Boughton Surgery

Quality Report

Boughton Surgery
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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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
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 comprehensive inspection at Boughton Surgery on 27 January 2015. Overall the practice is rated as requires improvement.

Specifically we found the practice requires improvement for providing safe services and for well led services. It was good for providing effective, caring and responsive services. It also required improvement for providing services for older people, people with long-term conditions, families children and young people, working age people (including those recently retired) and people experiencing poor mental health (including people with dementia).

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

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, safeguarding systems in place were not robust enough, monitoring of infection control and cleaning procedures were incomplete, security and storage of medicines were unsafe, and appropriate recruitment and competency checks on staff had not been undertaken. The systems to ensure the safety of emergency equipment, to mitigate against the risk of legionella and to ensure effective infection prevention and control were not robust.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- 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.
- Urgent appointments were usually available on the day they were requested. However patients said that they sometimes had to wait a long time to be seen by a GP once they arrived at the practice.
- The practice had a number of policies and procedures to govern activity; however some of these were over five years old and had never been reviewed. We were told the practice held regular governance

Summary of findings

meetings where issues were discussed. During our inspection we asked to be provided with minutes of meetings, but were only provided with a few which represented an 'ad hoc' approach to minute taking.
- The practice had not proactively sought feedback from staff or patients.

The areas where the provider must make improvements are:

- Review policies and procedures to ensure they are up to date and fit for purpose.
- Improve infection control procedures including monitoring the quality of the cleaning.
- Improve security in relation to medicines to ensure that they are not accessible to patients.
- Ensure improvement of the monitoring of the collection of dispensed prescriptions at external locations.
- Ensure there are sufficient supplies of emergency equipment available and implement a more effective monitoring system.
- Ensure there are policies and procedures in place for the management, testing and investigation of the risks associated with legionella.
- Ensure there are systems in place to regularly monitor and assess health and safety risks.
- Ensure the health and safety of medicines is addresses, for example the storage of medicines in the dispensary.

In addition the provider should:

- Ensure all staff are up to date with training relevant to their role.
- Ensure staff training and development objectives are reviewed and staff supervisions are completed.

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

The practice is rated as requires improvement for safe as there are areas where improvements should be made. Staff understood their responsibilities to raise concerns, and report incidents and near misses. When things went wrong, reviews and investigations were thorough and lessons learnt were communicated widely enough to support improvement. Risks to patients who used services were assessed, but systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example the systems to ensure the safety of medicines, to mitigate against the risk of legionella, to ensure effective infection prevention and control and to ensure there were safe recruitment processes in place.

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 health. Staff had received training appropriate to their roles. There was evidence of appraisals for staff, however not all staff had received supervision. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice well. Patients said they were treated with compassion and dignity and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff mostly treated patients with kindness and 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 Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example staff provided support to those patients unable to attend the practice by delivering medicines and providing holistic support to those in rural locations with no transport available. Patients said they were able to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the

Summary of findings

same day. However some patients commented on the length of waiting time once they arrived for their appointment. The practice facilities were equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led, as there are areas where improvements should be made. The practice had a small patient reference group (PRG). The practice was actively encouraging patient recruitment to this group. Staff said that they felt valued, well supported, and involved in decisions about the practice. There was strong teamwork and a commitment to improving the care and services for patients, but several aspects of the services were not well led. Some systems were in place to assess and manage risks and to monitor the quality of services provided. However, there were areas where effective systems were not established to drive improvements and to monitor the quality of the services provided. Practice staff had not monitored infection control, or carry out audits at regular intervals to provide assurances that policies were being followed.

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

Requires improvement

Although the practice is rated as good for providing effective, caring and responsive services they are rated as requires improvement for providing safe services and for well led services. The concerns which led to these ratings apply to all population groups including this one.

The practice offered a named GP for those patients who were 75 years and older in line with the new GP regulations. The practice was responsive to the needs of older people, including offering home visits and remote consultation sites in the local villages of Stoke Ferry and Northwold for those patients living in isolated rural communities and unable to travel to the main practice. Rapid access appointments were available for those with enhanced needs.

The practice held monthly multidisciplinary meetings with other healthcare professionals to discuss patients with palliative care needs to ensure they received appropriate care.

The practice delivered a direct enhanced service to avoid unplanned hospital admissions for those patients with a high risk of their health deteriorating rapidly. The practice also offered health checks for patients over the age of 75.

Immunisations to protect against flu, shingles and pneumococcal vaccinations were offered to older patients.

People with long term conditions

Requires improvement

Although the practice is rated as good for providing effective, caring and responsive services they are rated as requires improvement for providing safe services and for well led services. The concerns which led to these ratings apply to all population groups including this one.

There were registers of patients with long term conditions which enabled the practice to monitor and arrange appropriate medication reviews. The practice nurse supported patients with a variety of long term conditions such as chronic obstructive pulmonary disease, and blood pressure monitoring of patients.

The practice used the Quality and Outcomes Framework to monitor patient outcomes and worked on local initiatives. For example the admissions avoidance initiative. Longer appointments and home visits were available when needed. All patients with long term conditions had a named GP and a structured annual review to check

Summary of findings

that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Requires improvement

Although the practice is rated as good for providing effective, caring and responsive services they are rated as requires improvement for providing safe services and for well led services. The concerns which led to these ratings apply to all population groups including this one.

Mothers and babies received their six week post natal checks at the practice, babies' vaccines and immunisations were provided by the nurse. There were systems in place 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 A&E attendances.

The practice worked with other healthcare services to encourage parents to bring children for vaccinations when they had not had them. Immunisation rates were high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Staff were knowledgeable about child protection and a GP took the lead for safeguarding. Staff updated the patient record when safeguarding concerns were raised.

Working age people (including those recently retired and students)

Requires improvement

Although the practice is rated as good for providing effective, caring and responsive services they are rated as requires improvement for providing safe services and for well led services. The concerns which led to these ratings apply to all population groups including this one.

