Needham Market Country Practice

Quality Report

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Date of inspection visit: 24 November 2016
Date of publication: 12/01/2017

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

Ratings

Are services safe?	**Requires improvement**
Are services well-led?	**Requires improvement**

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced focused inspection at Needham Market Country Practice on 24 November 2016. This inspection was in follow up to our previous comprehensive inspection at the practice on 1 December 2015 where improvements were identified. The overall rating of the practice following the December 2015 inspection was requires improvement. We issued requirement notices to the practice to inform them where improvements were needed. After the December 2015 inspection, the practice wrote to us to say what they would do to meet legal requirements in relation to ensuring services were safe.

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

- The practice had employed a practice manager to assist the partners with the management of the practice. This staff member had been in post since April 2016. The practice staff told us that this had led to positive improvements.
- Some risk assessments had been carried out but there was scope for these to be improved further. For example, the practice had not undertaken a written fire safety risk assessment at the branch sites.
- The practice had improved the fire safety at the main site and regular fire drills were undertaken. However the fire risk assessment undertaken did not contain sufficient detail for the practice to be assured that patients and staff would be kept safe. For example, only four risks were assessed: source of ignition, storage of oxygen cylinder, electrical items, and keeping emergency exits clear. The risk assessment did not include the potential risks to patients with limited mobility during evacuation.
- Not all actions from risk assessments had been identified and completed. For example, the practice had recognised that the temperature of individual water heaters was below the required level and had adjusted the thermostats but they had not monitored the water temperature to ensure it was safe.

Summary of findings

- The practice had identified two clinical leads for infection prevention and control and improvements had been made. Further improvements were required to meet the requirements as detailed in the Health and Social care Act 2008; Code of Practice for health and adult social care on the prevention and control of infections and related guidance.
- Practice staff who acted as chaperones had received appropriate training. However, the practice had not followed their own policy and non-clinical practice staff, who performed chaperone duties, had not received a Disclosure and Barring check. The practice submitted a request for these on the day of the inspection.
- The practice had engaged a specialist company to check and calibrate the medical equipment.
- The practice had improved the management of complaints and recorded all feedback however minor.
- Practice staff had received some training deemed mandatory, for example, fire safety, but non-clinical staff had not received training such as infection prevention and control training.
- With the exception of the dispensary staff members, the practice had not undertaken annual appraisals for non-clinical or nursing staff.
- The practice had recently written 106 new policies and procedures and they were in the progress of training staff members how to access these via the electronic system. Further training sessions and meetings were planned to embed these further into the culture of the practice.
- Some of the changes implemented can only be assessed once the new methodology has been put into practice, then the appropriateness, workability and sustainability of the new systems and processes can be determined.

Areas where the practice must make improvements;

- Further improve the risk assessments undertaken at the practice with sufficient detail to ensure identified risks are mitigated and actions are taken to keep patients and practice staff safe from harm.
- The practice must follow its policy and ensure that all staff who undertake chaperone duties receive a Disclosure and Barring Service check.
- Ensure that staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Areas the practice should make improvements;

- Embed and monitor the recently introduced policies and procedures into the working of the practice.
- Ensure accurate records are kept in relation to the immunisation status of all appropriate staff including locum GPs.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We reviewed the actions taken by the practice in response to the requirement notices issued to them following the inspection on 1 December 2015.

- We found that safety systems had been improved but these needed to improve further.
- We found that all equipment had been calibrated.
- We found that practice staff had received appropriate chaperone training but not all staff had received a Disclosure and Barring Service check.
- Not all practice staff had received infection prevention and control training.

Are services well-led?

Requires improvement

- We found the practice had employed a full time manager. The practice told us the practice manager had a positive effect on the practice team, and organisation of systems and processes.
- The governance and management of the practice had improved. However, some of these systems and processes needed further improvement.
- The practice had started a programme to ensure all practice staff received an annual appraisal, the practice told us that they would complete this in January 2017.

