Wymondham Medical Partnership

Quality Report

Wymondham Medical Centre
Postmill Close
Wymondham
Norfolk NR18 0RF
Tel: Tel: 01953 602220
Website: www.wymmed.co.uk

Date of inspection visit: 06 November 2014
Date of publication: 19/02/2015

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?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this practice on 6 November 2014 as part of our new comprehensive inspection programme.

The practice operates from one site in Wymondham and also provides a service to a local boarding school.

The overall rating for this practice is good. We found the practice was good in the safe, effective caring, responsive domains and required some improvement in the well-led domain. We found the practice provided good care to older people, people with long term conditions, people in vulnerable circumstances, families, children and young people, working age people and people experiencing poor mental health.

Our key findings were as follows:

- Patients were satisfied with how they were treated and that this was with compassion, dignity and respect. They felt the GPs listened to them and gave them enough time.
- Patients reported good access to the practice, had a named GP and received continuity of care, with urgent appointments available on the same day.
- The practice was responsive to the differing needs of its patient population.
- There was a culture of learning and development at the practice.

We saw several areas of outstanding practice including:

- Palliative care kits were available for patients to have in their own homes, this ensured that there was immediate access to medication if required.
- A dedicated sexual health service was provided

However, there were also areas of practice where the provider needs to make improvements.

The provider should:

- Ensure that learning from significant events and complaints is communicated to all staff groups.
- Ensure that there is a clear protocol for staff to follow when making decisions about whether a patient should have an appointment with a GP or a nurse.

Summary of findings

- Ensure that risk assessments are all recorded.
- Ensure that there are checking arrangements in place to keep patients safe from the risk and spread of infection.
- Policies and procedures should be regularly reviewed.

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 with key staff to support improvement. There were robust systems in place to protect children and vulnerable adults from the risk of abuse. Information about safety was mostly recorded, monitored, appropriately reviewed and addressed. There were systems in place to keep patients safe from the risk and spread of infection. We did, however, find there was one area where improvements were required and these were taken on the day of the inspection to minimise risk. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. National Institute for Care and Health Excellence (NICE) guidance was referenced and used routinely. People'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 through regular appraisals. Multidisciplinary working was evidenced.

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). Both of these organisations commission healthcare locally. Patients reported good access to the practice, had a named GP and received continuity of care, with urgent appointments available on the same day. The practice had good facilities and was well equipped to treat

Summary of findings

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.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for well-led. All staff were able to describe a shared vision but there was no overarching strategy and plan for future developments. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity, but some of these were overdue for review. Governance meetings were held every three months but the lines of communication with other meetings, for example 'data management staff meetings' were not always clear. The practice proactively sought feedback from patients and had an active patient participation group (PPG). The 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.

All staff had received inductions and had been trained to do their jobs, however the meeting structures and records of meetings and access to the records required some improvement.

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.

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. A dedicated service was provided to a local boarding school where a dedicated sexual health service was delivered. 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. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and

Summary of findings

offered continuity of care. Opening hours were extended to 8pm on Monday evenings and the practice also opened on Saturday mornings between 8am and 11am during which two GPs were on duty. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this population group.

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 held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities and been pro-active in encouraging people to attend those checks so that a high number of these patients had received a follow-up. The practice offered longer appointments for people with learning disabilities.

People experiencing poor mental health (including people with dementia)

Good

GPs told us that health promotion for patients experiencing poor mental health was managed through the annual health checks and regular medication reviews. Those patients were offered annual health checks and the practice carried out the expected number. If patients did not keep appointments for health and other checks the GPs told us they would send those patients a text through the computerised records management service to tell them they had missed their appointment and to check they were alright. The practice maintained a register of patients with mental health needs.

Summary of findings

What people who use the service say

We spoke with 10 patients on the day of our inspection and met with members of the PPG (Patient Participation Group). We also looked at nine cards from a comments box which had been placed in the practice to give us feedback for up to two weeks before we inspected. All were positive and reflected satisfaction with the service they received.