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 provided early morning appointments with two regular locum GPs to support and accommodate patients who worked. The practice offered 'open surgery appointments' as well as pre-bookable appointments. All patients were offered referrals to hospitals of their choice by operating a 'Patient Choose and Book' service and appointments were made by the GP. The practice offered a full range of health promotion and screening that reflected the needs of this age group.

Summary of findings

People whose circumstances may make them vulnerable

Requires improvement

Although the practice is rated as good for providing effective, caring and responsive services they are rated as requires improvement for providing safe services and for well led services. The concerns which led to these ratings apply to all population groups including this one.

The practice kept a list of patients with learning disabilities and arranged support and an annual health check. Longer appointments for people with a learning disability were offered. The practice supported patients that were homeless to access health services and would signpost them to any relevant service. Translation services were available to ensure patients whose first language was not English could receive GP appointments and also access other local health care services. Staff told us local migrant workers were able to register at the practice and staff worked with them to ensure they attended appointments for health screening and treatments including vaccinations and immunisations.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Information was available for vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Requires improvement

Although the practice is rated as good for providing effective, caring and responsive services they are rated as requires improvement for providing safe services and for well led services. The concerns which led to these ratings apply to all population groups including this one.

The practice maintained a register of patients who experienced mental health problems. The register was used by clinical staff to offer patients full assessments an annual health check, seasonal vaccinations and medication review. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice provided dementia screening services and referrals were made to specialist services as required. The practice carried out advance care planning for patients with dementia.

The practice sign-posted patients experiencing poor mental health to various support groups and voluntary organisations including

Summary of findings

MIND. Patients were referred to local counselling sessions where appropriate and available. There were systems in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We found mixed evidence when we looked at the 2014 and 2015 National Patient Survey for Boughton surgery. The 2015 survey reported 94% of patients found it easy to get through to the surgery by telephone and 97% of respondents found receptionists at the practice helpful. However 40% of respondents reported they had to wait 15 minutes or less after their appointment time to be seen and 48% reported they had to wait a bit too long or far too long once arriving for their appointment.

We collected 34 Care Quality Commission comment cards from a box left in the practice a week before our inspection. The vast majority of the comments on the cards were positive about the care and treatment received at the practice.

Patients told us they did not know how to complain, but commented they would firstly speak with the receptionists. Patients told us they liked the continuity of care they received. Patients also knew they could get a same day appointment for urgent care when required. Patients told us they felt the staff respected their privacy and dignity. Patients told us they were happy with the practice facilities.

We spoke with a total of ten patients on the day of our inspection. Patients told us that they were satisfied they were treated with dignity and respect and with the systems in place for repeat prescriptions. Patients reported that all the staff were friendly and helpful. One patient told us that once they got to see the GPs they were caring, supportive and provided excellent treatment and that the practice and staff were lovely.

However we received mixed comments about individual members of staff. Seven patients we spoke with told us they felt a particular member of staff at the practice was unapproachable.

Most patients felt that they were able to access the service within a reasonable timeframe. Nevertheless some patients expressed dissatisfaction with the appointment system. In particular several patients we spoke with told us they often had to wait a long time to see the GP once they had arrived at open surgeries. Two patients also raised this as an issue of concern on comment cards. In addition several concerns were raised about the cleanliness of the furniture and carpets.

Areas for improvement

Action the service MUST take to improve

- Review policies and procedures to ensure they are up to date and fit for purpose.
- Improve infection control procedures including monitoring the quality of the cleaning.
- Improve security in relation to medicines to ensure that they are not accessible to patients.
- Ensure improvement of the monitoring of the collection of dispensed prescriptions at external locations.
- Ensure there are sufficient supplies of emergency equipment available and implement a more effective monitoring system.
- Ensure there are policies and procedures in place for the management, testing and investigation of the risks associated with legionella.
- Ensure there are systems in place to regularly monitor and assess health and safety risks.
- Ensure the health and safety of medicines is addresses, for example the storage of medicines in the dispensary.

Action the service SHOULD take to improve

- Ensure all staff are up to date with training relevant to their role.
- Ensure staff training and development objectives are reviewed and staff supervisions are completed.

Boughton Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by CQC lead inspector. The team included a GP specialist advisor, a CQC Inspection manager and a second CQC inspector.

Background to Boughton Surgery

Boughton Surgery provides general medical services Monday to Friday from 8am to 6.30pm. The practice offers 8am appointments with locum GPs to enable better access for patients.

The practice provides primary medical services to approximately 3,200 patients and is situated in the rural village of Boughton near Thetford, Norfolk. The premises were purpose built with limited room for growth. Access throughout the building is restricted, this meant that it was difficult for people using a wheelchair to access the toilets and the nurse treatment room. There are ample car parking facilities.

The practice has a team of four male GPs meeting patients' needs. Two full time GPs are partners meaning they hold managerial and financial responsibility for the practice. Two part time GPs operate on a locum basis and provide one to four pre-booked clinical sessions per week. In addition, there is one practice nurse who works 0.75 of a full time equivalent, one healthcare assistant, a lead dispenser and a team of receptionists/administration/dispensing assistants. In addition there is a practice manager, a medical administrator and a cleaner.

Patients using the practice also have access to community staff including the community matron, district nurses, community psychiatric nurses, counsellors, support workers and midwives. A neighbouring practice provided intrauterine coil fittings and the GPs are able to refer Boughton patients to the practice for treatment.

The practice provides services to a diverse age group, in an isolated rural location.

Outside of practice opening hours a service is provided by East Anglian Medical Care, by patients dialling the national 111 service.

The practice operates an open surgery, this meant that patients could arrive at the surgery and wait to be seen; routine appointments are available daily and are bookable up to six weeks in advance. Urgent appointments are made available on the day and telephone consultations also take place.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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.

Detailed findings

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

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
- 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 inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 27 January 2015. During our inspection we spoke with a range of staff including GP partners, the practice nurse, the health care assistant, dispenser, reception and administrative staff and the practice manager. We spoke with ten patients who used the service. We observed how people were being cared for and talked with family members and reviewed personal care or treatment records of patients. We reviewed 34 comment cards where patients and members of the public shared their views and experiences of the service.