Summary of findings

What people who use the service say

Areas for improvement

Action the service MUST take to improve

- Further improve the risk assessments undertaken at the practice with sufficient detail to ensure identified risks are mitigated and actions are taken to keep patients and practice staff safe from harm.
- The practice must follow its policy and ensure that all staff who undertake chaperone duties receive a Disclosure and Barring Service check.
- Ensure that staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Action the service SHOULD take to improve

- Embed and monitor the recently introduced policies and procedures into the working of the practice.
- Ensure accurate records are kept in relation to the immunisation status of all appropriate staff including locum GPs.

Needham Market Country Practice

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC lead Inspector undertook this inspection

Background to Needham Market Country Practice

Needham Market Country Practice is situated on the outskirts of Needham Market, Suffolk. The current locations provide treatment and consultation rooms situated at ground level. Parking is available with level and ramp access and automatic doors.

The practice has a team of seven GPs meeting patients' needs. All seven GPs are partners, meaning they hold managerial and financial responsibility for the practice. There is a team of five practice nurses, two health care assistants and two phlebotomists who run a variety of appointments for long term conditions, minor illness and family health.

There is a dispensary manager and a team of dispensers. In addition there are two practice administrators and a team of non-clinical administrative, secretarial and reception staff who support the practice manager. Community midwives run sessions twice weekly at the practice.

Patients reside in the town of Needham Market and the surrounding rural area. The practice offers general medical services to a practice population of 12,462. There is a dispensary on site and the practice currently dispenses to approximately 40% of its patient population. The practice provides a range of clinics and services, which are detailed in this report, and operates generally between the hours of 8am and 6.30pm Monday to Friday. Appointments are from 8.30 to 10.30 every morning and 3.30pm to 5.30pm daily. Extended hours or evening surgery pre-bookable appointments are offered from 6.30pm to 8pm Monday evenings and Saturday mornings. In addition appointments are available Monday and Friday mornings at satellite surgeries in Claydon and Tuesday mornings at Somersham. Appointments for these surgeries can be booked through the main surgery. In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent appointments are also available.

When the practice is closed patients are directed to the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.We carried out a focused inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the requirements of the requirement notices issued following a comprehensive inspection on 1 December 2015. The requirement notices were issued because we found risks that required attention by the practice. We returned on 24 November 2016 to ensure the practice had taken action to mitigate the risks.

Detailed findings

How we carried out this inspection

We reviewed the information received from the practice, spoke with a GP, practice manager and requested additional information from the practice.

We revisited Needham Country Practice on 24 November 2016.

Requires improvement

Are services safe?

Our findings

On the day of the inspection we found that the practice had made improvements to the issues identified in the inspection report from December 2015. However these needed to be improved further.

- During our previous inspection in December 2015, we noted that the practice had not given infection prevention and control training to practice staff and the staff member identified as the lead had not received appropriate training to undertake this role. An audit had not been completed.
- At our inspection in November 2016, the practice demonstrated that they had taken action. A GP and nurse had attended a two day course on infection prevention and control. We saw the practice had engaged a nurse experienced in conducting audits to assist them with an audit of the premises. We reviewed the report and noted that actions were identified and some of these had been completed.
- Clinical staff had received training but non-clinical staff had not. None of the practice staff had received hand washing training. The practice told us all training was booked and would be completed by January 2016.
- We saw that the practice had undertaken a risk assessment in relation to damaged flooring in a treatment room. The practice explained that plans for an extension had been agreed and the treatment room would be relocated. The risk assessment included a review, and monitoring, of the cleaning arrangements to mitigate potential risks of poor infection prevention.
- During our inspection in December 2015, we found that the practice did not have a record of the immunisation status of the clinical staff employed at the practice.
- On the day of the inspection November 2016, the practice held records of practice staff but had not recorded the status of locum GPs who, on occasions, worked at the practice. The practice was aware of this and had contacted the locums concerned.
- During our inspection in December 2015 we identified that the practice had failed to ensure that all equipment had been calibrated and was safe to use.
- On the day of the inspection November 2016, we saw the practice had engaged the services of a specialist company to calibrate and check all equipment. The practice told us that they had agreed an annual contract for this work to be undertaken.
- During our inspection in December 2015 we identified that the practice had not undertaken a risk assessment for the management of legionella's disease.
- On the day of the inspection November 2016 we saw a risk assessment had been completed but the practice had failed to ensure that regular monitoring of the water temperature was undertaken to mitigate the risk found.
- During our inspection in December 2015 we found patients and staff were at risk of harm, the practice had not ensured that regular fire drills were undertaken.
- On the day of the inspection November 2016 we saw the practice had arranged fire safety training for the staff and had undertaken regular drills. We reviewed the fire assessment completed in November 2016 and found that this was not sufficient to ensure that patients and staff would be safe from harm. For example, only four risks were assessed, the source of ignition, the storage of oxygen cylinder, electrical items, and keeping emergency exits clear. The risk assessment did not include risks to patients with impaired mobility or those who may be in a wheelchair or those who are undergoing a minor surgery procedure. The practice had not completed a risk assessment of the branch sites. They told us that they would undertake this immediately.
- During our inspection in December 2015 we found practice staff who undertook chaperone duties had not been trained in accordance with the recent best practice guidelines.
- On the day of the inspection November 2016, we saw training records to show staff had undertaken this training with the lead GP. A chaperone policy stated that all staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice had not followed their policy; non-clinical staff who undertook chaperone duties had not received a DBS check and the practice had not undertaken a written risk assessment. On the day of the inspection the practice applied for the necessary checks to be carried out.

