Watton Medical Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We conducted a comprehensive inspection on 25 November 2014 under the new approach.

Our key findings were as follows:

The practice was safe, effective caring and responsive and well led. The practice has a clear vision and set of values which are understood by staff and made known to patients. There is a clear leadership structure in place, quality and performance are monitored and risks are identified and managed.

Staff recognised and understood the needs of patients and tailored access to care and treatments to meet these needs. The practice was working in partnership with other health and social care services to deliver individualised care.

The practice provided a safe service in an environment which was well managed and risks to staff and patients were identified and minimised.

Staff were trained and supported to deliver high quality patient care and treatment and to improve outcomes and experiences for patients.

We saw several areas of outstanding practice including:

- The practice paramedic provided monthly basic life support and defibrillation training at the practice which staff could attend as often as they felt they needed to. This ensured that all practice staff felt competent and could effectively respond to an emergency in the practice. The practice paramedic also offered basic life support and defibrillation training to patient groups and local organisations. This meant that the practice was proactively offering health education around emergency response to staff and the local community.

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

Importantly the provider should:

- Ensure the process for recording and documenting all staff meetings is formalised.

Summary of findings

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 was safe. Policies, procedures and guidance were available to support staff to provide safe care, including reporting and investigating significant events, safeguarding concerns and complaints. We found that where concerns arose, these were investigated and responded to in a timely way. The practice had effective processes in place for recruiting clinical and non-clinical staff. This included checking the registration of nurses and GPs and undertaking appropriate background checks. Adequate and sufficient emergency medical equipment and medication was available.

Are services effective?

Good

The practice was effective. There were enough suitably trained and experienced staff to meet the needs of the patients who used the practice. We saw evidence that the practice worked well with other healthcare providers and the practice held and participated in a number of multidisciplinary meetings with other health and social care professionals. The practice had effective mechanisms in place to monitor, manage and improve outcomes for patients. Information was made available to patients around health promotion, prevention and health related travel advice. Staff we spoke with were able to demonstrate their understanding of the consent process.

Are services caring?

Good

The practice was caring. Patients told us that they were always treated with dignity and respect when using the practice. GPs delivered care which aimed to meet the holistic needs of individual patients. Patients commented on how they were involved in decisions about their own care and had their care and treatment options explained to them.

Are services responsive to people's needs?

Good

The practice was responsive to the needs of its practice population. Patients confirmed that they were able to access the care they needed at suitable times. A complaints procedure was in place and this was understood by and adhered to by staff. Patients were able to make suggestions to improve the services they received. Patients had been listened to and we saw that actions had been taken as a result of their comments and feedback.

Summary of findings

Are services well-led?

Good

The practice was well-led. There was effective leadership within the practice. Staff were clear about their roles and responsibilities. Future patient needs had been forecast and the practice understood how this might impact on service delivery. Governance arrangements were in place to ensure that the whole practice learned from errors, incidents and complaints and that clinicians worked in accordance with the latest available guidance. Risk management mechanisms were in place.

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

We saw that the practice offered relevant care to older patients; this included blood tests, blood pressure monitoring and general health consultations. Older people we spoke with told us that they could get an appointment on the same day if they needed it and that they were satisfied with the care provided.

Older patients were seen annually, or sooner depending on the complexity of their needs, by the nursing or medical team for health checks and to review their medicines. The practice had identified vulnerable older people who might experience a sudden deterioration in their health. This group of patients were offered regular health checks and, with the patient's consent, information was made available to the local out of hours and urgent care teams. Multi-disciplinary meetings were held to identify the best ways to provide care to older people and, where appropriate, to avoid them going into hospital. Continued monitoring helped to ensure that older patients received the right treatment and care when they needed it.

We saw that flu and pneumococcal vaccinations were offered to older patients to help protect them against these viruses and associated illnesses.

We spoke with representatives from nursing homes. They told us that patients were supported to make informed decisions about their treatment and that the practice offered effective care to their residents.

People with long term conditions

Good

The practice offered relevant care to patients with long term conditions which included blood tests, blood pressure monitoring, electro cardiography (ECG) (a test that measures the electrical activity of the heart) and flu vaccinations. There was a named GP lead for chronic diseases at the practice. This also ensured up to date guidelines and templates (a system for recording observations and tests on patient's records) were available for the wider nursing and clinical teams. The practice offered health checks for diseases such as asthma and heart disease and patients with these conditions were seen at least annually for a health and medication review. There was support and education provided to patients with conditions such as diabetes, smoking cessation or obesity.

The practice supported patients and carers to receive coordinated, multi-disciplinary care whilst retaining oversight of their care. Staff

Summary of findings

from the community palliative care team and the district nurses attended meetings with the GPs and the nursing staff, which enabled practice staff to discuss the needs of patients with chronic and terminal illness. They discussed arrangements for individual patients on advanced care plans and ensured the out of hours service was informed of the care arrangements when the practice was closed.

The practice was caring in the support it offered to patients with long term conditions. For example the practice provided care to local care homes. The care this group of patients received was monitored and kept under review by the GP lead for each home and the practice paramedic. The practice was responsive in prioritising urgent care that patients required and the practice worked towards improving outcomes for patients with long term conditions and complex needs.

Families, children and young people

Good

The practice offered lifestyle advice to pregnant patients. The practice worked with local midwives and health visitors to offer a full health surveillance programme for children. Expectant mothers attending the practice were seen for their initial antenatal assessment and then referred to the midwife who held at least weekly clinics at the practice. Mothers were seen routinely for a postnatal check at the six to eight week stage.

Babies were seen at the baby clinic within the practice where they were checked and given their first immunisations. Checks were also made to ensure the maximum uptake of childhood immunisations. Health and advice checks were available for 15 year old patients.

Working age people (including those recently retired and students)

Good

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Telephone consultations could be booked in person or by telephone; a GP would then telephone the patient back. Where patients were unable to take a call due to work or family commitments they could specify a convenient time for the GP to call. The GP would then schedule a call for example during the patients work coffee or lunch break or when home from the school run. Where a telephone consultation was not sufficient, an appointment was then offered for the same day or when most convenient for the patient. Patients did not have to telephone the

practice before a certain time in order to access an 'on the day' appointments. The practice offered late evening opening times till 8pm on Wednesdays to provide easier access for patients who were at work during the day.

