, the exception reporting for the review of patients with asthma had reduced from 38.1% to 4.3%.

Families, children and young people:

- Childhood immunisation uptake rates were in line with the target percentage of 90% or above.
- The practice had some arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation, however this was not always documented.
- The practice had completed an audit on children with a 'did not attend' code from November 2017 to July 2018 and found that 'in general, for all the patients that DNA, the standards of risk assessment, recording action/ follow up and act were not met'. Actions had been identified and were being implemented and a further audit was planned for January 2019.

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

- The practice's uptake for cervical screening was 72%, which was below the 80% coverage target for the national screening programme. The practice was aware of their uptake in this area and had improved uptake and were continuing to work to improve this. The practice sent a third reminder on pink paper to encourage attendance.
- The practice's uptake for breast cancer screening had reduced. The practice's uptake for bowel cancer screening had significantly increased. The practice was not aware of any reason for these changes.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. Minutes were comprehensive.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had 88 patients on the learning disabilities register; 12 of these patients had received a health review in the previous 12 months. The provider submitted data following the inspection to show that a further 14 health checks for patients with a learning disability had been undertaken before the day of the inspection. These had not been identified on the original search by the practice, as the appropriate codes had not been used. This showed a reliable system was not in place. The practice was aware of this low achievement and had set aside appointments for these reviews to be completed by two of the advanced nurse practitioners by the end of September 2018. All housebound patients had been identified and scheduled on the advance nurse practitioners home visit list during September 2018.

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

- 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.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medicines.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- The practice's unverified 2017 to 2018 quality and outcomes framework indicators, for mental health showed mixed achievement. There was some significant

improvement in achievement for example, patients with schizophrenia, bipolar affective disorder and other psychoses with a comprehensive, agreed care plan increased from 32% to 68%. However, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months, had reduced from 71% to 60% and the exception reporting had increased from 18% to 22%.

Monitoring care and treatment

The practice had a programme of quality improvement activity and reviewed the effectiveness and appropriateness of the care provided.

- The quality and outcome framework data used in the evidence table relates to the previous provider. The provider took over the practice on 1 November 2017, and shared with us their unverified performance data for 2017 to 2018. This showed the practice's overall performance had stayed the same, and exception reporting had increased. The practice had recently established a system to recall patients according to their month of birth and had a plan in place to effectively and proactively manage the recall of patients. The practice had recently introduced an electronic template system to ensure all monitoring was undertaken and information recorded correctly. The practice continued to work on improving the coding of patients so that these systems were effective. The success of these improvements had not been evidenced yet.
- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Clinical leadership and continuity of clinical staff had improved since the previous inspection. There was a GP clinical lead who had commenced in post in January 2018. There was a lead nurse at the practice. Two of the regular locums, a GP and an advanced nurse practitioner had agreed to become permanent members of staff. This was due to take effect from 1 October 2018. The Suffolk GP Federation had employed a primary care medical director, who provided leadership across all the primary care services, which included Kirkley Mill Surgery.
- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- The practice had a system to ensure the competence of all staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- 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 and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services, carers for housebound patients and with health visitors.
- 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 worked with patients to develop

personal care plans that were shared with relevant agencies. Clinical staff told us that they handed over to the out of hours service, however, there was no evidence, by read coding of the contact or other documentation.
- The practice ensured that end of life care was delivered in a coordinated way which considered the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may need extra support and directed them to relevant services. This included for example, patients in the last 12 months of their lives, patients at risk of developing a long-term condition and patients who were vulnerable.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- 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 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, tackling obesity.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Appropriate guidance was available to staff in policies.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the evidence tables for further information.

Good

Are services caring?

At our previous inspection published on 2 March 2018, we were unable to rate the practice because we did not have sufficient evidence. This was because the service had recently been reconfigured and the historical data related to the previous provider. The practice is now rated as good for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treated people.
- Staff understood patients' personal, cultural and social needs.
- The practice gave patients timely support and information.
- The practice GP patient survey results were in line with local and national averages for questions relating to kindness, respect and compassion.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- 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 carers and supported them.
- The practices GP patient survey results were in line with local and national averages for questions relating to involvement in decisions about care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues or appeared distressed, reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the evidence tables for further information.

Good

Are services responsive to people's needs?

At our previous inspection published on 2 March 2018, we were unable to rate the practice because we did not have sufficient evidence. This was because the service had recently been reconfigured and the historical data related to the previous provider. The practice and all the population groups are now rated as good for providing responsive services.

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.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions, children with safeguarding needs, and patients approaching the end of life was coordinated with other services.

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.

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. Consultation times were flexible to meet each patient's specific needs.
- The practice worked closely with the community matron to support the management of patients with complex medical needs.

Families, children and young people:

- The practice worked closely with the health visitor and had established clear guidance and systems for safeguarding children and young people. There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. However, we noted that the review of children who had not attended for secondary care appointments was not always documented.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

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. 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.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

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

- The practice employed a mental health nurse who was a non-medical 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 those patients living with dementia.

