# Great Massingham Surgery

## Quality Report

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Date of inspection visit: 2 February 2015
Date of publication: 20/07/2016

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

## Ratings

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

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced, comprehensive inspection on 2 February 2015.

Prior to our inspection we consulted with the local clinical commissioning group (CCG) and the NHS local area team about the practice. A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. Neither of these organisations had any significant concerns.

We spoke with patients and staff including the management team. The inspection focussed on whether the care and treatment of patients was safe, effective, caring, responsive and well led. During the inspection we spoke with patients and carers that used the practice and met with members of the patient participation group (PPG). A PPG is a group of patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care.

We also reviewed comments cards that had been provided by CQC on which patients could record their views.

We looked at patient care across the following population groups: Older people; those with long term medical conditions; mothers, babies, children and young people; working age people and those recently retired; people in vulnerable circumstances who may have poor access to primary care; and people experiencing poor mental health.

Our key findings were as follows:

The practice covered a large geographical and rural area, services had been designed to meet the needs of the local population.

Feedback from patients was overwhelmingly positive, they told us staff treated them with respect and kindness.

Staff reported feeling supported and able to voice any concerns or make suggestions for improvement.

Patients were treated with compassion, dignity and respect.

# Summary of findings

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies

Staff understood their responsibilities to raise concerns, and report incidents and near misses.

Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day.

The overall rating for The Practice  is 'Good'.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The practice is rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

**Are services effective?**

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. NICE guidance is referenced and used routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice could demonstrate that all staff had received an appraisal in which personal development plans were recorded. We saw evidence that staff worked well with other multidisciplinary teams.

**Are services caring?**

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

**Are services responsive to people's needs?**

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

# Summary of findings

**Are services well-led?**

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

# Summary of findings

## The six population groups and what we found

We always inspect the quality of care for these six population groups.

**Older people**

Good

The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs and home visits.

**People with long term conditions**

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check 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**

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. There were two young people who were part of the patient participation group (PPG).

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

Good

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

# Summary of findings

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice had carried out annual health checks for people with learning disabilities. The practice offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector 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 and out of hours.

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

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations including MIND and SANE. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for people with mental health needs and dementia.

# Summary of findings

## What people who use the service say

We spoke with five patients, including two members of the practice's Patient Participation Group (PPG). The patients we spoke with were very complimentary about the services they received at the practice; the overall friendliness of the staff, their caring nature and desire to help was mentioned. All patients said the doctors and nurses were extremely competent and knowledgeable about their treatment needs. They said that the service was exceptionally good and that their views were valued by the staff.Patients reported that staff treated them with dignity and respect and always allowed them time, they did not feel rushed.

We reviewed 50 CQC comment cards which had been completed by patients prior to our inspection. All were complimentary about the practice, staff who worked there and the quality of service and care provided. There were no negative comments recorded.

The latest NHS England GP Patients Survey completed in 2014 showed the large majority of patients were satisfied with the services the practice offered. The results were amongst the best when compared with GP practices nationally.The results were:

• The proportion of patients who would recommend their GP surgery – 94.4%

• GP Patient Survey score for opening hours – 83.2%

• Percentage of patients rating their ability to get through on the phone as very easy or easy – 85.9%

• Percentage of patients rating their experience of making an appointment as good or very good – 91.1%

• Percentage of patients rating their practice as good or very good – 97.1%.

The PPG also undertook their own survey of the practice in March 2014. There were very positive comments regarding patient's access and care, with 94% of respondents stating they were very satisfied with the care they received and 6% stated they were fairly satisfied. 91% recorded that they were able to book a GP appointment for the same or the next day.

# Great Massingham Surgery

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

The inspection was lead by a CQC Inspector. A GP Specialist Advisor also took part in the inspection.

## Background to Great Massingham Surgery

The practice is located in the rural village of Great Massingham in Norfolk and provides primary medical care services to approximately 5,900 patients within a defined geographical area. The practice does not remove existing patients from their list if outside the practice area but abides by the boundaries for prospective new patients. There is also a branch surgery located at Docking in Norfolk, where a minimum of 10 sessions per week are offered to patients.

District nursing and health visitor services are also based within the practice. There is also a room available for use by local voluntary organisations. There is a visiting midwife service and access to a community matron.