Patients were offered a choice when referred to other services. Information about annual health checks for patients aged over 74 years was available within the practice and on the website. The practice provided travel vaccination clinics with a practice nurse. Patients with caring responsibilities and those who required additional support were identified and this was recorded on their patient record.

People whose circumstances may make them vulnerable

Good

The practice had arrangements in place to ensure access to its services to patients who were vulnerable as a result of social or other circumstances. This included people with certain medical or mental health conditions, people who had learning disabilities and those who were homeless or from travelling communities or migrant populations.

The practice had systems for monitoring the health and attendance for patients who were vulnerable and those who had difficulty is accessing services. Information was shared with appropriate community health and social care agencies to help ensure that patients received safe and coordinated care.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for the care of people experiencing poor mental health (including people with dementia). Care was tailored to patients' individual needs and circumstances, including their physical health needs. Staff knew how to recognise and manage referrals of more complex health needs and the practice included other health professionals at their practice meetings when required. Staff were encouraged to be aware and to raise any concerns should a patient appear in distress or forgetful.

Annual health checks were offered to people with severe mental illnesses. The practice worked in conjunction with the local mental health team and the community psychiatric nurses. The practice ensured that patients with poor mental health were able to access the practice at a time that was suitable for them. Annual health checks were offered to people with dementia. Carers were involved in the reviews as necessary. Patients on regular medication were always invited for a medication review before their prescription was repeated. Information was shared with other health and social care professionals and information and signposting was available

through the practice website and leaflets in the surgery. The practice appointment system provided the flexibility for those patients who may need extra time during their consultation to have that time. For example those patients who may be experiencing poor mental health, depression or who may be experiencing complex or terminal health conditions.

Summary of findings

What people who use the service say

We spoke with twelve patients during our inspection. The practice had provided patients with information about the Care Quality Commission prior to the inspection and had displayed our poster in the waiting room.

Our comments box was displayed prominently and comment cards had been made available for patients to share their experience with us. We collected 11comment cards, all contained detailed very positive comments about the caring and compassionate attitude of the staff. Comments cards also included positive comments about the skills of staff, the way staff listened to their needs and being pleased with the on-going care arranged by practice staff. These findings were also reflected during our conversations with patients.

The feedback from patients we spoke with during our inspection was positive. Patients told us about their experiences of care and praised the level of care and support they received at the practice. The patients we spoke with said they were happy and they got good treatment. Patients we spoke with told us the GPs and nurses always gave them plenty of time during the consultation to explain things. Patients told us that the GPs were very supportive and they thought the practice was well run. Patients indicated that they had no concerns with regard to hygiene and the cleanliness of the practice.

Patients told us the appointment system was improving. Most patients felt that they were able to access the service within a reasonable timeframe, although four patients commented that it was not always possible to get through quickly on the phone or to see the GP who knew them best. Patients told us they did not know how to complain and had not had reason to complain. However we were told they would firstly speak with the receptionists.

Patients told us they liked the continuity of care they received. Patients also knew they could get a same day appointment for urgent care when required. Patients told us they felt the staff respected their privacy and dignity and the GPs were very approachable and supportive.

Patients told us they were happy with the supply of repeat prescriptions and satisfied with the practice facilities.

There was health care and practice information on display around the waiting room area.

Areas for improvement

Action the service SHOULD take to improve

- The process for recording and documenting all staff meetings should be formalised.

Outstanding practice

- The practice paramedic provided monthly basic life support and defibrillation training at the practice which staff could attend as often as they felt they needed to. This ensured that all practice staff felt competent and could effectively respond to an emergency in the practice. The practice paramedic also offered basic life support and defibrillation training to patient groups and local organisations. This meant that the practice was proactively offering health education around emergency response to staff and the local community.

Watton Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Watton Medical Practice

Watton Medical Practice is located in the rural town of Watton in Norfolk. The practice provides services for approximately 11,714 patients living in the area. It is situated purpose built surgery. The building provides good access with accessible toilets and disabled car parking facilities. The practice provides services to a diverse population age group, in a semi-rural location. The practice list is currently closed to new patients.

The practice has a general medical services (GMS) contract with NHS England. The practice has a team of five GPs meeting patients' needs. All five GPs are partners meaning they hold managerial and financial responsibility for the practice. In addition the practice employs a practice paramedic, one registered nurse prescriber, five nurses, a team of healthcare assistants who also sees patients for phlebotomy consultations, a practice manager and a team of receptionists' secretaries and administrators. The practice is currently in the process of recruiting salaried and partner GPs.

Patients using the practice also have access to community staff including the community matron, district nurses, community psychiatric nurses, health visitors, counsellors, support workers, health visitors and midwives.

The practice has implemented a total telephone triage system to manage demand for appointment bookings. The practice is open from 8.30am on Monday, Wednesday, Thursday and Friday with a 7am opening on Tuesdays. The practice closes at 6.30pm on Monday, Tuesday and Thursday with an 8pm closing time on Wednesdays and 4pm on Fridays.

Watton Medical Practice does not provide an out-of-hours service to patients. Outside of practice opening hours a service is provided by another health care provider (EEAS OOH) by patients dialling the national 111 service. Details of how to access emergency and non-emergency treatment and advice is available within the practice and on its website.

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.

This provider had not been inspected before and that was why we included them.

Detailed findings

How we carried out this inspection

Before our visit to Watton Medical Centre, we reviewed a range of information we held about the practice. This included information about the patient population groups, results of surveys and data from The Quality and Outcomes Framework (QOF). QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. We asked other organisations to share what they knew about the practice. This included the Local Commissioning Group and local Health watch.

We carried out an announced visit on 25 November 2014. Prior to our visit we provided comment cards for the practice to place in their waiting area so that patients could share their views and experiences of using the practice. During our visit we spoke with a range of staff including GPs, the practice nurses, the practice manager, reception and administration staff. We also spoke with 12 patients who used the practice. We observed how patients were cared for when they were being seen at the reception and talked with carers and family members and reviewed practice records, policies and protocols.

To get to the heart of patients experiences of care, we always ask the following five questions of every practice and provider:

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Good

Are services safe?

Our findings

Safe track record

We found that there were systems in place for reporting issues and concerns which may pose a risk to patients and staff. There was a robust system for reporting significant events and regular audits took place by clinicians to explore the effectiveness of care and whether changes in process were necessary.

