The Burnhams Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Burnhams Surgery on 2 February 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing caring, responsive, well led, safe, and effective services. The practice was also good for providing services for older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), people who circumstances may make them vulnerable, and people experiencing poor mental health.

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

• Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.

• Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.

• Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.

• Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

• Information about services and how to complain was available and easy to understand.

• Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with appointments available the same day.

• The practice had good facilities and was well equipped to treat patients and meet their needs.

• There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

• The practice had a clear vision which had quality and safety as its top priority. A business plan was in place

Summary of findings

which was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

However, there was one area of practice where the provider needs to make improvements.

Importantly, the provider should:

Ensure that all clinical staff receive training in the use of the practice information system in order to support robust QOF data production.

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?

Good

The practice is rated as good for providing safe services. There were enough staff to keep patients safe.

Staff understood their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated to support improvement. There were Health and

Safety and Infection Prevention and Control policies in place. There were processes in place for safe medicines management.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were average for the locality. Staff referred to guidance from National Institute for Health and Care

Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles. Any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of annual appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients who responded to CQC comment cards and those we spoke with during our inspection, said they were treated with compassion, dignity and respect and were involved in decisions about their care and treatment. This was also supported by results in the National GP survey that showed the practice was well above both the CCG and National averages in this regard. Information to help patients understand the services available was easy to understand. We saw that staff treated patients with respect and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and West Norfolk Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had good facilities and was well equipped to treat patients and meet their needs. Urgent appointments were available on the same day and there was continuity of care.

Summary of findings

Information about how to complain was available both in the practice and on the website. Learning from complaints was shared with staff. The practice had a very active Patient Participation Group (PPG) with eight full time members and they sought the views of patients through the Group and the friend and family test.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy and staff were clear about their roles and responsibilities in relation to this.

There was a clear leadership structure and staff felt supported and valued by management. The practice had a number of policies and procedures in place and held regular practice meetings. There were systems in place to monitor and improve quality and identify risk.

The practice proactively sought feedback from patients and staff which it acted upon. Staff received an induction, regular performance reviews and attended staff meetings.

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

Good

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

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The national patient survey showed 98% of practice respondents saying the last GP they saw or spoke to was good at involving them in decisions about their care was good at explaining treatment and results (CCG average 85%) and (National average 81%). The survey also showed that 98% of respondents said the last GP they saw or spoke to was good at listening to them as did 98% who said they felt that the GP who treated them did so with care and concern (CCG average 89%) and (National average 85%)

The practice was responsive to the needs of older people, offering home visits and longer appointments. The practice used a holistic care approach for all patients aged over 75, where clinicians assessed their health and social care needs. All patients over 75 had a named GP.

The practice worked closely with other health care professionals and agencies such as the community matron, district nursing team. The practice was fully involved in a community car scheme operated for patients. There was disabled access to the building and all patient areas and consulting rooms were on the ground floor. The patient areas were sufficiently spacious for wheelchair access

People with long term conditions

Good

The practice was rated as good for the care people with long term conditions

The practice had a GP led approach to long term conditions, supported by the nursing team. There were structured annual reviews in place to check the health and medication needs of patients were being met. Longer appointments and home visits were available when needed. For those patients with the most complex needs the named GP worked with other professionals to deliver a multidisciplinary package of care. The practice held scheduled clinics, such as diabetic clinics where a podiatrist was also available.

Families, children and young people

Good

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

Summary of findings

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Appointments were available outside of school hours and the premises were suitable for children and babies. Same day appointments were offered for children 16 years of age and under. The practice provided sexual health support and contraception, maternity services and childhood immunisations.

Working age people (including those recently retired and students)

Good

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

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

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks and offered longer appointments for people with a learning disability. The practice worked with multidisciplinary teams in the case management of vulnerable people, including persons who were of no fixed abode. Staff signposted patients to various support groups and services, such as drug and alcohol services. Staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

People experiencing poor mental health (including people with dementia)

Good

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

The practice offered annual health reviews, longer appointments and home visits as needed. The GPs actively screened patients for dementia and maintained a list of those diagnosed. The practice had a targeted focus on dementia screening and depression assessments and had identified significantly higher numbers than the predicted rate nationally. There was a system in place to follow

up patients who had attended accident and emergency (A&E) when they may have been experiencing poor mental health. Staff were aware of how to care for people with mental health needs and dementia.