The practice is located in a single storey building. It also offers on-site parking, disabled parking, two disabled WCs and step-free access. The practice has five GP partners, two practice nurses, two healthcare assistants, a practice manager, a dispensary manager and seven staff who carry out reception and administrative duties. Surgery opening times at Great Massingham are between 8:30am and 6:30pm every day. An extended surgery is provided at Docking Surgery on a Tuesday afternoon.

## Why we carried out this inspection

We inspected this service as part of our new 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.

## 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
- The working-age population and those recently retired (including students)

# Detailed findings

- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. This did not highlight any significant areas of risk across the five key question areas. As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. This included the local Clinical Commissioning Group (CCG). We also spoke with one member of the practice's Patient Participation Group (PPG) during the inspection.We carried out an announced visit on 2 February 2015. We spoke with five patients and six members of staff from the practice. We spoke with and interviewed the practice manager, four GPs, a practice nurse, the dispensary manager and two staff carrying out reception and administrative duties. We observed how staff received and spoke with patients as they arrived at or telephoned the practice. We reviewed 50 CQC comment cards where patients and members of the public had shared their views and experiences of the service. We looked at results from the NHS England GP survey and the survey carried out by the practice's PPG. We also looked at records the practice maintained in relation to the provision of services.

An internal incident within the Care Quality Commission resulted in a protracted delay in this report being reviewed and agreed with the practice. As a result we carried out a further focused inspection on 11 July 2016 to ensure that the practice managed medicines in a safe and timely manner.

Good

# Are services safe?

## Our findings

### Safe Track Record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. National Patient Safety Alerts (NPSAs) came into the practice manager. All of the NPSAs were stored in the practice's shared folder and information placed on EMISweb for everybody to see.

### Learning and improvement from safety incidents

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients.

We saw mechanisms were in place to report and record safety incidents, including concerns and near misses. The staff we spoke with demonstrated an understanding of their responsibilities and could describe their roles in the reporting process. They told us there was an individual and collective responsibility to report and record matters of safety. Where concerns had arisen, they had been addressed in a timely manner. We saw outcomes and plans for improvement arising from complaints and incidents were discussed and recorded within staff meeting minutes.

There were formal arrangements in place for obtaining patient feedback about safety. The practice had carried out an in-practice patient survey and had an active Patient Participation Group (PPG). The practice manager told us that any concerns raised would be used to inform action taken to improve patient safety.

We reviewed safety and incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term. Learning and improvement from safety incidentsThe practice had a system in place for the reporting, recording and monitoring of significant events, incidents and accidents. Records were kept of significant events that had occurred during the last year and these were made available to us. A slot for significant events was on the monthly practice meeting agenda to review actions from past significant events and complaints.

There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager. The practice manager showed us the system they used to manage and monitor incidents.

We tracked five incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, for example, an incident had occurred when medicine dosages were changed by the GP but not recorded on the patient's electronic treatment record. This was identified and altered, along with an explanation to the patient.

National patient safety alerts were also reviewed by the practice manager then disseminated to practice staff as appropriate. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours.

The practice had a dedicated GP appointed as the lead in safeguarding. They had been trained at a higher level of training (Level 3), and could demonstrate they had the necessary knowledge to enable them to fulfil this role. We saw that all other staff had attended Level 1 training sessions and all of the other GPs had attended Level 3. All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding

concern. A health visitor had an office at the practice which enabled staff to contact them easily to share information related to children.We were told that the GPs used relevant codes on their electronic case management system to ensure that vulnerable patients, children and young people were clearly highlighted within the patient's or family's treatment records.

The GP leads for safeguarding were aware of who were the vulnerable children and adults in the practice.Records demonstrated good liaison with partner agencies such as the police and social services. We saw an example where a child safeguarding issue had occurred in the practice.

Review of this incident showed us that the practice managed this correctly and referred to the appropriate team.A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff, including health care assistants. If nursing staff were not available to act as a chaperone then reception staff would be utilised. Four receptionists had undertaken training and understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination.

Patient's records were managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of letters and test results from hospitals.The practice held a register of frail and elderly, and housebound patients. This highlighted which of their patients were at risk.