Staff were aware of the significant event reporting process and how they would verbally escalate concerns within the practice. All staff we spoke with felt very able to raise any concern, however small. For example, we found staff had recorded a recent failure to record the temperature of a vaccine fridge and the failure of another service to follow its own discharge procedures which impacted on the care of a patient. Staff knew that following a significant event, the practice manager and GPs undertook a Significant Event Analysis (SEA) to establish the details of the incident and the full circumstances surrounding it.

We reviewed safety records and incident reports and saw minutes of clinical meetings where these were discussed for the last two years. 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 incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw a significant event policy and clear documentation which facilitated the process of significant event reporting, investigation and promoted review at regular intervals.

We spoke with staff who reported that an open and transparent approach existed within the practice and this was reinforced in our discussions with GPs in the practice. The GPs, nurses and practice manager demonstrated a genuine commitment to learning. They had adopted a culture of no blame, investigated incidents and shared improvements and changes as a result with an understanding of the importance of review. Monthly meetings took place, which were attended by all GPs and clinical staff. We saw minutes of these and the multidisciplinary meetings where significant events were discussed and changes made and shared with clinical staff. However we noted that not all staff meetings were minuted. We discussed these concerns with the GPs and the practice manager. The provider confirmed arrangements for regularly recording all staff meetings would be implemented following our inspection.

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 in older people, vulnerable adults and children. 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. Contact details were easily accessible.

The practice had dedicated GP's appointed as leads in safeguarding vulnerable adults and children who had the necessary training to enable them to fulfil this role. All staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern. 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.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans, patients diagnosed with dementia or learning disabilities.

Staff had been recruited safely, with robust checks being carried out before staff began to work at the practice. Employment files we looked at confirmed that relevant staff had been checked and were safe to work with vulnerable people.

A chaperone policy was in place and visible on the waiting room noticeboard. Chaperone training had been undertaken by all nursing staff. Staff were informed about their role and the implications for protecting both the patient and the GP. Clinicians documented that a chaperone had been offered and either accepted (with name of chaperone) or declined by the patient, in the patient record.

Good

Are services safe?

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system 'System One', which collated all communications about the patient including electronic and scanned copies of communications from hospitals. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Medicines management

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. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings that noted the actions taken in response to review of prescribing data. For example, patterns of diclofenac prescribing for patients. Diclofenac is a non-steroidal drug used to treat pain and inflammation associated with arthritis.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. The health care assistant also administered vaccines under directions which had been reviewed and approved in line with national guidance and legal requirements. We saw up to date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For

example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. The practice prescribing system allowed for the practice to inform patients what each of their prescribed medications was for. For example when a medicines has been prescribed for dizziness or asthma. The system also alerted patients prescribed medications such as amiodarone and warfarin when their next blood test was due. These are anticoagulant medicines used in the prevention of deep vein thrombosis.

Cleanliness and infection control

All areas of the practice, including consultation and treatment rooms were visibly clean, tidy and uncluttered. We saw there were hand washing facilities in each surgery and treatment room and instructions about hand hygiene were displayed. Hand wash and paper towels were next to

each hand wash basin, and hand gel was available throughout the practice. Protective equipment such as gloves, aprons and masks were readily available. Curtains around examination couches were disposable and had been replaced in September 2014. Examination couches were washable and were all in good condition. Each clinical room had a sharps disposal bin secured to the wall. There was a record of when each bin started to be used. Patients we spoke with said they were happy with the standards of hygiene at the practice.

Sharps and clinical waste were stored safely and appropriately and collected regularly by contractors. Steps had been taken to reduce the risk of infection to practice staff. All clinical staff underwent screening for Hepatitis B vaccination and immunity. People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.

The practice had both a clean and dirty sluice room. The dirty sluice room was used for the safe handling and packaging of specimens such as bloods or urine received by the practice. There were body fluid spills kits available for the safe disposal of body fluids. For example, vomit or blood. The practice manager told us only qualified staff with a Hepatitis B immunisation screening record would be responsible for cleaning these spillages. The 'clean' sluice room was used for the storage of equipment, dressings and the vaccine fridges.

Effective infection control practice had been adopted. A nurse had been appointed as the infection control lead for

the practice. Staff understood the importance of ensuring that the policies were followed. There were clear, agreed and available cleaning routines in place for the cleaning of the practice. We saw that cleaning materials were stored safely. The practice employed a cleaning company to oversee daily cleaning at the practice. The practice manager told us they did a daily visual audit of the practice any were recorded concerns in a log book for action. The practice had undertaken regular audits of the cleaning undertaken at the practice. Areas highlighted for attention and the actions taken were recorded. The results of these audits demonstrated that there were suitable arrangements for minimising the risks of infection to both patients and staff.

A legionella risk assessment had been carried out and the practice water lines had been checked and maintained regularly. The checks demonstrated that patients were protected from the risk of an infection associated with the legionella bacteria.

Equipment

We saw that staff had taken steps to protect patients against the risk associated with the

equipment they used. We saw evidence of appropriate maintenance of the equipment including electrical checks and calibration of clinical apparatus such as for example weighing scales and the blood pressure monitors. All had been checked, tested and passed as fit for purpose.

Staffing and recruitment

The practice had calculated minimum staffing levels and skills mix to ensure the service could operate safely, including extended surgeries. Each GP's diary was calculated several weeks in advance to assist with this. The staffing levels we saw on the day of our inspection met the practice's minimum requirement and there was evidence to demonstrate the requirement was achieved throughout 2014.

Monitoring safety and responding to risk

There was a proactive approach to anticipating potential safety risks, including changes in demand, disruption to staffing or facilities, or periodic incidents such as bad weather or illness. The practice had plans in place to make sure they could respond to emergencies and major incidents. Plans were reviewed on a regular basis. Staffing establishments (levels and skill mix) were set and reviewed to keep patients safe and meet their needs. The right staffing levels and skill-mix were sustained at all hours the service was open to support safe, effective and compassionate care and levels of staff well-being. We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies, this included responding to busy periods when demand for appointments increased. For patients with long term conditions there were emergency processes in place. The practice manager gave us examples of referrals made for patients that had a sudden deterioration in health.