They had a qualified cognitive behavioural therapy (CBT) practioner who attended the practice every Friday and offered and mental health liaison and counselling on site. (CBT is a type of talking treatment that focuses on thoughts, beliefs and attitudes that affect feelings and behaviour. It teaches coping skills for dealing with different problems). The practice regularly worked with multidisciplinary teams in the case management of people in this population group.

Summary of findings

What people who use the service say

We spoke with four patients in the reception and waiting areas of the practice including patients from a number of different practice population groups.

The practice was highly praised by all the patients we spoke with and they were very happy with the service they received. They told us that the GPs and the nurses were caring, patient, kind and treated them with respect. Patients told us they were much happier with the new access to appointments system that had been put in place.

Patients had completed CQC comment cards to tell us what they thought about the practice. We received 18 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Three comments were less positive but there were no common themes to these.

In the latest National GP Patient Survey from January 2015 on this practice 251 surveys were sent out and 140 were returned The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice good in these areas. For example, data from the national patient survey showed 98% of practice respondents saying the last GP they saw or spoke to was good at involving them in decisions about their care was good at explaining treatment and results (CCG average 85%) and (National average 81%). The survey also showed that 98% of respondents said the last GP they saw or spoke to was good at listening to them, 98% of respondents to the national patient survey said they felt that the GP who treated them did so with care and concern (CCG average 89%) and (National average 85%) and 85% of respondents with a preferred GP usually get to see or speak to that GP (CCG average 63%) and (National average 60%).

Areas for improvement

Action the service SHOULD take to improve

Ensure that all clinical staff receive training in the use of the practice information system in order to support robust QOF data production

The Burnhams Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and a practice manager specialist advisor.

Background to The Burnhams Surgery

The Burnhams surgery delivers primary care under a General Medical Services (GMS) contract between themselves and NHS England. As part of the NHS West Norfolk Clinical Commissioning Group (WNCCG), they serve the area of Burnham Market and the surrounding areas of West and North Norfolk, an area approximately of 150 square miles. It is responsible for providing primary care services to approximately 4500 patients. The practice is meeting the needs of an increasingly elderly population.

The practice is registered with CQC to provide primary care services, which includes access to GPs, family planning, surgical procedures, treatment of disease, disorder or injury and diagnostic and screening procedures. The practice has four partner GPs, a practice manager, a dispensary team, practice nurses and healthcare assistants, administrative staff and cleaning staff.

The practice is open 8:30am to 6.30pm on Monday to Friday, they offer extended opening on Tuesday mornings, Thursday mornings and Wednesday evenings for pre-booked appointments. Patients can book appointments in person, via the phone and online. Appointments can be booked in advance for the doctors and for the nursing clinics. When the practice was closed patients accessed the out of hours NHS 111 service.

Why we carried out this inspection

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

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 CQC at that time.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people

Detailed findings

- 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)

Before our inspection we carried out an analysis of the data from our intelligent monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service.

We reviewed the policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas. We reviewed all areas of the practice including the administrative areas. We sought views from patients through face-to-face interviews and via comment cards completed by patients of the practice in the two weeks prior to the inspection visit. We spoke with GPs, dispensary staff the practice manager, clinical nurses, health care practitioners, administrative staff, data quality manager and receptionists. We observed how staff treated patients visiting and phoning the practice. We reviewed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service. We reviewed 18 CQC patient comment cards where patients had shared their views and experiences of the practice.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last three years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed the records of significant events that had occurred during the last two years. Significant events were a standing item on the weekly practice meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system they used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. This person was also a GP trainer and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was an alert system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans or domestic violence issues.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

All GP's and staff had carried out the safeguarding training in regard to vulnerable children and adults and discussed improvements at a partners meeting. In addition the practice had provided training in how to recognise signs of domestic violence and how to escalate concerns to all staff and had a written protocol; this was in response to an identified need.