They told us that all staff were friendly and helpful, that they were treated with respect and that their dignity was protected. Patients described examples of when they thought staff had gone above and beyond what was expected of them. They said staff understood their needs, listened to them and took time to explain what was happening. Patients said they found the appointments system was good and if they needed an appointment on the same day they always got one.

Areas for improvement

Action the service SHOULD take to improve
Action the provider SHOULD take to improve:

- Ensure that learning from significant events and complaints are communicated to all staff groups.
- Ensure that there is a clear protocol for staff to follow when making decisions about whether a patient should have an appointment with a GP or a nurse.
- Ensure that risk assessments are all recorded.
- Ensure that there are checking arrangements in place to keep patients safe from the risk and spread of infection.
- Policies and procedures should be regularly reviewed.

Outstanding practice

- Palliative care kits were available for patients to have in their own homes.
- A dedicated sexual health service was provided.

Wymondham Medical Partnership

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector**.** The team included a second inspector, a GP, a practice manager, and an Expert by Experience. An Expert by Experience is someone who has extensive experience of using a particular service, or of caring for someone who has.

Background to Wymondham Medical Partnership

The Wymondham Medical Centre provides primary medical services from one surgery, The practice has a registered list of approximately 18,500 patients and provides a service to the town and villages within a five to six mile proximity.

The practice team consists of 10 GP partners, four salaried GPs, 14 nurses and a prescription manager supported by a practice manager. In addition there is a team of administrative and reception staff. There are five male and five female GP partners. This provides patients with a choice of the gender of the GP they would prefer to see. The practice provides training for medical and nursing students.

The practice does not provide an out-of-hours (OOH) service but they have alternative arrangements for patients to be seen when the practice is closed. Outside surgery hours patients can phone the surgery and will be directed to the OOH service.

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.

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?

Detailed findings

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 visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 6 November 2014. During our visit we spoke with a range of staff and spoke with patients who used the service. We observed how people were being cared for and talked with carers and family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. Reported incidents and national patient safety alerts as well as comments and complaints received from patients were reviewed and discussed at the quarterly clinical governance meetings. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We saw how two incidents had been reported and a record was made of the actions taken to minimise the risk of reoccurrence.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The minutes of clinical governance meetings showed how incidents and complaints were discussed and staff we spoke with were able to describe the learning that had taken place. Systems were in place to ensure that actions agreed at clinical governance meetings were cascaded to relevant clinical and non-clinical staff. Although the meeting minutes were saved onto the practice intranet, not all staff we asked were able to find these on the day of the inspection visit. The practice acknowledged that there was scope to better signpost all staff to the meeting minutes held on the system.

There was evidence that the practice had a culture of learning. Staff, including receptionists, administrators and nursing staff, knew to raise issues of concern with the practice manager. Staff used incident forms on the practice intranet and sent completed forms to the practice manager. 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.

National patient safety alerts were disseminated by the intranet to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for, the intranet identified recent alerts. We also saw in the minutes of meetings that alerts were discussed amongst clinical staff. On the day of the inspection visit we observed that when an alert had been received identifying that a medicine required recall, a search of all patients on this medicine was made and immediate action was taken as recommended.

Reliable safety systems and processes including safeguarding

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

The practice had appointed a dedicated GP as the lead for safeguarding vulnerable adults and children. They had been trained and 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 to in the practice if they had a safeguarding concern.

All nursing staff had been trained to be a chaperone and a rota system ensured that there was always a nurse available if required. A formal chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure and is a witness to continuing consent of the procedure. Family members or friend may be present but they cannot act as a formal chaperone.

GPs were appropriately using the required codes on their electronic case management system called System One to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults, and records demonstrated good liaison with partner agencies such as the police and social services. We saw two examples referred to in meeting minutes where the practice had taken responsibility to make appropriate referrals to the safeguarding teams.

Are services safe?

Medicines management

A qualified prescription manager had been in post at the practice for 20 years; this post holder was trained and competent in the area of managing prescribing, he was a valued member of the practice team.

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

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

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

All prescriptions were signed by a GP before they were given to the patient.

Blank prescription forms were not handled in accordance with national guidance as these were not tracked through the practice and kept securely at all times. The prescription manager immediately addressed this and introduced a system to ensure national guidance would be adhered to.