We looked at various records and documents connected with how the practice carried out its work. We conducted a tour of the premises and looked at records in relation to the safe maintenance of premises, facilities and equipment.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. Staff were able to give examples of dealing with concerns and were aware of the process they should use to report safety concerns and the named staff member with responsibility for various areas at the practice such as health and safety and infection control.

Records held of significant events and complaints showed that recent issues had been considered in a timely way. We reviewed safety records, incident reports where these were discussed. This showed the practice had managed these over time and so could show evidence of a safe track record.

There were systems for dealing with alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA). The alerts had safety and risk information regarding medication and equipment, often resulting in the withdrawal of medication from use and return to the manufacturer. There were also arrangements for reviewing and acting on National Patient Safety Agency (NPSA) alerts. These alerts are issued to help reduce risks to patients who receive NHS care and to improve safety. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were tasked to all relevant staff to ensure they were aware of any that were relevant to the practice and where they needed to take action.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw a significant event policy and documentation which facilitated the process of significant event reporting, investigation and promoted review at regular intervals. We saw that learning had taken place from an incident where the incorrect medicine was dispensed to a patient. The medicine was returned by the patient, the correct medicine provided and an apology issued. We were told that the situation was discussed in a practice meeting to ensure all staff members learned from the incident. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration and told us they felt encouraged to do so.

We tracked incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result such as changes to GP referral processes. 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.

Staff including receptionists, administrators and nursing staff told us the practice had an open and transparent culture for dealing with incidents when things went wrong or where there were near misses. They told us that they were supported and encouraged to raise concerns and to report any areas where they felt patient care or safety could be improved.

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 staff had received relevant role specific training on safeguarding.

There were GP leads in safeguarding vulnerable adults and children and they could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. There was a 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 and patients with co-morbidities/multiple medications who required repeat medication reviews. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information.

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). The nursing staff, including health care assistants, had been trained to be a chaperone. Other staff required to act as a chaperone if nursing staff were not available had undertaken chaperone training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. However, not all staff had undertaken DBS

checks and the practice had not undertaken any risk assessment in relation to the level of DBS checks required of the administrative staff who undertook chaperoning duties.

Medicines management

The practice provided a dispensing service to its patients. However we identified a number of issues which did not assure us that there were effective systems in place to ensure the safety of medicines.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. 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.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were not stored securely in all instances. Medicines were accessible to staff, but two pharmaceutical fridges containing vaccines were stored in an upstairs hallway and could potentially be accessed by patients.

There was a 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. We saw that daily temperature recordings were present and up to date.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Prescription forms were handled electronically in accordance with national guidance as these were tracked through the practice. We saw these were stored securely.

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 these were managed. We saw that these procedures were followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. If prescriptions were not signed before they were dispensed, staff were able to demonstrate that these were risk assessed and a process was followed to minimise risk.

Records showed that not all members of staff involved in the dispensing process had received appropriate training. One dispensing assistant who had recently joined the dispensary teams training was overdue, which the practice informed us they would address. There was no evidence that all dispensing staff's competence had been checked regularly. All the dispensary staff we spoke with told us they felt they and their development was well supported by the practice, however there were no records to verify this.

The practice had established a service for patients to pick up their dispensed prescriptions at two external locations. This allowed for better access for patients who would otherwise be unable to obtain their medication due to the isolated rural locations, limited transport and difficulty accessing services. The practice manager told us there were no systems in place to monitor how these medicines were collected. There were no arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required, that identities were checked, nor were there any risk assessments on the collection of medicines from these locations. We discussed this with the practice manager who agreed to take actions to assess these concerns; however we have not received confirmation of these actions since our inspection.

The dispensing area had limited space, resulting in storage issues for medicines, which as a result were stored on the floor. This created a work space with trip hazards and medicine storage risks.

Cleanliness and infection control

Patients we spoke with commented to us that the practice could improve on its cleanliness. We spoke with the practice manager about the cleaning schedules for the chairs and carpets in the reception area. We were told these were steam cleaned monthly. We were also told there was a cleaning schedule for all the curtains in the practice.

However we observed the chairs and carpets were stained and worn and there were no records to support there were cleaning schedules. Cleaning equipment was stored securely, but the practice could not provide evidence to demonstrate that any cleaning schedules were in place.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. Patients said that they saw the staff use personal protective equipment when they received treatment. Staff informed us they disposed of materials appropriately and cleaned surfaces after clinical interventions. However areas of the practice were limited in space and this prevented effective medicine, equipment and record storage. For example we saw boxes of medications on the floor in the dispensary and treatment rooms were cramped and cluttered.

The practice carried out a limited range of minor surgical procedures. However the treatment room used for this had not been risk assessed to ensure that infection control measures were in place to reduce the risks of spreading infection. For example, we noted the room was cluttered with limited storage space for equipment. We asked staff to provide evidence to demonstrate that the treatment room was cleaned between patients when minor surgical procedures were undertaken. This information was not made available to us.

The practice nurse was new in post and had taken on the role as lead for infection control. We were told by this member of staff they had undertaken infection control training in their previous employment. However we saw no records to support this. We saw evidence that some staff had received on-line infection control training. However, records did not indicate whether newly appointed staff had received any infection control training as part of their induction. One new member of staff told us they hadn't received any training since they started at the practice, but they added they had received training at their previous job in a GP surgery. The practice manager told us infection control audits had been undertaken, however it was not clear that any improvements identified for action had been completed. The GP told us no infection control issues had been identified at the practice.

Staff knew the procedure to follow in the event of a needle stick injury. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. A yellow contaminated waste bin was locked, but was free standing in the practice car park. This meant contaminated waste was not securely stored. We discussed this with the practice manager who told us this would be stored securely in one of the two new lockable sheds being erected in the practice car park. However we did not received confirmation of this action being taken following our inspection.