There was emergency medicines and equipment available to use in the event of an emergency, for example a defibrillator. A defibrillator is an electrical device that provides a shock to the heart when there is a life-threatening arrhythmia present. There was a system in place to ensure emergency medicines were in date and stored correctly and the equipment was available and fit for purpose. We saw that staff at the practice had received annual cardiopulmonary resuscitation (CPR) training. The staff we spoke with confirmed this and training certificates were available. We saw that staff were able to attend CPR training as often as they felt necessary to ensure they were comfortable and fully understood the procedures. The practice paramedic provided this training monthly at the practice for any member of staff to attend.

Staff confirmed if they had any concerns they would speak with the GP's, the practice manager, the practice paramedic or the nurses for support and advice. The GPs discussed risks at patient level daily with the other clinician's in the practice and at the monthly clinical meetings. Staff told us they felt happy they could raise their concerns and were comfortable that these would be listened to and acted on. We saw that staff were supported in their role and knew what to do in urgent and emergency situations.

There was information displayed in the reception area, in the patient leaflet and practice website regarding urgent medical treatment both during and outside of surgery hours.

Arrangements to deal with emergencies and major incidents

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

Good

Are services safe?

recorded to reduce and manage the risk. Risks identified included adverse weather and power failure, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

A health and safety and fire risk assessment had been undertaken that included actions required to maintain health and safety and fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Risks associated with service and staffing changes were included on the practice risk log. We saw an example of this where the practice was undergoing an exercise to develop future service plans against assessed risks. 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). We saw that the practice was suitably equipped with the necessary equipment to help clinicians investigate and diagnose a range of conditions patients might present with. For example, there were weighing scales available for people who used a wheelchair.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice reviewed, discussed and acted upon best practice guidelines and information to improve the patient experience. A system was in place for National Institute for Health and Care Excellence (NICE) quality standards to be distributed and reviewed by clinical staff. The practice used systems such a GP notebook (an on-line encyclopaedia and reference resource for clinicians) and Knowledge Norfolk which provided daily information and resources to health care professionals to support patient care. The practice participated in recognised clinical quality and effectiveness schemes such as the national Quality and Outcomes Framework (QOF). QOF is a national data management tool generated from patients' records that provides performance information about primary medical services. We saw that the practice had used this information to improve services for groups of patients, including patients with high blood pressure, asthma and chronic kidney disease.

We saw that clinical templates were in place to deliver consistent needs assessments and recording for all patients. We found detailed care plans in place for people with end of life needs and monthly palliative care meetings were held between practice staff and partner services. A palliative care template was used to record the care needs of patients approaching the end of their life. This was a multi-disciplinary record, including input from the hospice team, district nurses, the voluntary sector and the out of hour's service. As a result patients' holistic, cultural and medication needs were recorded so that healthcare professionals could ensure that the patient received the best and most appropriate care at all times.

A coding system was used to ensure that patients with a chronic disease were placed on a register in order that their needs and medicines could be reviewed effectively. GPs were alerted by the system when patients were due to have a review of their condition. They were also prompted to follow up review requests if patients did not attend.

We found that patients had their needs assessed and that their care was planned and delivered in line with guidance and best practice. Patients were referred in line with guidance and best practice to secondary and other community care services. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process used to review patients recently discharged from hospital and noted that GPs undertook reviews where appropriate. We saw appropriate use of the "Two Week" wait referrals, (two week wait referrals are a fast track referral system for managing urgent referrals for patients with suspected cancers).

We saw that care and treatment decisions were based on people's needs without unlawful discrimination. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. The GPs each held responsibility for local care homes and learning disability homes. GPs attended the homes to proactively manage and co-ordinate patients care.

We saw that care and treatment decisions were based on people's needs without unlawful discrimination. Interviews with GPs 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.

The practice held educational sessions including CPR and Diabetes management training for patients and local organisations, both within the practice and at prearranged local venues. The practice had attended local schools and health promotion events in the town to provide education around health issues and to promote good health. This led to improved outcomes for patients from the different population groups in the area.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. GPs told us clinical audits were often linked to medicines management information and safety alerts. We saw an example of a clinical audit cycle relating to the prescribing of specific medicines. We saw that Watton Surgery had undertaken clinical audits on prescribing and referrals. The practice was undertaking a clinical audit in the prescribing of anticoagulant medicines (anticoagulants are medicines used to reduce the ability of the blood to clot), for patients diagnosed with a deep vein thrombosis (a thrombosis is the formation of a blood clot within a vein). We saw that the practice had completed clinical audits in the use of simvastatin (a cholesterol reducing medication) and amlodipine (a drug used to improve blood flow).

Care plans had been put in place for elderly patients most at risk of unplanned admissions and regular review

Good

Are services effective?

(for example, treatment is effective)

meetings were held to assess performance. The practice liaised closely with district nurses, the multidisciplinary team coordinator and the out of hour's service to try and reduce unplanned admissions. The practice held monthly multi-disciplinary meetings to discuss the most vulnerable patients and to organise the care required to keep patients in their own homes, when appropriate to do so.

The practice also used The Quality and Outcome Framework (QOF) to measure their performance. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF data for this practice showed that they generally achieved high or very high scores in areas that reflected the effectiveness of care provided. The local clinical commissioning group (CCG) data demonstrated that the practice performed in comparison to other practices within their CCG area.

Repeat prescription and medication reviews were carried out annually for patients and where it was felt a change in prescribing guidelines would affect their medication. Records were kept of the decision making process. Where changes to medicines were not appropriate the reasons were recorded.

The practice monitored the number of patients who attended for regular reviews of their long term conditions. Where the practice found it difficult to engage with patients they received a text or telephone call see if there were any underlying reasons for their lack of engagement.

Effective staffing

The GP partners and practice manager told us how the practice was dedicated to ensuring there were sufficient staff to deal with all aspects of the service. We were told the practice had made extensive and repeated efforts to recruit additional GPs, but until recently had not been able to do so. The practice had arrangements in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw that the practice monitored individual clinical capacity and this ensured they were able to meet patient needs. There was an arrangement for the regular use of locum GPs to cover GP absence and for the nurse team and the administrative staff to cover their teams annual leave. At the time of our inspection the practice had recently appointed a nurse practitioner and were in the process of recruiting one whole time equivalent GP partner and a half whole time equivalent salaried GP. This meant there was still a shortfall in GPs at the practice and we were told with local development this would impact on the patient to GP safe ratio. We saw that the practice continued to endeavour to recruit GPs and we were assured they were taking all necessary steps to ensure that they could meet patient demand.