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

The prescription manager undertook regular audits of 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 (CDAO) in their area. The CDAO is responsible for a range of measures relating to the monitoring of the safe use and management of controlled drugs.

There was an area of outstanding practice where packs of medication were readily available for those patients requiring palliative care. These kits assist GPs, palliative care nurses and community nurses to have all the medication, equipment and instructions to administer care in people's own homes whenever required.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. The practice commissioned a cleaning agency to undertake all cleaning; they were present on the day of the inspection. The agency demonstrated that they carried out monthly audits on the quality of their cleaning; however the practice had not implemented their own system to check the quality of cleaning undertaken. There were some issues with the way cleaning equipment was stored and some needed replacement. The practice manager addressed these issues immediately and agreed that they would implement a system to ensure the practice checked the cleaning arrangements.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received annual infection control training about infection control specific to their role and received annual updates.

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. There was also a policy for needle stick injury.

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 (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Are services safe?

Equipment

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

The appropriate signage was not displayed to identify the risks relating to the storage of oxygen and liquid nitrogen, this was addressed on the day of the inspection. There were also some issues identified with some out of date needles being found, this was immediately addressed and the system to check this was amended to ensure the risk of this happening again was minimised.

Staffing and recruitment

Records we looked at contained evidence that on one occasion not all appropriate recruitment checks had been undertaken prior to employment. Proof of identification, references, qualifications, registration with the appropriate professional body were evident, however a criminal records check through the Disclosure and Barring Service (DBS) was applied for but not received before a member of staff started work. The practice manager described the risk assessment he had made but this was not recorded. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups which include, children. It replaced the Criminal Records Bureau (CRB).

The practice had a staffing structure which provided sufficient cover at all levels from GPs through to reception and administration staff. The skill mix ensured that GPs were able to cover for one another and leave could be managed within the practice. For example, six GPs provided the service to five local care homes over three and a half days per week. GPs were organised into buddy groups and told us this ensured they were familiar with one another's patients. This ensured that when they provided cover within their groups they were familiar with the patient lists held by their buddies. There was a large team of receptionists and administrative staff who worked a mix of full and part-time hours to ensure there was sufficient staff to cover the front desk, the separate prescriptions desk, the appointments team and other administrative duties.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice manager explained that this included annual and quarterly 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. Although systems were in place, the practice of completing risk assessments was not sufficiently robust. The practice manager explained how he undertook the assessments and took action but did not make a record of this.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. The practice manager described how the system worked and we observed staff responding in a calm and coordinated way in response to an emergency on the day of the inspection.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that 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). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and low blood sugar levels.

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 identified 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. The practice manager explained how the plan had not been fully implemented as staff did not have copies available in accordance with the plan. Action was taken on the day of the inspection visit to address this.

Are services safe?

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised fire drills on an annual basis.

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 NICE (National Institute for Health and Care Excellence) and from local commissioners. NICE provides national guidance and advice to improve health and social care.

We saw minutes of clinical governance 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 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 nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas, the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. Examples were described to us of occasions when GPs had required input on clinical expertise from their colleagues and how this had resulted in improved care for the patient. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders.

We saw no evidence of discrimination when making care and treatment decisions.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and medicines management. The practice showed us clinical audits that had been undertaken and they were able to demonstrate the changes resulting from completed audit cycles. There were six clinical audits in progress at the time of the inspection visit. A recent audit undertaken related to coding of pre-diabetes, the outcome was that reviews were arranged for some patients and pro-active health checks were offered where appropriate. A recommendation was also made to re-audit in one year. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, 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 that the latest prescribing guidance was being used. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice had a keen interest in research and employed their own research nurse. The nurse described how the additional scrutiny relating to being a research practice benefitted the outcomes for patients, for example learning improved techniques when using inhalers.

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 attending training deemed to be mandatory by the practice, such as annual basic life support. We noted a good skill mix among the GPs, they were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

F2 doctors offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the medical student we spoke with. The practice also mentored student nurses on placement; again this provided evidence of the culture of learning and improvement.

Are services effective?