The practice manager confirmed that there was no policy and procedure in place for the management, testing and investigation of the risks associated with legionella (a bacteria found in the environment which can contaminate water systems in buildings). We observed that there was an unused bath in the staff toilet on the first floor that contained a number of bags of paper for shredding which would not allow these taps to be run daily to prevent the risks associated with legionella. The practice could not provide us with any evidence to demonstrate they had carried out a risk assessment to determine whether any action was needed to prevent the risks of legionella.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Medical equipment including blood pressure monitoring devices, scales, thermometers and emergency equipment were checked and calibrated to ensure accurate results for patients. We looked at the policy which was up to date.

We found the practice completed annual portable appliance tests (PAT) of their electronic equipment (PAT testing is an examination of electrical appliances and equipment to ensure that they are safe to use). There were also regular checks completed by staff to ensure that equipment was ready for use.

Staff told us that fire fighting equipment was regularly serviced. However, the practice was unable to produce records to confirm this when we requested. We asked staff about fire training and they were able to describe the fire training they received and the last fire drill. The practice manager showed us that staff had recently been asked to complete fire training through the e-learning system by the end of March 2015.

Requires improvement

Are services safe?

Staffing and recruitment

The practice did not have a recruitment policy that set out the standards it followed when recruiting both clinical and non-clinical staff. We discussed this with the practice manager who told us they were working with the practice CQC lead GP to update all the practice policies, procedures and appraisal systems. However they were unable to advise us of a timeframe for completing this work. This meant there were not clear and updated protocols in place to provide effective guidance when recruiting staff.

We looked at five staff records, these contained evidence that recruitment checks had been undertaken prior to employment. For example, we saw proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS).

There was an arrangement in place for members of staff, including dispensing and administrative staff, to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager could explain the system in place to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. However the records we saw did not assure us that risk assessments and regular tests had been undertaken as required. The practice manager told us the practice had carried out a fire risk assessment that included actions required to maintain fire safety in 2014. Staff confirmed they had undertaken fire evacuation drills and staff were up to date with fire training, but there were no records available to confirm this. The practice manager told us the fire risk assessment and testing documents had not been returned to them from the company that undertook the tests. We asked if copies of these could be sent to us after the inspection, but we did not receive them until August 2015.

We were not assured there was a robust, systematic and effective system in place at the practice to enable the practice to identify, assess and manage actual and potential risks to patients. For example the risks associated with medicines, recruitment practices and those associated with infection prevention and control. As the practice had not identified these risks, they had not taken action to assess and manage the risks to staff, patients and visitors.

Staff were able to demonstrate how they would escalate concerns about an acutely ill or deteriorating child or a patient who was experiencing a mental health issue or crisis.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. Emergency equipment was available, but limited, for example there was access to oxygen, but no oxygen mask in situ to use with the oxygen. An automated external defibrillator was available (used to attempt to restart a person's heart in an emergency). However records we saw and interviews with staff did not provide us with assurance that the emergency equipment had been checked regularly to ensure it would be effective in an emergency. For example there was no evidence of regular checks for equipment used for emergency airway management.

Emergency medicines were available in a secure area of the practice and staff we spoke to knew of their location. These included medicines for the treatment of cardiac arrest and anaphylaxis. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

We looked at the current business continuity plan. The practice manager told us the practice was currently reviewing the plan to ensure it was updated to deal with a range of emergencies that may impact on the daily operation of the practice. We were told there was a reciprocal arrangement with local practices in the event of the loss of building. The practice manager was able to describe the actions the practice would take in the event of power failure, adverse weather, unplanned sickness and access to the building. The practice manager told us the new document would also contain relevant contact details for staff to refer to.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing 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. We were told new guidelines were disseminated at practice meetings where the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurse that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The practice GPs took a lead role in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurse supported this work. The practice nurse carried out reviews for patients with long term conditions and carried out well man and well woman checks through pre-booked appointments. This enabled the GPs to treat patients with more complex medical conditions.

The senior GP partner showed us data from the local CCG of the practice's performance for prescribing, which was performing above average when compared to similar practices. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. The GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks. We were told regular reviews of referrals were discussed at meetings, and that improvements to practice were shared with clinical staff.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients.

These roles included data input, child protection alerts management and medicines management. The practice had a system in place for completing clinical audit cycles, a process by which practices can demonstrate on-going quality improvement and effective care. Clinical audits are ways in which the delivery of patient treatment and care is reviewed and assessed to identify areas of good practice and areas where practices can be improved. The GPs told us clinical audits were often linked to medicines management information and safety alerts.

We looked at the records for one completed clinical audit, which had been carried out around the interaction of combined drug therapy. We saw that patient medicines had been reviewed and amended where necessary. The monitored patients and audit were then reviewed after eight months so as to ensure that medical conditions and prescribing practices were in line with current National Institute for Health and Care Excellence (NICE) guidelines, in the best interests of patients and cost effective.

The practice kept a register of patients who were receiving palliative care and treatment and were monitoring and planning care in line with the requirements of these services. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. Staff described the process for ensuring that repeat prescriptions were checked and reviewed and the processes for alerting the GPs if they had any concerns. The IT system flagged up relevant medicines alerts when the GP prescribed medicines. We saw evidence to confirm that following the receipt of an alert the GPs reviewed the use of the medicine in question, prescribed alternatives or, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs and reviewed their treatments appropriately.

We looked at a selection of information about the practice. This included information from the practice Quality and Outcomes Framework (QOF) results. The QOF is a voluntary annual reward and incentive programme for all GP surgeries, detailing practice achievement in resourcing good practice. The practices overall QOF score for clinical

Good

Are services effective?

(for example, treatment is effective)

indicators were 93.9. This was slightly below the national average of 96.47. However this still demonstrated that the practice was providing effective assessments and treatments for patients with a range of conditions such as diabetes, dementia, learning disabilities and mental health disorders.