Other practice staffing included clinical, nursing, managerial, reception and administrative staff. We reviewed seven staff records and the staff training spread sheet and saw that staff were up to date with attending courses such as annual basic life support, information governance and safeguarding of vulnerable adults and children. We were told that the GPs were up to date with their yearly continuing professional development requirements.

We saw that staff were appropriately qualified to carry out their roles safely and effectively in line with best practice. We saw that all new staff, from GPs to receptionists, were provided with an induction pack and a formal induction to Watton practice. When a new staff member started work the length of the induction period was discussed with them. However, we saw that there was an ethos of supporting staff and the induction period could be extended when necessary. We saw evidence that when a staff member was not performing to the required standard this was investigated and appropriate action was taken.

Systems were in place to ensure all nurses were registered with the Nursing and Midwifery Council (NMC) and GPs with the General Medical Council (GMC). GPs were 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 practice and remain on the performers list with the General Medical Council).

All staff had an annual appraisal. During these meetings a personal development plan was put in place and training needs were identified. The learning needs of staff were identified and training put in place. Staff told us they felt well supported in the training programme. All staff were aware of the practice objectives and their performance was measured against these, and their personal objectives. All the patients we spoke with were complimentary about the staff. We observed staff who appeared competent and knowledgeable about their role.

Good

Are services effective?

(for example, treatment is effective)

The practice manager told us that poor performance was identified during observation of staff performance and in the staff appraisal process, and addressed with staff as a training or development requirement.

Working with colleagues and other services

The practice worked closely together to provide an effective service for its patients. Staff worked collaboratively with community services. For example, the midwife who had an allocated room in the building and professionals from other disciplines who visited daily, such as the community nursing team to ensure all round care for patients. Minutes of multidisciplinary meetings evidenced that district and palliative nurses attended meetings to discuss the palliative patients registered with the practice. This detailed good information sharing and integrated care for those patients at the end of their lives. The practice shared information with the out-of-hours service, for example, special patient notes about patients with complex health needs. Telephone messages about specific patients were always passed to the named GP for that patient, as were home visit requests. This encouraged continuity of care for the patient. Where this was not possible, the telephone message was triaged by the duty GP to decide whether the patient could wait for a routine visit or required a more urgent visit by another clinician.

Information about patients who had contacted the out of hours service, had been admitted to hospital, were seen in hospital clinics or had been discharged from hospital were reviewed daily by the GPs at the practice. Results of tests received by the practice, such as blood or urine results were seen by the patients GP and then scanned into the patient's records and further action taken as appropriate. Patients were contacted by GPs to discuss the findings. This ensured that patients had the opportunity to ask questions about their results. There were systems in place which gave permission to other external health care providers such as the community nurse and midwife to send patient information and requests for information to the patients GP and patients treatment records. The practice system allowed for other health professionals such as community nurses to add relevant information to patient's records. For example the results of blood tests or other examinations. There was also a facility for the health professionals to send electronic messages and requests linked to the patient's record to their GP. Providing continuity and an audit trail of patient care.

Information sharing

The GPs met regularly with the practice nurses, practice manager, healthcare assistants and the practice paramedic. Information about risks and significant events was shared across all the staff teams within the practice. The practice manager and paramedic attended community lead health promotion events, such as Diabetes management, promoting health awareness in local schools and offered basic life support and defibrillation training to local clubs and groups.

Patients were discussed between the practice clinicians and other health and social care professionals who were invited to attend practice meetings. We were told a Learning Disabilities consultant had attended the practice clinicians' meeting for training purposes, to raise awareness of the care and treatment available for patients with learning disabilities. They had worked with the practice to improve the health checks recording template used by the practice to maximise care and treatment for these patient. The practice manager and patient liaison group representatives attended local community meetings and shared feedback with practice staff and the GP partners where relevant.

There was an informative practice website which offered up to 80 translations of the information available. The practice produced a quarterly patient newsletter which was available within the practice and other locations around the town such as the local pharmacy and library. Members of the patient liaison group distributed these to people. There were information leaflets available within the practice waiting area and at the request of the clinicians on request. These were available in a variety of languages other than English such as Latvian, Lithuanian and Polish.

Consent to care and treatment

Patients' capacity to consent was assessed in line with the Mental Capacity Act (MCA) 2005. From our conversations with staff and our review of training documentation we saw that all staff had received MCA training. MCA guidance was available on the practice intranet. The staff we spoke with, including the reception staff team, demonstrated a clear understanding of the MCA and its implications for patients at the practice. Staff were also aware of the Gillick competency test, a process to assess whether children

Good

Are services effective?

(for example, treatment is effective)

under 16 years old are able to consent to their medical treatment, without the need for parental permission or knowledge. Staff we spoke with gave examples and we observed examples of its use in the practice.

Health promotion and prevention

New patients who registered at the practice were contacted by a GP to ascertain details of their past medical and family histories, social factors including occupation and lifestyle, medications and risk factors (e.g. smoking, alcohol intake). Where the GP felt necessary the patient was then seen by a clinician for a physical health check and medication review. Patients with long term health conditions or who were prescribed repeat medications were seen by a GP to review their repeat medications. Staff showed us and told us about the New Patient's Registration pack.

Up to date information on a range of topics and health promotion literature was readily available to patients at the practice and on the practice website. This included information about services to support them in doing this, such as smoking cessation advice. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. This included advising patients on the effects of their life choices on their health and well-being. We saw a clear process that was followed for patients who did not attend for cervical smears.

Flu vaccinations were offered to all patients over the age of 65, those in the identified at risks groups and pregnant women. A one off Pneumococcal vaccination was offered to patients over 65. The practice offered a travel vaccinations service to patients. The practice provided a fortnightly Ultra Sound Scanning service which meant patients could locally access these tests promptly. The Community Respiratory Service also attended the practice fortnightly and offered home visits for those patients unable to travel to the practice. Health checks were offered to patients over 75 who did not attend the practice regularly and the Norfolk Recovery Partnership provided weekly drug and alcohol clinics from the practice, providing advice and treatment for adults with drug and alcohol problems.

The practice proactively identified patients, including carers who may need on-going support. The practice offered signposting for patients; their relatives and carers to organisations such as Help the Aged. Where appropriate, referrals were made to health or social care services so that patients and their carers received additional support according to their needs.