All GPs had a "usual doctor" list that enabled them to keep track of vulnerable persons and discuss their care and treatment at practice meetings. We were told that same day telephone consultations with those patients took place when required.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff who had been risked assessed and DBS checked would act as a chaperone if nursing staff were not

available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

The practice offered a dispensing service during opening hours to patients living more than a mile from the chemist in Burnham Market. The service was open to all patients who requested the service. The dispensing team was led by a dispensary manager. Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance.

Prescriptions were reviewed but were not signed prior to collection and only then signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a safe and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

We saw that the practice were monitoring prescribing patterns and were taking action in response to issues identified.

Cleanliness and infection control

During the inspection we looked at the areas of the surgery used by the practice which included the GP consulting rooms, treatment rooms, store rooms, patient toilets and waiting areas. We observed the areas to be clean and tidy. We saw there were daily cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a practice nurse who was the lead for infection control. They had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. The infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves and aprons were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. We saw evidence the lead nurse had carried out audits for the last year and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed and acted on if required.

There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. Each clinical room had clinical waste bins which were foot operated and lined with the correct colour coded bin liners. We saw disposable curtains were in each clinical room to ensure that patients had privacy when being examined. These had been replaced every six months in line with the infection control policy.

Good

Are services safe?

We saw that there were notices displayed in staff and patient toilet facilities about hand hygiene techniques. All sinks including those in treatment rooms had hand soap, hand gel and hand towel dispensers available.

The practice had a policy for the management, testing and investigation of legionella (water borne bacteria found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice routinely checked the professional status of the GPs and practice nurses against the General Medical Council (GMC) and Nursing and

Midwifery Council (NMC) registers. All staff received an induction and there was a policy and checklist in place, which was kept in the staff member's file upon completion. We saw evidence of this.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. All staff had annual appraisal with training and development needs identified and planned for.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy.

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Staff we spoke with knew it was important to report incidents and significant events to keep patients safe from harm. They were aware of the most appropriate person to report their concerns to.

We saw that a log of incidents, complaints and significant events had been kept at the practice. We saw they had all been appropriately investigated. We saw that reviews of incidents and significant events over time had been completed to identify if there were any reoccurring concerns across the service. Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings.

Arrangements to deal with emergencies and major incidents

A range of medicines were available to cover most emergencies encountered by the practice, recognising that it often provides front-line emergency care with the nearest A&E department being 18 miles away. Charts on the wall in the treatment room showed pathways for management of CPR and anaphylaxis in adults and children. Emergency equipment was available including access to oxygen and an automated external defibrillator which was used to attempt to restart a person's heart in an emergency, an electrical suction unit (used for sucking up blood or secretions) was also available. All staff asked knew the location of this equipment and how to use it and records we saw confirmed these were checked regularly. All staff were trained in Cardiopulmonary resuscitation (CPR) training according to guidelines. All staff were aware of where emergency equipment was stored and the nurse lead updated staff regularly.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs, nursing and dispensary staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient has fair access to quality treatment. We saw that NICE guidelines were available to all clinicians on the practice computers.

We were informed that GPs had a lead in specialist clinical areas such as diabetes, respiratory, cardiology and dermatology and the nursing staff supported this work. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

We were shown data from the CCG of the practice's performance for antibiotic prescribing, which was comparable to other local practices.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits and other improvements to the service. Clinical audit, clinical supervision and staff meetings were used to assess performance. The practice had a system in place for completing clinical audit cycles. We were shown examples which included prescribing audits such as dyspepsia (indigestion) and the use of antibiotic prophylaxis (prevention of infection complications using antibiotics) in splenectomy patients. Following each clinical audit, changes to treatment or care were made where needed and the audit to be repeated to ensure outcomes for patients had improved.