Effective staffing

The practice benefited from some reception staff who were qualified as dispensary assistants, healthcare assistants and in phlebotomy services. (Phlebotomy is the act of drawing or removing blood in order to obtain a sample for analysis and diagnosis). Practice staffing included medical, nursing, managerial, dispensing and administrative staff. We reviewed staff training records and saw that some staff were up to date with attending the training courses such as annual basic life support. However this was not true of all practice staff. Records showed that not all members of staff involved in the dispensing process had received training updates. One assistant was overdue training, which the practice informed us they would address. There was no evidence that all dispensing staff's competence was checked regularly. We discussed this with the practice manager who told us they would be reviewing staff training and supervision.

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

We reviewed five staff files for clinical and non-clinical staff. Staff received annual appraisals and had some training and development objectives set. However there was mixed evidence as to whether staff had received the necessary training to ensure they could carry out their role and responsibilities to the required standard. The practice nurse was expected to perform defined duties and was able to demonstrate that they were trained to fulfil these duties. For example, on the administration of travel vaccines. Following the inspection the practice were able to provide confirmation that staff refresher training had been updated, all non-clinical staff had received safeguarding training and the GPs and nurse had received adult and children safeguarding training.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of 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. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held monthly multidisciplinary meetings with external healthcare professionals to discuss those patients identified at risk of their health deteriorating rapidly. They had identified patients who were at risk of an unplanned hospital admission and their care was discussed so this risk could be reduced. This involved considering their care and treatment needs and monitoring them. GPs told us due to staffing issues within the local community nursing teams, the practice nurse and healthcare assistant had provided home visiting services for those patients in isolated rural communities and those unable to travel to the practice. This ensured patients who required necessary blood tests, ear checks and syringing received the treatment required to prevent health deterioration. The practice team told us this had worked so well they were arranging for this service on a regular basis to enable those isolated patients with overdue recalls for blood tests, clinical checks, dementia reviews to be visited by the practice team to complete health checks and reviews. We were told that as a small rural practice the majority of patients were known to the practice staff on a personal level along with their family members who lived locally and that several members of the practice staff visited vulnerable isolated patients to deliver repeat and necessary medication and to provide palliative help and support with other problems as required.

In addition we were told the multidisciplinary team meetings discussed the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses when available and other health care

Good

Are services effective?

(for example, treatment is effective)

professionals such as the local falls team who also offered patients medication reviews as part of their service. We looked at minutes of one meeting and saw that decisions about care planning were documented. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to co-ordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. There were systems for making sure test results and other communications detailing patient treatments and care needs were seen by GPs and dealt with appropriately.

The practice took part in the falls prevention scheme; vulnerable elderly patients who were most at risk of falls had been identified and a care plan created which identified the patients' carers, social services and community nursing team and next of kin. The practice had systems for making information about patients with complex care needs, such as those receiving end of life care, available to the out of hours service. The information included the patients' preferred place of care and resuscitation preferences to ensure the practice was able to comply with the patient's choices. We saw that treatment records for patients who had used the out of hours service were reviewed by the GPs when the practice opened so as to ensure that patients received the appropriate treatment. GPs and nurses at the practice worked closely with other health care professionals and agencies who support people with life limiting illnesses.

We were told and records we saw showed that multidisciplinary meetings took place at the practice monthly with a range of other health professionals in attendance to co-ordinate care and meet the needs of the patients. GPs met with other health care services to ensure that care and support was delivered in a co-ordinated way that met patients changing needs.

Electronic systems were also in place for making referrals, such as the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use. For emergency patients, a printed copy of a summary record could be provided for the patient to take with them to the hospital.

Consent to care and treatment

There was a practice policy for documenting consent for specific interventions. For example, cervical smears and minor surgical procedures. Patients' verbal consent was documented in their electronic patient notes. We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 1989 and 2014 and their duties in fulfilling it. These provided staff with information about making decisions in the best interest of patients who lacked the capacity to make their own decisions about their care. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

The practice had policies and procedures in place for obtaining patient's consent to care and treatment where people were able to give this. The procedures included information about people's right to withdraw consent. GP's and nurses we spoke with had a clear understanding of 'Gillick' competence in relation to the involvement of children and young people in their care and their capacity to give their own informed consent to treatment (a nationally recognised way of assessing whether children under sixteen are mature enough to make decisions without parental consent). Clinical staff demonstrated how they provided information, answered questions and obtained parental consent to baby immunisations.

Staff we spoke with were aware of patients who needed support from nominated carers. Clinicians ensured that carers' views were listened to as appropriate. Staff were able to give us examples of how a patient's best interests were taken into account if a patient did not have capacity. There was access to a telephone translation service should patients not have English as their first language although we were told there had been little need to use this facility.

Good

Are services effective?

(for example, treatment is effective)

The practice had not had an instance where restraint had been required in the last 3 years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

We noted a culture among the clinicians to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic flu vaccination for patients whose health placed them at an increased risk of complications from influenza and healthy living advice such as smoking cessation advice.

Newly registered patients were offered routine health checks with the GP. Patients between 40 and 74 years old who had not needed to attend the practice for three years and those over 75 years who had not attended the practice for a period of 12 months were offered a health check. Health checks were also available for patients with a learning disability with saw that of the 12 patients on the learning disability register 50% had received health checks in the previous year.

Information about the range of immunisation and vaccination programmes for children and adults such as shingles vaccination were signposted throughout the practice and on the website. Staff we spoke with and records we viewed demonstrated that last year's performance for all but one (meningitis c) immunisation were above average. The practice offered health checks and immunisations for older children when required.

The practice had mechanisms for identifying 'at risk' groups of patients, for example patients who were receiving end of life care, patients who were carers or with learning disabilities. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese. These groups were offered further health support and guidance in line with their needs.

The practice monitored patients due for cervical smear tests. Patients were sent a letter advising them that they should be tested and the practice were also informed. Patients failing to book appointments were contacted three times by letter by the practice to try and encourage them to attend. If they still did not attend further attempts were made either by phone or when attending the practice for other matters. Patient records were marked up accordingly so that they could be easily identified when they attended the practice. We looked at data which showed that for the year 2014 to 2015, the practice were in line with other practices nationally for cervical screening uptake by patients.