(for example, treatment is effective)

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, specialist nurses worked specifically with patients with certain long term conditions.

We checked the staff training records and saw staff were trained in accordance with their roles and that all training was up to date. In addition to mandatory training staff were encouraged to participate in two education groups: the Practice Education Groups (PEGs) and the Little Education Groups (LEGs). The LEGs provided practice staff the opportunity to meet in small groups and identify gaps in their knowledge and other training needs. These were then escalated to the PEGs and training was delivered during protected learning time, an hour of which was available to all practice staff every Wednesday afternoon. We saw notes of the meetings of the PEGs and LEGs which confirmed that issues such as Ebola awareness, the appointment system and needs for mentoring were discussed and escalated as appropriate.

The practice used a computerised online records management system (System One) which stored care plans, notes, test results and all other records related to patients' care and treatment. Care was planned and delivered in accordance with a template system in order to ensure that this was consistent regardless of which GP or nurse a patient had a consultation with. All staff we spoke with told us this was an effective way of informing them of patient needs and reminding them of actions which needed to be taken when patients were seen.

Data staff told us that patient discharge records were received electronically and in a timely way from the local hospitals (including attendances at A&E) and from the out of hours service. This information was reviewed daily by the patient's own GP; if their own GP was not available a system was in place to ensure any changes to treatment or medication which may be required was taken.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. 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. All staff in the dedicated call centre within the practice were aware of their responsibilities and acted 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. However, staff were not able to identify a policy which described this role and the associated responsibilities; this was discussed with the practice manager as a potential risk and they agreed to review this.

The practice held multidisciplinary team meetings to discuss the needs of patients with complex needs, for example those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and 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. Professionals who had regular contact with the practice explained how there was a willingness amongst the practice team to work in partnership to ensure that patients' needs were met.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP 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 and staff reported that this system was easy to use.

For patients who attended the practice and required emergency care, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, 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.

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We found that some staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. 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. There had been no staff training in this area; however this was planned for January 2015.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing.

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 with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

The practice offered health checks to patients aged between 40 and 75 which were promoted on the TV screens in the patient waiting areas and by writing to patients in that age group, particularly those who had not recently attended the practice for an appointment. We spoke with members of the nursing staff and GPs who confirmed that opportunistic screening and treatments were provided when patients attended for other appointments. A member of the administrative team, who was responsible for booking appointments, told us that patients who did not routinely attend appointments were given longer time slots when they did attend to ensure that opportunities to carry out reviews, checks and vaccinations were available during the single appointment.

The practice manager told us that a flu clinic had taken place on the Saturday before our inspection at which approximately 2000 patients had received their flu vaccination. Any patients who had not attended this clinic and were at risk if they developed flu were followed up with reminders to come into the practice for their vaccination. The shingles vaccination was also provided to designated patient groups.

Patients with learning disabilities were offered annual health checks. In the past year the practice had managed to significantly increase the number of patients attending for these checks by a member of the reception staff making contact by telephone rather than by writing to them.

The practice kept a register of patients who had caring responsibilities and they were flagged as carers on Sysetm One to remind clinical staff when those patients attended the practice. There was a 'carers table' in the entrance to the practice at which patients could pick up a carers' pack which included a list of support groups for carers of all ages and leaflets and booklets giving advice to carers on a range of issues.

The PPG (Patient Participation Group) described Wymondham as a dementia-friendly town and the practice actively promoted the local support available to people living with dementia and those who cared for them.

In addition there were smoking cessation clinics provided by two healthcare assistants and some patients were referred to a local gym where they could get three months membership at a reduced price and no joining fee. Nursing staff and some GPs have been trained in health coaching which is a way of encouraging patients to take responsibility for their own health and wellbeing.

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 named practice nurse.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction, this included information from the national patient survey and the PPG (Patient Participation Group) survey carried out for 2013 to 2014. The evidence 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 that 93% of patients had confidence and trust in the last GP they saw or spoke to and 84% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care.

Patients completed CQC comment cards to tell us what they thought about the practice. We received nine completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, courteous, friendly and caring. We also spoke with at least 10 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and common themes were that they were treated with dignity, respect and care.