Information collected for the Quality and Outcome Framework (QOF) and performance against national screening programmes was also used to monitor outcomes for patients. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures.) We reviewed the QOF data; this showed that the practice was an outlier for a number of clinical outcomes. For example carrying out reviews of patients with mental health conditions and those with dementia and the practice antibiotic prescribing. (This was discussed in full with the practice manager and GP's who stated that after investigation the anomaly appears to have risen due to an issue of the input of clinical coding within the computer system. The practice was in the process of reviewing all QOF outcomes for the previous 12 months and resubmitting this data.

All the GP's in the surgery are qualified to undertake minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. They also regularly carried out clinical audits on their results and used that in their learning. All minor surgery consent was in recorded in the patient notes

Effective staffing

Practice staff included medical, nursing, dispensing, managerial, administrative staff, cleaning and grounds maintenance staff. We reviewed staff training records and saw staff were up to date with training courses, such as annual basic life support and safeguarding adults and children.

GPs were up to date with their continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council (GMC) can the GP continue to practise and remain on the performers list with NHS England.)

The practice nurses were registered with the Nursing and Midwifery Council (NMC). To maintain registration they had to complete regular training and update their skills. The nurse we spoke with confirmed their professional development was up to date and training records reflected this.

The clinical and non-clinical staff confirmed they had annual appraisals. They told us it was an opportunity to discuss their performance and any appropriate training

Good

Are services effective?

(for example, treatment is effective)

they either needed or wanted to attend. All the staff we spoke with felt they were well supported in their role and confident in raising issues with the practice manager or GPs. The most recently employed staff told us about the induction programme they had undertaken and how they had been supported through the first few weeks of working in the practice.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice had implemented principles of delivering appropriate care to patients who were approaching the end of their life. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. Those meetings were held fortnightly. They include the senior practice nurse a link nurse and community matron who are district nurses, link workers from adult social care, practice GP partners and the practice secretary. Decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice told us they had established a good working relationship with two local residential care homes. A number of residents were registered with the practice and staff from the homes confirmed that the service they received from the practice was very good and that the GP's who attended treated the patients with care and respect at all times.

Information sharing

The practice used electronic systems to record and store patient data. Staff used an electronic patient record to co-ordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from the local hospital, to be saved in the system for future reference. Electronic systems were in place for making referrals and, in consultation with the patients; these could be done through the Choose and Book system. (The Choose and Book system is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.)

Information regarding consent for data sharing was available in reception and also via the practice leaflet and website.

Consent to care and treatment

We found the clinicians were aware of the Mental Capacity Act 2005 and Children Acts 1989 and 2004 and were able to describe how they implemented it in their practice. All the clinical staff we spoke with understood the key parts of the legislation and confirmed their understanding of capacity assessments. Clinicians were able to give examples where consent for care and treatment had been discussed and mental capacity had been assessed. We were shown the electronic template the practice used and an example of how the mental capacity assessment had been recorded in a patient's electronic record. We discussed providing patients with specific information sheets relevant to the procedure being done and written consent forms which may then be incorporated into the patient record.

Clinical staff we spoke with demonstrated a clear understanding of Gillick competency and Fraser guidelines. These are used to assess whether a child under 16 has the maturity and understanding to make their own decisions

Health promotion and prevention

The practice offered a full range of immunisations for children, flu vaccinations and travel vaccinations in line with current national guidance.

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant / practice nurse. The GP was informed of all

Good

Are services effective?

(for example, treatment is effective)

health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing.

The practice offered cervical cytology screening. Eligible patients were invited and the practice proactively followed up non-attendance and recalls. The practice's performance for cervical cytology screening uptake was 70% which was lower than other practices in the CCG area. The practice was looking at implementing new strategies for increasing the uptake.