There was a range of health promotion leaflets available in the waiting area with information to promote good physical, mental and lifestyle health choices. We saw information about domestic violence advice and carer support displayed in waiting areas with helpline numbers and service details. Information available included advice on smoking cessation, alcohol consumption and contraception. Sexual health and smoking cessation sessions were provided. There were also leaflets signposting patients to other local and national support and advice agencies. Information about health promotion was available on the practice website.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the data available for the practice on patient satisfaction. This included the most recent information from the national patient survey, published in July 2015, based on responses from 109 patients. We also considered a survey of 107 patients undertaken in 2013/14 by the practice's patient reference group (PRG). The PRG is an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care.

Data from the national patient survey, published in July 2015, indicated there was a difference in the patient satisfaction results when compared with the local clinical commissioning group (CCG)and national average. For example 79% of patients surveyed felt that the GP treated them with care and concern. In comparison with 89% CCG average and a national average of 85%. 80% said the GPs were good at listening to them in comparison to the CCG average of 92% and national average of 89%. The PRG survey reported that just over 70% of patients surveyed felt they were treated with courtesy at the practice.

100% of patients surveyed, in the national patient survey carried out in July 2015 responded they had confidence and trust in the last nurse they saw or spoke with. 95% responded they had confidence and trust in the last GP they saw or spoke with. 58% of patients said that they would recommend the practice to somebody new to the area. The 2013/2014 PRG survey reported 83% of patients as rating the practice good, very good or excellent.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 34 completed cards and all 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. However six comments raised concerns regarding the length of time patients waited during open surgeries. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. We discussed these findings with the practice manager and registered manager who told us they were aware of patient concerns, but felt that patients historically were happy with the 'open surgery' the practice offered and they were continuing to monitor patient feedback and waiting times.

We spoke with 10 patients during our inspection and received mixed evidence about patients' satisfaction which aligned with the responses to the 2014 and 2015 National Patient Survey. Some patients told us they were very happy with the practice and with the staff. One patient told us that once they got in to see the GPs, they were very caring and supportive and provided excellent treatment. However, they found the waiting time during open surgery was unsatisfactory. Seven patients told us they had been waiting over two hours to be seen that morning. We asked patients if this was unusual and we were told there was usually a long wait to be seen. Patients we spoke with told us it was not unusual to wait in excess of one hour to be seen by the GP during open surgery.

We received mixed views from patients about how they were treated with some indicating the standard of caring and service they received was good. Others said that they had not been satisfied with the service provided by a staff member who, we were told, could be rude and dismissive to them and that they and their partners would not want to be seen by that person again. One patient told us they felt a staff member had been very rude to them and their partner, but they told us for personal reasons they had not felt comfortable raising this as a complaint with the practice. Another patient who told us they were unhappy and also told us they hadn't complained as they felt they didn't think they should. We discussed this with the practice manager who told us this would be discussed with the relevant member of staff.

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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by a sliding glass partition which helped keep patient information private.

Good

Are services caring?

Care planning and involvement in decisions about care and treatment

Data from the national patient survey, published in July 2015, reported that patients felt that 88% of the practice nurses were good at involving them in their care and treatment with 77% of GPs being good at involving them in their care and treatment. 98% of patients felt the nurses were good at listening to them with 80% reporting the GPs were good at listening to them. 98% of patients felt the nurses were good at explaining their tests and treatment and 83% reported the GPs were good at explaining their tests and treatment.

We asked patients if they felt involved in making informed decisions about their care or their family members where appropriate. They told us they felt options were explained to them to enable them to understand the choices available and potential outcome of any decision. However we were told that some patients didn't always feel they were listened to and preferred to see the GP of their choice.

Patients told us staff provided both verbal and written information to assist them to understand their assessment, diagnosis and treatment options. Where appropriate patients were referred to other sources of information such as websites and community support groups to assist them.

Patient/carer support to cope emotionally with care and treatment

The reception team managed a daily diary where information, comments and concerns were noted for the attention of the practice team. We were told tasks were sent to the clinicians and these were viewed daily to ensure they were aware of any changes or deterioration in patients' needs. For example we saw that comments received by reception regarding patient on end of life care had been recorded and passed onto the team for their attention.

Where people had carers or had disclosed caring responsibilities these were documented on the patient record and considered when care and treatment were being discussed, agreed and delivered. For example, the practice had arranged district nurses to attend a patient when the carer was unable to support the patient, to monitor their condition and administer medication. Where there had been a shortfall in local district nurses the practice nurse and healthcare assistant had provided a service for vulnerable patients in isolated rural locations.

Data from the national patient survey, published in July 2015, reported that 98% of respondents felt that the nurses were good at treating them with care and concern. 79% reported the GPs were good at treating them with care and concern in comparison to 89% of patients within the CCG area and 85% of patients nationally .

We asked the practice about how they assisted bereaved patients. Where patients had disclosed a recent bereavement the GPs provided individual care to meet the patient's needs. Staff gave us an example of the loss of a patient and how they had identified family members affected by the unexpected death. Patients told us staff had spoken with and supported them to see their GP and obtain timely advice. Several members of the reception and management team visited patients living remotely in their own home delivering repeat and acute medications and providing help and pastoral support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood and was responsive to the different needs of the population it served and acted on these to plan and deliver services. The practice kept registers for patients who had specific needs including those with dementia, mental health conditions, learning disabilities and those with life limiting conditions who were receiving palliative care and treatment. These registers were used to monitor and respond to the changing needs of patients.

The practice utilised an electronic medical records system to record and collect information regarding patients. The practices used a central booking system for making referrals to secondary care which gave patients a choice of location for their appointments.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example promoting integrated care amongst health and social care professionals within the area to ensure coordinated care for patients; including the patients at risk of falls and for people with mental health needs. One GP partner attended local CCG meetings. They told us their involvement in these meetings enabled them to gain a wider perspective on service delivery and challenges within the area; therefore informing service improvement to their practice. Examples given included optimisation of prescribing and reduction in prescribing costs. We saw examples of nine reviews of prescribing trends across the GPs, eight of these showed evidence of appropriate reduction in prescribing spend in comparison to local CCG averages.