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 in an office away from the reception area which helped keep patient information private. In the national patient survey 88% of patients found the receptionists at this surgery helpful.

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. For example, data from the national patient survey showed 84% said the last GP they saw or spoke to was good at involving them in decisions about their care and 88% described their overall experience of this surgery as good. In the PPG survey 96% of patients said they were satisfied with the medical treatment they received.

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.

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 with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and on the patient website also told people how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

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

The GPs at the practice held their own patient lists meaning that all patients in the practice had a named GP. The GPs we spoke with told us this gave them a good knowledge of the needs of their patients and ensured they were able to respond to their changing needs.

Are services caring?

Patients with mental health needs were supported by their GP to access support from the community services offered by the local NHS trust. The GPs then described how they followed up these patients to ensure they were happy with the care they were receiving. If patients who were experiencing problems with their mental health did not attend appointments the GP would send them a text to encourage them to make an appointment when they were able to.

GPs told us that where patients were at the end of their life they were signposted to support services and their needs discussed at palliative care meetings which were attended by the palliative care nurse from the local hospice. We saw minutes of those meetings which showed that individual patients were reviewed regularly and their current treatments discussed. Patients who had died were also discussed and reference made to their bereaved relatives. GPs told us that bereaved patients were flagged on the computerised system and the GP would either visit the family or encourage them to come into the practice following the death of their loved one.

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 people'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 in the way services were delivered. The practice considered the needs of the local population and how they responded to them, for example the staff talked about the growth of the population due to housing developments and the plans they would need to make to meet their needs.

The practice provided a GP service to three local care homes, two of which had units for people with dementia. The homes were visited by GPs twice weekly at which they carried out health checks, medicine reviews, blood tests and any new or on-going health issues addressed. One of the care home managers reported in a positive way about the way the practice provides continuity and expertise as and when required. The GPs told us they worked closely with staff on the units for people with dementia. The staff were able to identify where patients had deteriorated or had subtle changes in their condition. A dementia health check template had been developed within the practice which ensured that all aspects of the patient's health and well-being were identified and reviewed at each check.

The lead nurse for diabetes told us that where she was concerned about the health of patients with learning disabilities she would liaise with the learning disabilities nurse who would carry out a home visit to advise that person on their diet and other issues relevant to their health. Patients with learning disabilities were given 20 minute appointments to enable them to have sufficient time to speak with the nurse or GP.

The practice provided health services to a local school, Wymondham College, at which some students were boarders. Nurses and GPs told us they provided general health advice including a sexual health clinic to those young people. In addition a drop in clinic was available to young people registered with the practice at which they could receive health advice or treatment including sexual health services.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services and there was a plan to have equality and diversity training for all staff in early in January 2015.

Staff told us they offered patients interpreting services if English was not their first language. We saw the practice policy which demonstrated that this service could be requested either over the telephone or face to face.

The premises and services had been adapted to meet the needs of people with disabilities.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The practice was open from 8am to 6pm on weekdays and 8am to 11am on a Saturday. On a Monday the practice also opened from 6.30pm to 8pm. A dedicated call centre at the practice responded to all calls for appointments and decisions were made about whether a GP of nurse appointment should be made. There was no protocol to assist call staff in making these decisions. We heard from staff that occasionally patients would be made appointments with nurses when a GP appointment was needed.

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.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to or see another doctor if there was a wait to see the doctor of their choice. 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. Patients were

Are services responsive to people's needs?

(for example, to feedback?)

less satisfied with access to appointments in the longer term and we had comments from the local Healthwatch that indicated that this was sometimes a challenge. The practice described that sometimes it wasn't possible for a patient to get an appointment with their named GP at a time of their choice but they could accommodate appointments with other GPs.

The practice's extended opening hours were particularly useful to patients with work commitments and telephone appointments were available. The practice was also starting to explore the use of email communication with patients with plans to develop this further in the future.

A vaccination programme to protect older patients against shingles, flu and pneumonia had been carried out. Patients who were unable to attend the surgery were visited by practice nurses and given the vaccinations in their own home.