### Medicines Management

The dispensary manager had responsibility for ensuring medication dispensing was safe and monitored.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described. Processes were in place to check medicines were within their expiry date and suitable for use. This was the responsibility of the healthcare assistant.We checked a sample of medicines and found they were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.Vaccines were administered by nurses and the healthcare assistant in line with legal requirements and national guidance. We saw evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

There was a system used for repeat prescribing. We found that repeat medicines supplied at the dispensary were handed to patients before prescriptions were signed by the doctors. An internal delay within the Care Quality Commission resulted in us not discussing this with the practice until 11 July 2016. To ensure that the practice had mitigated any risks we visited the practice and discussed their system with them.

We found that the practice did have robust systems in place to ensure that patients were kept safe. Only NVQ level trained dispensing staff produced repeat prescriptions, these staff knew most of their patients very well.

Any changes to patient's medicines, for example from a hospital discharge or clinic letter were only made by GPs. All prescriptions for controlled drugs and acute medicines were signed before dispensing to patients and all repeat prescriptions were signed within 12 hours. Repeat medicines were authorised by GPs for a period of six months or less, The practice in line with the CCG guidelines) only issued one month's supply of medicines at each time.

The practice demonstrated a strict process to manage patient's medicine reviews. Any patient with a medicine review date looming or due was contacted by the staff and appointments booked with a GP. For patients who were housebound their GP visited them at their home. Patients who did not attend their review were limited to a further seven days supply; this ensured that all patients received a full medicines review each six months.

The practice had robust systems to manage patients who were taking high risk medicines. The practice undertook weekly searches to ensure that patients were followed up appropriately. A three monthly audit was performed to ensure that they were prescribing these medicines in line with best practice.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.The practice had established a service for patients to pick up their dispensed prescriptions. There were systems in place to monitor how

these medicines were collected. They also had arrangements in place to ensure patients collecting medicines were given all the relevant information they required.

### Cleanliness & Infection Control

We saw that the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness.The practice had a lead for infection control. They had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and annual updates thereafter.

The CCG had carried out infection control audits for each of the last two years, we saw that the practice attained 92% compliance in both audits.An infection control policy and supporting procedures were available for staff to refer to. This enabled them to plan and implement infection control measures 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 in order to comply with the practice's infection control policy. Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

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

### Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date, which was November 2014. A schedule of testing was in place.

### Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and where required, criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The practice manager was in the process of developing a system for checking that staff's registrations were up to date.Staff told us there were usually enough people on duty to maintain the smooth running of the practice and there were always enough to ensure patients were kept safe.

### Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For patients with long term conditions there were emergency processes in place to support patients when they became ill. Staff gave us examples of referrals made for patients that had a sudden deterioration in health.

The GP's had direct admission rights to the local community hospital. All patients with any identified risk were placed on an appropriate register. We saw that patients on the register were discussed individually at the monthly multi-disciplinary team meetings. The practice acknowledged they had a low percentage of learning disabled patients who had had annual health reviews. This was 43%. The practice visited patients on at least a weekly basis when they carried out ward rounds at the residential home. The practice was confident that their health needs were being met, however a formal annual health check could be distressing and challenging for patients.

A register for patients who suffered mental health problems was in place and patients were coded on the clinical

electronic records system. We were told that all patients with mental health problems received an annual review. Arrangements to deal with emergencies and major incidents.

### Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff we spoke with knew the location of this equipment and there was a notice in each room advising staff of its location. Records we saw confirmed this equipment was checked regularly.

In the minutes of one of the practice's significant event meetings, we saw that a medical emergency concerning a patient had been discussed and appropriate learning taken place.Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included, for example, those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia . Processes were also in place to check emergency medicines were within their expiry date and suitable for use.

All the medicines we checked were in date and fit for use.A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. There was a document in the practice but key staff also had a copy of the document at home as well.

Due to the rural nature of the practice, the practice had developed a winter planning policy. This identified where each of the members of staff lived, their usual transport into work and arrangements if they could not get in.A fire risk assessment had been undertaken. We saw records which showed staff were up to date with fire training and that regular fire drills were undertaken.

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 treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated. The implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them.

We were told that each GPs had the lead in specialist clinical areas such as diabetes, heart disease and asthma. The practice nurses supported this work which allowed the practice to focus on specific conditions by staff who had up to date knowledge on the condition. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with followed national standards for referrals. We saw minutes from meetings where regular reviews of elective and urgent referrals were carried out, and improvements to practise were shared with all clinical staff. Nursing staff had received the appropriate clinical training which ensured they were able to undertake their designated speciality roles, using the most up to date guidelines. For example one of the practice nurses had respiratory (asthma and lung disease(COPD)) and cardio vascular care diplomas.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs and other staff showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

### 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, clinical review scheduling, child protection alerts management and medicines management.