The practice monitored patients who were elderly and those considered to be frail and at risk of an unplanned hospital admission. The target for this service was 2% of the patient population. The practice had identified additional numbers that required support and there were currently monitoring younger palliative patients requiring this type of support. We were told that as a small practice patients and families were well known to staff on a personal level and therefore they were able to identify patients through an awareness of their needs and through patient records. Patients identified were recorded in a register and then their health was monitored. One of the GPs and a nurse at the practice had taken the lead role in this service and this involved visiting all of the patients on the register in their own homes.

Each patient was assessed and asked to complete a form about them in order to accurately identify their healthcare needs. Multidisciplinary meetings then followed with the GP, nurse, a member of the falls team, community matron and other health care professionals to design an individualised care plan for each patient. A new local initiative was put in place to improve care for the elderly through improved communication across health agencies. The practice had since reviewed A&E admissions for this group of patients and identified a theme that indicated that falls caused a high percentage of these admissions. This had resulted in more emphasis on referrals to the local falls prevention team in order to further reduce the risk of an unplanned hospital admission.

Tackling inequity and promoting equality

The practice understood and responded to the different needs of patients from different ethnic backgrounds and those who may be vulnerable due to social or economic circumstances. Staff were able to describe examples of the support they provided patients whose circumstances meant they were vulnerable. The practice manager told us that the majority of patients were English speaking and that they had very few patients from minority ethnic communities. Patients who were affected by alcohol or substance misuse were referred by the GPs to the Norfolk Recovery Partnership.

Patients who needed extra support because of their complex needs were allocated a longer time for their appointments. We saw patients with learning disabilities and those affected by dementia had specific tailored care plans in place to meet their needs as well as those with long term medical conditions.

The practice services for patients were situated on the ground floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for access to the treatment and consultation rooms. Toilet facilities were available for all patients attending the practice, however access through doorways and corridors were restricted for people who had

Good

Are services responsive to people's needs?

(for example, to feedback?)

limited mobility or were in wheelchairs. We discussed this with the practice who told us they were aware wheelchair access was challenging due to the constraints of the building. Staff told us they were available to assist patients with access to these areas of the practice when required.

Access to the service

Data from the national patient survey, published in July 2015, reported that 48% of patients responding to the survey reported having to wait a bit too long or far too long after their appointment time to be seen. 94% of patients found it easy to get through to the surgery by telephone and 97% of respondents found receptionists at the practice helpful. Data from the national patient survey, published in 2014, reported that 39% of patients responding to the survey at that time reported waiting more than 15 minutes after their appointment time. We discussed this with the management team who reported that they felt the open surgery remained popular with a high proportion of the patient population; however we were told they continued to monitor this. We were told longer appointments were available for patients who needed them and those with long-term conditions. This also included appointments with a named GP. Patients we spoke with confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed those in urgent need of treatment had been able to make appointments on the same day of contacting the practice.

Seven patients made negative comments about the length of waiting times to be seen during open surgeries or about getting appointments when they needed them. This was particularly highlighted as difficult for patients at work during the day, school children during term time and parents with young children. Others told us that they were able to get appointments readily, but were often prepared for a wait to be seen.

Positive comments were made about the helpfulness of staff when dealing with appointment demand and about the care and treatment received once seen. 97% of patients surveyed reported that the reception staff were fairly or very helpful.

Staff told us that the GPs visited patients at home if their health and mobility prevented them from coming to the practice for their appointments. This was the case for acute health problems and for patients with long term conditions whose health needed to be monitored. The practice provided consultations in local community buildings in the villages of Stoke Ferry and Northwold for those patients in rural isolation and unable to travel to the main practice.

The practice was open from Monday to Friday. Patients could book appointments by telephone, online or in person for pre-bookable or open appointments. This meant patients' could opt to sit and wait to see a GP. Patients were able to book appointments for the same day or in advance. In addition patients could opt to sit and wait at 'open surgeries' between 11am and 12 noon, Monday, Tuesday and Thursday and between 8.30am to 9.30am on Friday. Booked appointments were also available with two regular part time GPs operating on a locum basis from 8am to 10 am and 4pm to 6pm, these ran as one to four clinical sessions per week. The practice did not offer extended hours appointments.

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.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system on the practice website and the practice leaflet. Patients we spoke with were not aware of the process to follow if they wished to make a complaint, but said they would speak with a member of staff in the first instance. We were told by some patients that they were not comfortable to make a complaint.

We looked at one complaint received in the last 12 months and found this was on-going, but had been responded to in a timely way. The practice reviewed complaints annually to

Good

Are services responsive to people's needs?

(for example, to feedback?)

detect themes or trends. We looked at the report for the last review and no themes had been identified. However, GPs told us lessons learned from individual complaints had been acted on. Where necessary appropriate explanations and apologies were offered to patients.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a vision to deliver friendly, efficient, high quality services and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's mission statement. Senior staff supported the GPs in delivering a day to day service to meet the needs of patients. The practice aims and objectives were to provide the best quality care to patients in a safe and confidential environment.

We spoke with three members of staff who were not aware of the vision of the practice, but they all knew and understood what their responsibilities were. All staff were clear that they placed patients' best interests and welfare at the centre of everything they did, and that they aimed to provide the best quality care.

Governance arrangements

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. Staff we spoke with told us they knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We were told that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice manager told us about a local practice manager peer group that they took part in when possible, with neighbouring GP practices and the reciprocal arrangements in place with a neighbouring practice to provide specific care for Boughton patients such as contraceptive coil fittings.