The practice offered longer appointments for patients with long-term conditions and provided opportunistic health screening and advice at reviews. GPs worked with patients to agree their treatment and frequency of reviews in order to promote those patients to manage their health as appropriate.

Patients with asthma were sent questionnaires to which a good response was received. These were reviewed by a GP with a special interest in respiratory medicine and where necessary the patients called in for an early review. The practice had particularly targeted patients of working age who had not recently visited the practice.

The practice offered drop in clinics for young people in order to promote good sexual health as well as address the general health concerns appropriate to their age group. These services were extended to young people who were boarders at Wymondham college where the practice provided GP and nurse services three times per week.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. For example, the lead nurse for diabetes worked closely with the community learning disabilities nurse to support those patients to manage that long-term condition. The practice had sign-posted vulnerable patients and their carers 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.

GPs operated their own lists and followed up their own patients following referral to the community mental health teams which included a community psychiatric nursing team, consultants and the alcohol and drugs service all of which were managed by Norfolk and Suffolk NHS Foundation Trust.

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. The practice manager was responsible for the handling of all complaints in the practice.

We saw that information was available to help patients understand the complaints system. The practice leaflet and website directed patients to ask for a complaint 'pack' at reception, we saw that the 'packs' were readily available and the information provided was very clear, there was no poster on display describing how to make a complaint. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had needed to make a complaint about the practice.

The practice manager was able to demonstrate how complaints were responded to and a record of all complaints was held, this assisted with the identification of common themes. Last year's complaints had a theme relating to the difficulty some patients had accessing appointments. The practice had responded to this and the number of complaints in this area had reduced.

Are services well-led?

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

Our findings

Vision and strategy

The practice demonstrated that they had delivered high quality care and promoted good outcomes for patients, this was despite not having a formal strategy or business plan. The practice manager and partners were able to describe how they had responded over the years to changes in policy, legislation and needs of the local population and we found a flexible and adaptable approach to the way the service was delivered. An example of this was the way additional clinical staff had been recruited in response to patient feedback about access to appointments. Staff we spoke with described the philosophy of the practice and included words such as 'friendly', 'happy place to work', 'well supported' and 'we all work well together'. We saw staff interacting in a relaxed and positive way on the day of the inspection and there was a calmness about how all activities were delivered.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. The practice manager agreed that the review system could be further improved to ensure that it is more timely and robust.

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 a GP partner was the lead for safeguarding. We spoke with at least 10 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and 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 saw that QOF data was regularly discussed at monthly meetings and actions were agreed to improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice held quarterly governance meetings; the nursing staff were invited to attend alternate meetings and were also invited if there was a nursing issue on the agenda. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed. When reviewing how learning had been described in the meeting minutes we found that the practice did not always evidence the discussions staff described. The staff we spoke with acknowledged this and agreed that a clearer record would have assured a robust audit trail.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues either informally with the practice manager or during meetings. We saw evidence of some meetings between different staff groups through calendar entries and meeting logs, however minutes of the meetings were not always made or actions recorded. When we reviewed the dates of meetings and records we found that this was less than that described by the practice manager, he explained that this was due to prioritising patient care over meetings. It was therefore not always easy to evidence how decisions were made,messages cascaded to staff and learning achieved. This had not had a negative impact in the way the practice was run but did create a potential risk.

The practice manager was responsible for human resource policies and procedures. We reviewed three staff files and saw evidence that staff had been safely recruited.

Seeking and acting on feedback from patients, public and staff

The practice had an active PPG (patient participation group) which included representatives from various population groups; including students from the local college. The 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. The PPG had carried out its last survey in February 2013. The results and actions agreed from these surveys are available on the practice website. In addition patients were able to provide comments informally to the PPG.

The practice had not formally gathered feedback from staff but there was a culture of openness and transparency

Are services well-led?

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

where staff felt able to feedback to colleagues or the management team. Staff told us they felt involved and included in decisions about how the practice is run to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring and staff told us that the practice was very supportive of training.

The practice was a training practice for medical students and all of the GPs at the practice were involved in the training programme.

The practice had completed reviews of significant events, complaints and other incidents and shared the results with staff via meetings and protected learning time to ensure the practice improved outcomes for patients.