There was a large range of health promotion information available at the practice. This included information on requesting a chaperone, victim support and support for patients and their carers on the noticeboards in the reception area.

We saw that the practice worked closely with the Practice Patient Liaison Group (PLG) to support health promotion and prevention in the local community. A PLG was a group of active volunteer patients who were established to ensure patients have a voice in the current and future direction of the practice and offer feedback and suggestions as to how the practice may make changes to further improve the care offered to patients. The practice PLG was working closely with the practice and other health care organisations to offer falls prevention education and advice to patients. We saw evidence of the PLG working with the practice to provide support and advice for vulnerable patients who may require help keeping well and warm in winter.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that all staff spoke with patients in a friendly, professional and helpful manner. All staff spoken with demonstrated a good understanding of how patient's privacy and confidentiality was preserved. During our inspection we overheard and observed that staff responded compassionately to patients in discomfort or emotional distress. We noted that staff approached patients in a person centred way; we saw they respected patients individual preferences, habits, culture, faith and background.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 11 completed cards, all were positive about the service they experienced. Patients said they felt the practice provided excellent care and treatment. Patients commented that staff were supportive, efficient, helpful, caring and pleasant to deal with. They said staff were respectful and treated them with dignity

We saw that staff were careful to follow the practice confidentiality policy when discussing patients' treatment in order that confidential information was kept private. This was respected at all times when staff were delivering care, in staff discussions with people and those close to them, and telephone conversations and in written records. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Facilities were available for patients to speak confidentially to clinical and non-clinical staff. The practice had a range of anti-discrimination policies and procedures. 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.

We spoke with 12 patients and reviewed the most recent data available for the practice on patient satisfaction, including comments made by patients who completed comment cards. We looked at information from the national patient survey and a survey of patients undertaken by the practice's Patient Liaison Group. The evidence from all these sources showed patients were generally satisfied with how they were treated. They commented that they were treated with dignity, respect and compassion with 88% responding that they had confidence and trust in the last GP they saw or spoke to. With 83% responded they had confidence and trust in the last nurse they saw or spoke with and 96% responded that the last appointment they had was convenient. 81% responded that the last GP they saw or spoke with was good at listening to them. The Patient Participation Group conducted a survey. The responses showed that patients were happy with how the staff, including GPs, receptionists and nurses responded to their needs. Patients we spoke with told us that they were treated with respect and dignity and felt their concerns were listened to.

There were systems in place to support patients and those close to them, to receive emotional support from suitably trained staff when required (particularly near the end of a person's life and during bereavement). Bereaved family members were offered the opportunity to speak with the GP or nurse whenever they wanted. Information was available for patients for bereavement support; patients we spoke with told us they felt supported by the practice. A record of patients who had recently died was in place to ensure that inappropriate correspondence was not sent.

The practice was easily accessible to patients with mobility issues. Corridors leading to consulting and treatment rooms were suitable for wheelchair access. There were accessible toilets, equipment and baby changing facilities. There were hearing loop facilities for patients who were hearing impaired.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us they felt involved in decisions about their treatment, planning their care, choosing and making decisions about their care and treatment, and were supported to do so where necessary. We were told the practice routinely involved them with their care and treatment and their choices were respected. Patients told us that they had time to discuss their concerns or treatments when they attended for appointments. It was also possible to book a double appointment when they needed to discuss more than one

concern or complex problems. If a patient needed to be referred to another service or specialist this was discussed during their appointment and they were given a choice of location, where possible.

The practice had arrangements for obtaining patients' wishes for the care and treatment they received as they approached the end of their lives. Patients' wishes in respect of their preferred place to receive end of life care were discussed. Doctors worked with other health care professionals and organisations to help ensure that patients' wishes were acted upon. The practice worked in close partnership with other health and social care professionals. We saw examples of integrated care and care planning which generated positive impact for the patients concerned. The practice was undertaking care planning as part of a national enhanced service. GPs carried out the planning with the involvement of the patients' family or carers. Staff we spoke with knew how to access Language Line when required (Language line is a telephone language translation service). Information was available for people at the practice and on the website in different languages

Patient/carer support to cope emotionally with care and treatment

Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service.

Guide and hearing dogs were welcomed at the practice. The practice had a policy and cleaning procedure which was put in place following any attendance from a support animal.

Notices in the patient waiting room and the practice website signposted people to 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.

Patients experiencing poor mental health received treatment, care and support at the practice and in the community when they needed it. The practice held a register of its patients known to have poor mental health and had effective procedures for undertaking routine mental health assessments. The practice worked in conjunction with the local mental health team and the community psychiatric nurses. Patients with poor mental health were invited to attend an annual health review. The practice held a register of patients with dementia. These patients were offered a full annual health review. Carers were involved in the reviews as necessary.

The practice recognised that some vulnerable patients may find it difficult to attend the practice for care and support. The practice offered telephone consultations, text and also used fax (when the practice had the patients permission) to communicate with patients with reduced hearing. This ensured the practice was able to inform patients of any clinical needs, appointments or home visits for those patients that found it difficult for whatever reason to attend the surgery

The practice appointment system provided the flexibility for those patients who may need extra time during their consultation to have that time. For example, those patients who may be experiencing poor mental health, depression or who may be experiencing complex or terminal health conditions.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood and was responsive to the different needs of the population it served and acted on these to plan and deliver services. The practice maintained links with local area commissioners and we were told meetings took place on a regular basis to review and plan how the practice would continue to meet the needs of the patients and potential service demands in the future. The practice worked collaboratively with other agencies such as district nurses, community mental health teams, alcohol and substance misuse services, social services and regularly shared information (such as special patient notes) to ensure efficient and timely communication of changes in patients care and treatment.

The practice provided care to local care homes. The practice worked closely with the staff at the homes to ensure continuity of care. GPs visited the homes for any routine issues and for any additional medical input.

Nurses and GP's attributed the early detection of conditions through the health assessment and screening checks. Patients we spoke with told us they were advised of their test results promptly and we were told the GPs discussed the results with them if further treatment was required. The practice maintained a palliative care register and had regular internal as well as multidisciplinary meetings, to discuss patients and their families care and support needs. Patients who were carers were offered support through the carer's support group.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings, to discuss patients and their families' care and support needs. The practice had developed a personalised care pathway for the care of the dying patient. It involved advanced planning and symptomatic support and was supported by an end of life policy and a palliative care policy and protocol.