The GPs told us that clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). The practice showed us a number clinical audits that had been undertaken. In all of these completed audits the practice was able to demonstrate the changes had been introduced following the audit. We looked at two clinical audits that had been carried out. One audit looked at patients who were prescribed simvastatin and amlodipine, following a prescribing alert stating the maximum safe dose of simvastatin was 20mg. Patients were identified and their dose adjusted to be within safe levels. The practice intends to repeat this audit in six months. The second audit was in relation to pregabalin and any patients who had a dosage frequency of more than twice a day. We saw that patients were identified and their dosage frequency changed, unless the frequency change was countermanded by secondary care.

We also saw that the practice used computer software, ECLIPSE, which was an online audit system which ran in the background of EMISweb. The audit software monitored patients for side possible side effects of medication, for example patients on non-steroidal anti-inflammatory drugs were monitored for blood loss. The system flagged trends and identified potential problems before they became serious issues.

The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, the practice had met all the minimum standards for QOF in diabetes, asthma and COPD. This practice was not an outlier for any QOF (or other national) clinical targets and the practice's QOF scores were above the national average.The team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be

Good

# Are services effective?

(for example, treatment is effective)

improved. Staff spoke positively about the culture in the practice around audit and quality improvement and they told us that there was an expectation that all clinical staff should undertake at least one audit per year.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and dementia and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP prescribed medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

### Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with mandatory training such as annual basic life support. A good skill mix was noted amongst the doctors and GPs were up to date with their yearly continuing professional development requirements. All had been revalidated (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 practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals. These identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were in training to be qualified as GPs were offered extended appointments with patients and had access to a senior GP throughout the day for support.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for example seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease and people with learning disabilities were also able to demonstrate they had appropriate training to fulfil these roles.

### Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage complex cases. Blood results, x-ray results, letters and discharge summaries from the local hospital, out of hours providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in, reading, passing on and addressing any issues arising from communications with other care providers on the day they were received. All documents were scanned onto EMISweb, if they were not received electronically. The GP saw these documents and results and was responsible for taking necessary action to address any concerns. All staff we spoke with understood their roles and felt the system in place worked well. There was one instance within the last year of test results not being reviewed correctly. The practice could demonstrate that it had learned from this incident and had put new procedures in place.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patents for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers and palliative care nurses. Any decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice manager and the four GP's we spoke with told us the benefit of having both the district nurses and the health visitors based in the premises, although they did comment that there was a large turnover of these staff and lengthy times in between visits to the practice. This encouraged better and timely communication and an understanding of challenges to services.

### Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and

Good

# Are services effective?

## (for example, treatment is effective)

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.

### Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke to 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). Patients with learning disabilities and dementia were seen on almost a weekly basis by GPs from the practice. All patients on the registers lived in a local residential homes which was covered by the practice. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make certain decisions. All clinical staff demonstrated a clear understanding of Gillick competencies (these help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes, along with a record of the relevant risks, benefits and complications of the procedure.

### Health Promotion & Prevention

The practice had met with the Public Health team from the Local Authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant or practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. Electronic treatment records were used to highlight any concerns.

Members of the practice had recently attended a day set up by the PPG to give a talk about the practice and what it can offer. A number of other health agencies were also in attendance.

Information on a range of topics and health promotion literature was available to patients in the waiting area of the practice. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. The practice's website also provided some further information and links for patients on health promotion and prevention.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse led smoking cessation clinics to these patients. Similar mechanisms of identifying at risk groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the practice nurse.

A counsellor from mental health services held a session in the practice each week to support patients with mental health problems.

Good

# Are services caring?

## Our findings

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of patients undertaken by the practice's Patient Participation Group.

The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients rating the practice as good or very good.

The practice was also higher than average for its satisfaction scores on consultations with doctors and nurses with 94% of practice respondents saying the GP was good at involving them in decisions about their care and 97% saying that their experience at the surgery was very good.Patients completed CQC comment cards to provide us with feedback on the practice.

We received 50 completed cards and all were very 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.

We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments.

We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private.