The practice routinely took blood samples from patients on site. The practice also performed electrocardiograms (ECG) that recorded the electrical activity of the heart. The heart produces tiny electrical impulses which spread through the heart muscle to make the heart contract. Those impulses could be detected by the ECG machine. The practice conducted spirometry tests used to diagnose asthma, chronic obstructive pulmonary disease (COPD) and other conditions that affect breathing. They also carried out ambulatory blood pressure monitoring (ABPM); this is a non-invasive method of obtaining blood pressure readings over a 24-hour period, whilst the patient is in their own environment, representing a true reflection of their blood pressure.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the National Patient Survey published in January 2015. The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also comparable with the local and national average in its satisfaction scores on

consultations with doctors with 98% say the last GP they saw or spoke to was good at listening to them and 96% saying the GP gave them enough time. Patients at the practice rated the care given by the practice nurses highly. The national patient survey we reviewed showed that satisfaction scores were significantly above both the local and national average. For example 95% of practice respondents said the nurse treated them with care and concern and 100% of respondents said that they had confidence in the nurse who treated them.

We asked patients to complete Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 18 completed cards and the vast majority were positive about the service experienced. Most patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with four patients on the day of our inspection who all told us staff treated them with dignity and respect and they were satisfied with the care they received.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice good in these areas. For example, data from the national patient

survey showed 98% of practice respondents saying the last GP they saw or spoke to was good at involving them in decisions about their care was good at explaining treatment and results, this compared with a CCG average of 85% and a national average of 81%. The patients we spoke with also told us health issues were discussed with them in a way they could understand. They felt involved in decision making about their care and treatment. They told us they felt listened to and had enough time during a consultation to make an informed decision about the choice of treatment they wished to receive.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Patient/carer support to cope emotionally with care and treatment

All of the GP national patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example 98% of respondents to the national patient survey said they felt that the GP who treated them did so with care and concern (CCG average 89%) and (National average 85%) The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who suffered bereavement had confirmed they had received this type of support and said they had found it helpful**.** The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice offered a full dispensary service to patients.

Tackling inequity and promoting equality

The practice had recognised the needs of the different population groups in the planning of its services. For example, the practice had systems in place which alerted staff to patients with specific needs or who may be at risk. The practice responded to the needs of the patients who were registered in a local residential care home and attended on a weekly basis to asses and review patients.

There was disabled access to the building and all patient areas and consulting rooms were on the ground floor. The patient areas were sufficiently spacious for wheelchair and pram access. Accessible toilet facilities were available for all patients and had baby changing facilities. The present building lacked space, and was therefore unable to expand and offer patients any further enhanced services. We were told that the GP partners and the practice manager were in discussion with NHS England regarding those matters. We also noted that although the practice does have car parking facilities these were limited. This was being addressed by the removal of trees to extend the car park by an additional 10 spaces and included two disabled spaces.

Staff told us they had access to translation services during consultations using language line (a telephone based system) for patients who did not have English as a first language.

People whose circumstances make them vulnerable were easily able to register with the practice, (including those with "no fixed abode") care of the practice's address; people not registered at the practice were able to access appointments through drop in services that were available.

Burnham Market is a popular market town near to the North Norfolk coast and as such it has a large number of temporary residents particularly in summer months. There were also a large number of second home owners in the practice area in some places that exceeded over 50% of the properties. The result of the tourism and second home owners increased the number of medical related visits to the practice. We saw that the practice adjusted opening hours in the summer to meet the demand, opening at 8am and closed at 8pm.

Access to the service

The practice was open 8:30am to 6.30pm on Monday to Friday, they offer extended opening on Tuesday mornings, Thursday mornings and Wednesday evenings for pre-booked appointments. Patients can book appointments in person, via the phone and online. Appointments could be booked in advance for the doctors and for the nursing clinics.

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

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

Data from the national GP patient survey showed the practice scored considerably higher than CCG and National averages regarding patient satisfaction and this was confirmed in our conversations with patients and on our CQC comment cards. The practice showed that 85% (CCG average 78%) of respondents found it easy to get through to the practice by telephone and 99% (CCG average 92%) said the last appointment they got was convenient. The majority of patients we spoke with said they found it easy to get an appointment with 88% of those with a preferred GP usually get to see or speak to that GP (CCG average 62%).

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy is in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw that information was available to help patients understand the complaints system displayed on the waiting room wall and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at how complaints received by the practice within the previous twelve months had been managed. The records showed the complaints had been dealt with in line with the practice policy.