The practice had systems in place to seek and act on feedback from patients. There was a suggestions and comments box available for patient's feedback in the waiting room areas. The practice had an active Patient Liaison Group (PLG) to help it engage with a cross-section of the practice population and obtain patient views. A PLG was a group of active volunteer patients who were established to ensure patients have a voice in the current and future direction of the practice and offer feedback and suggestions as to how the practice may make changes to further improve the care offered to patients. The practice had appointed a PLG chairperson and secretary who worked closely with the practice to increase patient awareness of the group, and provide health education and support to patients. There was evidence of quarterly meetings with the PLG throughout the year.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice understood and responded to the different needs of patients from different ethnic backgrounds and those who may be vulnerable due to social or economic circumstances. The staff culture evidenced that patients could access the practice's services without fear of prejudice. The practice offered telephone consultations for patients that found it difficult for whatever reason to attend the surgery.

Staff were prepared to assist patients with hearing and visual impairment, or whose first language was not English accessing healthcare where necessary. The practice had identified patients with learning disabilities. These patients had individual care plans. People with learning disabilities were offered appointments that suited their working hours.

The practice had an equality and diversity policy and staff were aware of it. Patients we spoke with did not express any concerns about their rights about how they were treated by staff.

Access to the service

The practice used an appointment system called Total Telephone Triage. Patients telephoned the practice and were asked for brief information about why they needed to see a GP; a GP would then telephone the patient back. Where patients were unable to take a call due to work or family commitments they could specify a convenient time for the GP to call. The GP would then schedule a call for example during the patients coffee or lunch break or when home from the school run. Where a telephone consultation was not sufficient, an appointment was then offered for the same day. The GP would determine the length of the appointment according to the patients' needs. Patients did not have to telephone the practice before a certain time in order to access an 'on the day' appointments. All calls made throughout the day were actioned in the same way or referred to the duty GP.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The patients we spoke with told us there was no difficulty contacting the practice by telephone, and telephones were answered. However, they felt they were often kept on hold for lengthy periods. We looked at information on access to the practice from the national patient survey. The evidence from this survey showed patients were generally unhappy with access to the practice. Of the 256 surveys sent to patients, only 132 completed surveys were received, giving a 52% response rate. Of those responses 68% stated they were able to get an appointment to see or speak to someone the last time they tried, 33% responded they had found it easy to get through to the practice by telephone, 55% responded they were happy with the surgery's opening hours and 45% responded that they didn't normally have to wait too long to be seen. However 83% responded that the last appointment they had was convenient and the last GP they saw or spoke with was good at listening to them. 90% responded they had confidence and trust in the last GP they saw or spoke with and 95% responded they had confidence and trust in the last nurse they saw or spoke with. We discussed this with the GPs and practice manager who told us monitoring of this was on-going. The practice was evaluating installing a call management software which would monitor and provide audit data on missed and active telephone calls. We saw that the practice continued to endeavour to recruit GPs and clinical staff to the surgery to meet patient demand.

The practice offered a range of telephone triage appointments and appointments from Monday to Friday. There were paramedic afternoon clinics and morning baby immunisation clinics. The practice offered a range of healthcare assistant and GP pre-booked appointments, plus GP and nurse appointments. The practice offered an ultrasound scanning service and on alternate weeks a respiratory nurse specialist clinic. The respiratory nurse provided home visits for those patients who were unable to attend the practice. Telephone triage and appointments were available. The practice also offered a walk in phlebotomy service from 8.30am to 11am Monday to Friday.

The practice employed a paramedic who was available to respond urgently to patients on a daily basis. The paramedic also undertook welfare visits to patients on their register and prioritised home visits to those patients who had an urgent need. For example those patients who have frequent attendance at A&E or are high users of the OOH service (a local organisation providing GP services to patients with urgent conditions that cannot wait until the GP surgery is next open). Patients who used the OOH service were assessed by the paramedic who attended the patient where required and reported back to the duty GP for treatment where necessary. The paramedic was also able to admit patients to other services when necessary.

The patients we spoke with and the comment cards we viewed told us the system worked well; patients reported they never had to wait to see a GP. However we were told they did not always see the GP who knew them best and they sometimes had to wait to be seen on arrival at the practice. We were told that an appointment was made whenever it was required. The practice worked actively with the PLG to improve the appointment service it provided. We saw evidence of audits completed and repeated by the PLG. The practice continuously monitored the appointments system, this evidenced improved access for patients and a reduction in waiting times and did not attend (DNAs) for appointments at the practice.

The practice was accessible for patients with disabilities. There were car parking facilities including disability parking spaces. Consultation and treatment rooms were located on the ground floor and were accessible along wide corridors. There was a passenger lift to the first floor office areas.

The practice were aware of patients registered at the practice who were homeless. There were processes in place to ensure they could access the GPs or nurses without telephoning the practice.

We spoke with two members of the PLG. We were told the practice had developed the appointment system to meet the needs of its patients. Details of the services available, how to book, change or cancel appointments were available at the practice and displayed on the website in up to 80 different languages. In addition these were available in four languages on posters in the reception area. The practice manager told us these were also displayed in three food outlets in the local town where the customer base would be predominantly patients whose first language was not English. The automated checking in system also provided multi-lingual capabilities. Staff we spoke with were aware of how they could access translation services for patients who did not speak English as their first language. Staff also confirmed that where a translation service was booked a longer appointment for the GP or

Good

Are services responsive to people's needs?

(for example, to feedback?)

nurse was made to accommodate the patients' needs. The practice manager told us the telephone call back system enabled the GP to have a three way conversation with the patient using the telephone translation service.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. There was a designated responsible person who handled all complaints in the practice and these were discussed at the weekly clinical meetings. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England. On receipt of a complaint an acknowledgment letter was sent to the complainant within a fixed timeframe. Following an investigation a response was provided. The final response gave complainants details of external agencies they could contact, should they remain dissatisfied.

There was a complaints procedure which patients were informed of by the practice website and in the practice leaflet. Staff told us that if someone wanted to make a complaint, the receptionist would see if there was anything they could help with immediately, or they would refer patients to speak with or see the practice manager. Staff we spoke with were aware of the complaints policy and told us they would direct any complaints to the practice manager. Patients we spoke with told us they hadn't needed to complain, but would speak with the receptionist for advice. We were told they felt the practice would listen to their concerns.