The practice switchboard was located in a separate room away from the reception desk. There was a partitioned wall between the reception desk and the patient waiting area. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. In the national GP survey results there was a higher than average percentage of patients who felt that in the reception area other patients could not be overheard.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

We looked at data from the National GP Patient Survey data, published in 2014. This demonstrated that patients were satisfied overall with the practice. In particular, the practice performed better than comparators on the helpfulness of reception staff, the experience of making an appointment, and on GPs and nurses treating them with care and concern.

The practice had an active PPG, with representatives from a cross section of patient population groups. The participation group members we spoke with told us that the practice valued their contribution to the operation of the service and listened to their insights into the patient experience. The members told us how they felt the PPG was a two way bridge between the practice and the patients. They also said they felt listened to and that action was taken to address any issues identified.

We saw from the review of minutes from PPG meetings these claims were supported. The PPG had been instrumental in setting up community days within the village hall, inviting other health providers to attend. At the most recent day 18 organisations including the CCG attended. The PPG also regularly attends the regional PPG groups and has direct links with the CCG to ensure that they obtain current information.

### Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas.

Good

# Are services caring?

For example, data from the national patient survey showed 97% of practice respondents said the GP involved them in care decisions and felt the GP was good at explaining treatment and results. Both these results were above average compared to CCG area/national.

The results from the practice's own satisfaction survey showed that 98% of patients said they were very satisfied with the care they received at the practice.Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language, however they only had one patient on their list who did not have English as a first language.

QOF data showed us that 87% of patients on the register who had a comprehensive care plan had had this agreed between individuals, their family and /or carers as appropriate.Within the minutes of the practices prescribing meetings we saw that the practice was addressing concerns with a medicine Domperidone. All patients currently prescribed Domperidone had received letters asking them to attend for a medication review. This was because patients needed the current risks explained to them and a trail plan introduced for the stopping of the medication.

### Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area.

The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded with care and concern when they needed help and provided support when required.The practice had a policy for carers and hold a carers meeting at the practice monthly.

We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and support groups. Notices in the patient waiting room and patient website also signposted patients to a number of support groups and organisations.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs.

The NHS Local Area Team (LAT) 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.

There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for patients who needed them and those with long term conditions. This also included appointments with a named GP or nurse.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). For example, the group identified that better access to information and services for patients who do not regularly attend the practice was a priority. It was decided that a patient newsletter was a good way of disseminating information. We saw that newsletters were now being produced and a member from the PPG told us they were hand delivering to all patients home addresses and copies were available in local village halls and the library. The PPG had also organised a practice information day at the local village hall, with other organisations in attendance.

The practice had achieved and implemented the gold standards framework for end of life care. The gold standards framework (GSF) enables generalist frontline staff to provide a good quality of care for patients nearing the end of life. There was a palliative care register in place. Care plans were drawn up for patients on the palliative care register and were treated according to local Norfolk guidelines (which had been adapted from NICE guidelines).

The practice had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs. The practice worked collaboratively with other agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment. The community matron and health visitors had office space at the practice which assisted with multi agency working. The practice did comment that they never see or were contacted by social workers.

### Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. We asked staff how they made sure that patients who spoke a different language were kept informed about their treatment. Staff told us they had access to an interpretation service, however this had never been used due to all patients having English as a first language.

Free parking was available in a car park directly outside the building. We saw there were marked bays for patients with mobility difficulties. The practice building was accessible to patients with mobility difficulties. We saw there were low level buttons on the walls at the entrance to the practice, when pressed the doors would open automatically. The consulting rooms were large with easy access for all patients. There was also a toilet that was accessible to disabled patients. There was a large waiting room with plenty of seating; including smaller chairs for children.

### Access to the service

Surgery opening times at Great Massingham are between 8:00am and 6:30pm every day. The surgery at Docking is open between 8:30 and 6:30pm except Tuesday when extended hours are offered 8:30am-5pm (historically the surgery closed at 12 noon).

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 in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances.Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. This was reflected in the results of the most recent GP Survey (2014). This showed 91.1% of respondents

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

were satisfied with booking an appointment and 83.2% were satisfied with the practice's opening hours. These results were 'among the best' in comparison with GP practices nationally.

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. All patients we spoke with told us that they had not had to wait for an appointment if they felt it was urgent. The practice had a duty doctor telephone system so patients could receive telephone advice from a GP without initially visiting the practice. Repeat prescriptions could also be ordered either over the telephone, in person or on the practice's website. Patients had the opportunity to ask for prescription to be collected from the surgery or from a chemist, or a home delivery service, however 95% of prescriptions were dispensed from the practice due to its rural location.

### Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system There were information leaflets around the practice and information was also available in the practice handbook and on the web site.

The practice had a comments and suggestions box in the waiting area, however the practice manager told us that this was rarely used. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice. In addition, none of the 50 CQC comment cards completed by patients indicated they had felt the need to make a complaint.

Staff we spoke with were aware of the complaints policy. They told us they would deal with minor matters straight away, but would inform the practice administrator of any complaints made to them. This meant patients could be supported to make a complaint or comment if they wanted to. We looked at the three complaints received in the last twelve months and found that these were satisfactorily handled, dealt with in a timely way and feedback was provided to the complainant.

The practice reviewed complaints on an on-going basis to detect themes or trends. We were told, and review of the complaints data, confirmed that no themes had been identified, however lessons learnt from individual complaints had been acted upon.

# Are services well-led?

Good

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

## Our findings

### Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's aims and objectives. The practice vision and values included the provision of good quality primary care services, proactive management of long term conditions and liaison with other agencies and NHS colleagues to focus on what is best for the patient.

We spoke with seven members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. They all told us they put the patients first and aimed to provide person-centred care. The practice had in the past carried out team building away days. Due to staff changes a practice team building event was planned for the near future.

### Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at four of these policies and procedures and saw most staff had completed a cover sheet to confirm when they had read the policy. All the policies and procedures we looked at had been reviewed in 2014.

The practice held monthly governance meetings. We looked at minutes from the last meeting and found that performance, quality and risks had been discussed. The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with or above national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had completed a number of clinical audits, for example, first-line choices of medicines prescribing and attendant patient care audits. Audits were also conducted in response to specific triggers, with one GP undertaking a review of coeliac disease practice patients to check whether they had been reviewed.

The practice also undertook an audit of patients who did not attend (DNA) booked appointments. This was performed when it was noticed that there seemed to be an increase in the number of missed patient appointments. The practice manager monitored patient appoints for a one week period. They found that during the period from 23 to 27 June 2014 there had been 50 DNA appointments. Discussions on how to reduce this number were held at the partners practice meeting.

The practice had reviewed room security and computer security in unlocked clinical rooms during one lunchtime. Three rooms were found in breach of security arrangements. As a result of this an email was sent to all staff to share this information as a reminder regarding information governance and computer security. Findings were also shared to all computer users in the message of the week as a reminder.

Staff told us they were aware of the decision making process. For example, staff who worked within reception demonstrated to us they were aware of what they could and couldn't do with regards to requests for repeat prescriptions. We also found clinical staff had defined lead roles within the practice, for example, safeguarding and infection control. The purpose of the lead roles was to liaise with external bodies where necessary, act as a point of contact within the practice and ensure the practice remained up to date with any new or emerging guidance. Other staff were aware of who the leads were and told us they would approach them if they had any concerns or queries.

### Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. Staff told us they were aware of the decision making process. For example, staff who worked within reception demonstrated to us they were aware of what they could and couldn't do with regards to requests for repeat prescriptions. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for implementing the human resource policies and procedures. We looked at

# Are services well-led?

Good

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

the recruitment file of a new member of staff and files for two other staff members. These demonstrated that the practice had adhered to recruitment policies and staff had been recruited in an open and transparent way.

### Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through comments cards and the PPG practice survey. We looked at the results of the annual patient survey and 98% of respondents were either very or fairly satisfied with the care they received from the practice.

The practice's patient participation group (PPG) had remained a similar size with a small number of representatives. PPG members told us they were fully involved in how the practice operated. They told us they were fully involved in setting objectives with the practice for the year ahead, and contributed to any changes required following the annual patient survey. They said they were listened to and felt that patient opinion and feedback was always welcomed by the practice and suggestions were acted upon.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

### Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place and staff had personal development plans. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

We saw practice staff met on a regular basis. Minutes from the meetings showed the team discussed clinical care, audit results, significant events and areas for improvement.

The practice team met monthly to discuss any significant incidents that had occurred. The practice had a robust approach to incident reporting in that it reviewed all incidents even ones that were out of their control but involved their patients. The practice manager shared one such incident with us relating to a member of the community healthcare team. The practice communicated this to the community matron who responded to the staff member and the patient concerned.

The team discussed if anything, however minor, could have been done differently at the practice. All staff were encouraged to comment on the incidents. All of the staff we spoke with told us this was done in an open, supportive and constructive way.