Staff told us that complaints were discussed at meetings and we saw minutes from meetings that evidenced this.

Are services well-led?

Good

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

Our findings

Vision and strategy

All practice staff were encouraged by the all GP partners and the practice manager to deliver high quality care and promote good outcomes for patients. One of the partners attended locality and Clinical Commissioning Group (CCG) meetings to identify needs within the community and shared information with all practice staff. Another Partner is a member of the Norfolk and Waveney Local Medical Committee (LMC) The Local Medical Committee is a statutory body, recognised by successive NHS Acts as the professional organisation representing individual GPs and GP practices as a whole to NHS England, CCGs and Public Health Departments.

Details of the practice future planning evidenced that they aimed to correspond to the needs of the population and deliver a service which met those needs. Their vision and values offered patients a level of service which met their needs, offered them dignity and respect and kept them well. All the staff we spoke to shared the values promoted by the practice, knew their responsibilities in relation to them and told us how they would put them into practice. Most of the staff had been employed by the practice for many years and were familiar with the patients and their level of need.

We saw that reception, dispensary and healthcare staff treated patients with kindness and empathy and helped them as much as possible. For instance we were in the waiting room when a person entered who was in need of urgent treatment, immediately a member of staff assisted and they were taken straight into the surgery for treatment.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to each member of staff on the computer desktop. We looked at a number of these policies and procedures and saw that they had been reviewed annually and were up to date. All of the staff we spoke with knew of the existence of policies and procedures and where to access them.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out and actions implemented. For example, we saw a fire risk assessment had been completed; fire alarms tested and staff had received regular fire safety training. The practice used the Quality and Outcomes Framework (QOF) to measure its performance. We reviewed the QOF data; this showed that the practice was an outlier for a number of clinical outcomes. For example carrying out reviews of patients with mental health conditions and those with dementia and the practice antibiotic prescribing. This was discussed in full with the practice manager and GP's who stated that after investigation the anomaly appears to have risen due to an issue of the input of clinical coding within the computer system. The practice was in the process of reviewing all QOF outcomes for the previous 12 months and resubmitting this data.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection prevention and control and a lead GP for safeguarding children and adults. The staff we spoke with all understood their roles and responsibilities and

knew who to go to in the practice with any concerns. We found the management team and staff continually looked to improve the services being offered.

Leadership, openness and transparency

We saw from minutes that partners meetings were held weekly, these were minuted with any actions to be taken. At those meetings quality and QOF data were discussed. Prescribing meetings with CCG pharmacist and the dispensary manager took place on a regular basis.

Team meetings were held regularly, at least monthly where complaints were discussed and actioned. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. GP partner meetings were held weekly.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the practice disciplinary procedures and the induction policy, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required

Practice seeks and acts on feedback from its patients, the public and staff

Staff at the practice and members of the patient participation group (PPG) met on a bi-monthly basis to

Are services well-led?

Good

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

discuss issues concerning the operation of services at the practice. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. The PPG had 8 members and contained members from both male and female gender.

The group had recognised that they were underrepresented with members from young adult age.

We reviewed minutes of PPG meetings and saw that the PPG had worked with the practice to gain the views of patients by undertaking surveys. The results of previous survey in 2014 were discussed and an action plan produced with the PPG to address issues raised. For example helping out patients with new technology in the reception area in the use of the automated check-in service and to help patients and staff at flu clinics.

The practice also participated in the NHS friends and family test and information was available both in the practice and on the website.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us annual appraisals took place, which included a personal development plan. This was evidenced in the staff files we looked at.

We saw that a log of incidents, complaints and significant events had been kept at the practice. We saw they had all been appropriately investigated. We saw that reviews of incidents and significant events over time had been completed to identify if there were any reoccurring concerns across the service. The practice shared the information at staff meetings to ensure the practice improved outcomes for patients. We saw evidence of this in minutes of meetings and logs of events.

The practice took part in the education of doctors in training from medical students up to final year GP trainees. They were reviewed and accredited by the Deanery and we saw copies of positive feedback from both trainees and their supervisors.