We saw the practice's log and annual review of all complaints received. The review recorded the outcome of each complaint and identified where learning from the event had been shared with staff. The practice staff we spoke with and records we looked at evidenced that the outcome and any lessons learnt following a complaint were discussed at practice meetings

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

From the discussions we had and the evidence we reviewed we saw that the GPs and management team had a clear vision and purpose. The practice had development plans in place to recruit more GPs and develop the practice building to include further treatment rooms and maximise clinical appointment times. There were succession plans in place for staff in key roles within the practice. The GPs we spoke with demonstrated a clear understanding of the needs and demands of the rapidly growing local population in Watton and their role in ensuring a safe high level of service was provided to their patients.

The practice leaflet, website and PLG encouraged the views of their patients and carers and those views were fed into the partnership to improve the service. A PLG was a group of active volunteer patients who were established to ensure patients have a voice in the current and future direction of the practice and offer feedback and suggestions as to how the practice may make changes to further improve the care offered to patients. The practice had a clear main focus on improving outcomes for their patients. They achieved this through reviews, audits and responding to feedback from staff and patients.

Staff we spoke with told us they knew and understood the vision and values of the practice and knew what their responsibilities were in relation to these. Staff felt they were encouraged to make suggestions that led to improved systems and patient care. The practice manager told us they were very proud of the staff team and the hard work and support they put into providing a smooth running service for the patients.

Governance arrangements

There were systems in place to manage governance of the practice. The practice had structured clinical meetings that ensured information was shared. For example, we looked at records of meetings GP held weekly to discuss clinical issues. GP partners and the practice manager met to discuss matters relating to the running of the practice such as recruitement, significant events and complaints. This ensured that matters that may have an impact on patient care and safety were discussed to ensure awareness and effective service delivery.

There were clearly identified lead roles for areas such as Quality Outcomes Framework ((QoF) an annual reward and incentive programme), medicines management, GP training, complaints, significant events and safeguarding.

The practice used the QOF to measure their 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 clinical meetings and action plans were produced to maintain or improve outcomes.

The practice had completed a number of clinical audits, for example prescribing and vulnerable patient outcomes. We saw that where actions had been identified the practice had shared learning points with staff and completed recommended actions.

There were a number of policies and procedures in place to govern activity and these were available to staff. All the policies and procedures we looked at had been reviewed annually and were up to date.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as health and safety, legionella, infection control and fire safety. We saw that the risk log was regularly updated. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, the practice regularly reviewed the risks associated with staff welfare (pregnant staff risk assessments), staff capacity and skill mix and had put plans in place to mitigate risks to both staff and patient care.

Leadership, openness and transparency

There was a clear leadership structure at Watton Medical Practice with named staff members in lead roles. Staff were clear about their own roles and responsibilities and told us they felt supported by the management team. All the staff we spoke with knew who they could go to within the practice should they have any complaints or concerns. Staff told us team meetings were held regularly and they felt comfortable raising any concerns at these meetings. However not all of these meetings had been minuted.

The GPs and management staff were aware of the needs of the practice population and tailored the service to meet the needs of the local population groups. The clinical team had lead areas of responsibility as did each member of staff such as the paramedic and practice nurses who led on

Are services well-led?

Good

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

infection prevention control, welfare of the elderly and diabetes services. All staff worked closely and effectively together to ensure patients received timely and appropriate care.

The practice held a variety of regular practice clinical meetings. These included a review of practice learning points or significant events, training requirements and audits. Actions taken and lessons learned from these were discussed and recorded. There were on-going checks of the safe running of the practice such as fire safety, infection control monitoring and testing of equipment and utilities, for example legionella testing of the water tanks and servicing of the lift.

We found there was daily monitoring of the patient appointment system to ensure the system was as accessible and responsive to patient needs as possible.

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

Staff we spoke with told us they felt encouraged to provide feedback and comments and felt these were listened to and acted upon. Staff told us they felt very well supported and felt they all worked well together as a team. The nurses we spoke with told us they felt well led by the GPs and the practice manager and felt the meetings and discussion with their peer groups proved valuable and supportive. The practice actively encouraged the participation and involvement of staff through annual appraisals.

The practice recognised the importance of the views of patients and had systems in place to do this. This included the use of patients' comments, analysis of complaints, patient surveys and working in partnership with the Patient Liaison Group (PLG). A PLG was a group of active volunteer patients who were established to ensure patients have a voice in the current and future direction of the practice and offer feedback and suggestions as to how the practice may make changes to further improve the care offered to patients.

Results of the patients' surveys and PLG comments were shared with patients through the practice website and the quarterly practice newsletter. We saw that the PLG had developed an action plan and the practice had worked with the group to resolve outstanding actions. The chairperson for the PLG confirmed that they had a very good working relationship with the practice and that the partners were open and honest and listened to what they said.

Members of the PLG were also active outside of meetings with the local community. This was achieved by delivering the practice newsletters, discussing issues with patients and noting comments and feedback from patients that would help the practice improve its services to patients. The PLG played a major role in undertaking the patient survey, auditing the practice appointment system and agreeing focus areas with the practice for the coming year. PLG members also attended training, seminars and regional PLG events and represented the practice and group on local health forums such as Dementia Care.

Management lead through learning and improvement

We saw that patient referrals were discussed at clinical team meetings and learning points considered and shared between clinicians. Audits on A& E attendance had been completed and learning points and action plans put in place. The practice was designated as a 'teaching practice' where trainee GPs was offered placements to develop their knowledge, skills and clinical competencies.

Records showed that clinical staff were supported to access on-going learning to improve their skills and competencies. For example, attending specialist training for cardiac arrest managements, smear taking and cytology and childhood immunisation. In addition, opportunities to attend external forums and events to help ensure their continued professional development. Non-clinical staff were also supported to improve their skills and knowledge. For example, by attending training in employment law, infection control, information governance and customer service skills.

We saw evidence that learning from significant events and complaints took place. There were systems in place to audit and review significant events and complaints. These audits resulted in action plans and implementation of changes to improve patient safety, care and practice performance.

Staff told us that the practice supported them to maintain their clinical professional development through training

Are services well-led?

Good

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

and mentoring. We looked at six staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.