Timely access to care and treatment

Good

Are services responsive to people's needs?

Patients could 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.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The practice's GP patient survey results were in line with local and national averages for questions relating to access to care and treatment. Satisfaction with appointment times was lower than the CCG and national average. The practice was reviewing how they may be able to further adjust the services offered to ensure these were accessible, flexible and offered continuity of care.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance.
- Complaints were reviewed and learning shared, across all the GP practices at the monthly primary care review meeting, which was attended by the GP clinical lead for the practice.
- The systems in place for complaints were not effectively embedded at a practice level; on the day of our inspection staff were unable to access the records of complaints.

Please refer to the evidence tables for further information.

Are services well-led?

We rated the practice as requires improvement for providing a well-led service because:

- The systems in place for managing, monitoring and learning from significant events and complaints were not embedded at the practice level. Managerial staff at the practice were not able to access monitoring and learning information on significant events and complaints and staff reported that they did not know the outcome of identified learning. The agreed process for responding to complaints had not always been followed.
- Although staff had been employed and training undertaken to improve the coding of patients, work was still needed to ensure that patients were coded appropriately and patients' notes were summarised. Outcomes for patients as measured by the Quality and Outcomes Framework required improvement.
- Risks were not all identified and monitored.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care, however some systems and processes were not operating effectively.

- Work was needed to ensure that The Suffolk GP Federation systems and processes systems and processes in place, were fully implemented at the practice level.
- Practice leaders 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 leadership at the practice had improved. Staff reported that they were supported by management and by the GP clinical lead. Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- 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. It had been agreed the practice would be based on the first floor of the building.
- 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.
- Suffolk GP Federation had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

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.

- Most of the staff stated they felt respected, supported and valued. They were proud to work in the practice.
- 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 could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. All staff had received an appraisal since November 2017. Clinical staff were given protected time for professional development and evaluation of their clinical work. Staff were supported to meet the requirements of professional revalidation where necessary.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams at the practice; however, changes implemented since the change of senior management were still being communicated and embedded.

Are services well-led?

Governance arrangements

There were responsibilities, roles and systems of accountability to support good governance and management, however the systems in place for significant events and complaints were not embedded at the practice level.

- Systems which were in place for the monitoring and recording of significant events and complaints were not always followed. For example, a complaint had been responded to at a practice level but information on how to escalate complaints if dissatisfied, had not been included.
- Clinical leadership at the practice had improved. A GP clinical lead had been in post as a permanent member of staff since January 2018. There was clinical oversight to ensure staff were working within their competence and to agreed policies.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended, although these were not all followed.
- The Suffolk GP federation and practice, had identified staff in lead roles, which included, 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; however, at the time of our inspection these were not all effective.

- Many risks had been identified, actions identified and completed and monitoring was in place. However, there were no risk assessments for health and safety and premises/security. The practice completed and submitted these following the inspection. A written risk assessment had not been undertaken in relation to emergency medicines, although the provider confirmed that benzylpenicillin had been ordered following the inspection.
- Practice leaders had some oversight of medicine and safety alerts, incidents, and complaints.
- Audit had had some positive impact on quality of care and outcomes for patients. There was evidence that action had been taken to change practice and to improve quality, although work was still needed in some areas, for example embedding recent work on children who do not attend for appointments.
- The practice had plans in place for major incidents. There was no evidence that staff had been trained.
- The practice considered and understood the impact on the quality of care of service changes or developments. However, changes and developments made since 1 November 2018 had not all been embedded to evidence improvement in the quality of care, for example through the quality and outcomes framework.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to monitor performance, however improvements to performance could not be evidenced in all areas.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information. Minutes of meetings were detailed and actions monitored, these were available to staff.
- The practice used information technology systems in an attempt to monitor and improve the quality of care. The practice had recently introduced an electronic template system to ensure all monitoring was undertaken and information recorded correctly. The outcomes of this had not been evidenced at the time of the inspection.
- 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.
- The practice had recently established a patient participation group to ensure that patient views and feedback was included in the future development of the practice.

Are services well-led?

- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were some systems and processes in place for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- The practice made use of internal and external reviews. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the evidence tables for further information.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is 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 **The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:** • There was no risk assessment for deciding what emergency medicines were needed at the practice. • Children who had failed to attend appointments were not all reviewed and outcomes documented. • Reception staff were aware of guidance for recognising the deteriorating patient, but specific guidance, for example for sepsis was not in place.

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 operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:** • A significant number of patient's notes had not been summarised. • Patients were not all coded appropriately, to enable the effective monitoring and recall of patients. • On the day of the inspection, managerial staff at the practice were not able to access the electronic system where significant events and complaints were logged and reviewed. Staff we spoke with were not all aware of the outcomes of significant events. The process of learning from significant events and complaints was not embedded at a practice level and the agreed reporting mechanisms were not always followed.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these. We took enforcement action because the quality of healthcare required significant improvement.