The practice had policies and procedures in place to govern activity and these were available to staff as hard copies. We looked at the dispensary policies and procedures and all had been reviewed annually and were up to date. The dispensary staff had completed a cover sheet to confirm that they had read the policy. However, we found that not all policies were in place or had been reviewed and updates. For example, there was no human resource policy in place for recruitment and to manage and support staff. We discussed this with the practice manager who told us they were working with the practice CQC lead GP to update all the practice policies, procedures and appraisal systems. However they were unable to advise us of a timeframe for completing this work. This meant there were not clear and updated protocols in place to provide effective guidance to staff.

Our evidence indicated that the systems in place to identify assess and manage risks to patients, staff and visitors were not robust. For example recruitment practices, legionella testing, fire safety and equipment in place for managing emergency situations. Further we were not assured that the practice had robust and effective systems in place to enable the partners to assess and monitor the quality of the service by considering the views of patients, staff and visitors. For example we were concerned that the practice had not always acted on direct feedback from the patients with regard to being treated with respect. We were aware some patients had raised concerns regarding the way they had been spoken to and this was not always addressed by the practice.

Leadership, openness and transparency

The leadership structure included two GPs, a practice manager, a practice nurse, dispensary lead and a health care assistant. Within the small team all staff had lead responsibilities.

The practice held multidisciplinary clinical meeting once a month that were attended by the GPs, nurses and practice manager. We were told there were informal management meetings where complaints, significant events and safety issues, amongst other things, were discussed.
We requested to see minutes of these meetings and evidence of actions taken, but very few were provided. The practice told us that minutes were not routinely recorded. As a small practice they shared information on an informal basis and when speaking with staff we were assured that relevant issues had been discussed with them. However due to the absence of minutes this could not be evidenced by the practice and where learning had been identified and improvements made there was no audit trail to confirm they had taken place. The practice recognised this as an area for improvement and was open with us about this issue.

Staff we spoke with were clear about their roles and responsibilities and said that they felt valued and

Are services well-led?

Requires improvement

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

supported. Staff described the culture of the organisation as supportive and open, however not all the staff we spoke with felt comfortable to raise issues with the senior partner. Staff told us the practice manager had an 'open door' policy to discuss any concerns or suggestions. A whistleblowing policy was in place and staff were aware of this, but told us they had not had cause to use it.

Seeking and acting on feedback from patients, public and staff

The practice had a small patient reference group (PRG). However as there were only seven members we were told they were actively encouraging patient recruitment to this group. The PRG is a group of patients registered with the practice who have an interest in the service provided by the practice. The practice had gathered feedback from patients through annual surveys, complaints and compliments, and suggestion boxes within the waiting room area. We looked at the results of the 2015 annual patient survey. 94% of patients found it easy to get through to the surgery by telephone and 97% of respondents found receptionists at the practice helpful. However 48% reported they had to wait a bit too long or far too long once arriving for their appointment. We discussed the waiting times for open surgeries with the management team who reported that they felt the open surgery remained popular with a high proportion of the patient population; we were told they continued to monitor patient feedback and waiting times. However, we felt that the practice had not taken on board the fact that there were high numbers of patients who continued to feel they had waited too long once they arrived for open surgeries.

We saw that the practice and the PRG members had developed an action plan to address any issues arising from the patient group 2014/2015 survey. From this plan we saw that the practice was proactive in responding to the needs of patients. For example we saw that the practice had prioritised three areas of action; these included publication and hand-outs to offer patients more knowledge on what services were available at the practice, the practice was also looking into an updated telephone system to improve patient access and arranging increased online access to prescription ordering and appointment bookings.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and one of the partners. One member of staff told us that they had asked for specific training around dementia and diabetes awareness and this had happened. Some other members of staff mentioned that they were awaiting further training, but had not been provided with any yet. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us the practice manager was approachable and supportive. However, there were no formal supervision arrangements in place for some clinical and dispensary staff. Although they told us they were able to freely consult with the GPs when clinical issues arose and were invited to clinical and practice meetings, not all staff felt they were able and empowered to express their views and opinions or that any suggestions they had for improving the service would be taken seriously.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was very supportive of training. However we spoke with one member of staff who had been with the practice for several months, they told us they had recently been offered on-line customer care training. We were told that other than basic life support training they had not undertaken any training prior to this and they had not received any supervision or competency assessments since they started. The practice manager told us they were working with the practice CQC lead GP to update staff training and the practice policies, procedures and appraisal systems. Following the inspection the practice manager provided confirmation of training undertaken by staff since the inspection and confirmed that the practice would continue to monitor all staff training.

The practice had completed reviews of significant events and other incidents and we were told these were shared with staff at meetings to ensure the practice improved outcomes for patients. We saw evidence that learning from significant events took place and appropriate changes were implemented. We saw evidence of a significant event where the wrong medicine had been issued to a patient and the learning that took place from this incident.

We saw that there were immediate and daily reviews of issues through the daily diary in reception as opposed to trends or themed analysis.

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 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective systems and processes in place to ensure they assess and monitor their service against Regulations 4-20A of part 3 of the Health and Social Care Act 2008 (Regulated Activities). The provider must have a process in place to make sure this happens at all times and in response to the changing needs of people who use the service. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not protected people, or others who may be at risk against the risks of inappropriate or unsafe care and treatment because they did not assess, monitor and mitigate the risks relating to the health, safety and welfare of people and others, who may be at risk which arise from the carrying on of the regulated activity. For example we found that the registered person did not have a robust system in place to ensure that legionella checks were carried out. The registered person did not have a system in place to assess the risk of, and prevent, detect and control the spread of infection by means of adequate general cleaning and infection control. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1)(2)(a)(b)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

The registered person did not have a system in place to ensure the proper and safe management of medicines. The provider did not ensure there are adequate systems in place for the risk assessment of medicines supplied to patients from external locations. The provider did not ensure there are systems in place for the safe and secure storage of medicines at the practice. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person did not have a system in place to ensure the health and safety of staff and others in the general dispensary environment. This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person did not have a system in place to ensure that where emergency equipment is used by the service for providing care or treatment there are sufficient quantities to ensure the safety of service users and to meet their needs and it is safe for such use and is used in a safe way. This was in breach of regulation 16 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010, which corresponds to regulation 12(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.