Are services well-led?

Requires improvement

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

Our findings

- During our inspection in December 2015 we found the practice was not protecting patients against the risks associated with the lack of availability of information in relation to the protocols and policies required in the governance of the practice. The practice did not have adequate risk assessments in place to ensure that patients and staff were kept safe from harm.
- During our inspection in November 2016 we found that the practice had employed a full time practice manager who had been in post since April 2016. The practice explained they had recognised, following our previous inspection, a need to introduce this role to make the improvements required. The staff member told us the GPs in the practice were supportive and advice and guidance was available.
- Following the practice manager's induction, the practice had made improvements. 106 policies and procedures had been written and a process to ensure these were embedded and part of the culture of the practice was ongoing.
- Risk assessments had been completed, for example, fire safety and infection prevention and control, but these needed further improvement. The practice manager told us that a training course had been booked and this would give them the knowledge and skills to improve risk assessments undertaken.
- The practice had improved communication within the practice, a programme of regular meetings was in place, and a process to ensure the minutes were shared electronically with the whole practice team was recently introduced. Further training was planned to ensure that all staff were able to access the practice intranet.
- Regular training events had been held. For example in October 2016 a training event was held to inform practice staff how to use the recently implemented electronic system for viewing protocols and policies.
- The system to manage complaints had been improved. All feedback however minor was recorded and reviewed. A book for verbal feedback had been introduced in reception, this enabled the practice to identify trends and encourage improvements. Fifteen complaints had been received since April 2016; we saw that appropriate action had been taken. The practice is continuing to develop the system to ensure that shared learning is shared with all the staff members in the practice.
- Not all staff had received an annual appraisal; the practice had a programme for these to be completed in January 2016. The practice manager told us that they had an open door policy for any staff member to speak with them at any time.
- On the day of the inspection, we noted that the practice manager had been in post for seven months prior and had not fully completed all the improvements identified in our previous inspection. In addition, some of the changes implemented can only be assessed once the new methodology has been put into practice – then the appropriateness, workability and sustainability of the new systems and processes can be determined.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** • The practice had not completed a training programme to ensure all practice staff had received timely, all training deemed mandatory. • The practice had not completed the programme of annual appraisals to ensure that all practice staff receive the opportunity to discuss their performance and future development plans.

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The practice did not fully assess, monitor, and mitigate the risks relating to the health, safety, and welfare of service users and others who may be at risk. • Some of the risk assessments undertaken at the practice did not contain sufficient detail to ensure identified risks are mitigated and not all actions identified had been taken to keep patients and practice staff are safe from harm. • The practice had not followed its own policy and had not ensured that all staff who undertook chaperone duties received a Disclosure and Barring Service check nor had a written risk assessment been undertaken.