Wyndham House Surgery

Quality Report

Wyndham House Surgery
Silverton
Devon
EX5 4HZ
Tel: Tel: 01392 860034
Website: www.wyndhamhousesurgery.co.uk

Date of inspection visit: 26 August 2015
Date of publication: 17/12/2015

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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Good ●

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Wyndham House Surgery on Wednesday 26 August 2015. Overall the practice is rated as outstanding.

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

- There was a safe track record and staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed. Medicines were well managed and the practice had good facilities and was well equipped to treat patients and meet their needs
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- There were clear recruitment processes in place. Staff had received training appropriate to their roles and any further training needs had been identified and planned
- The practice was well organised and there was a clear leadership structure. The practice proactively sought feedback from staff and patients, which it acted on.

We identified areas of outstanding practice:

The practice had two schemes in place that particularly supported older frail patients, housebound patients with long term conditions and vulnerable patients.

Summary of findings

- A 'BERTIE' pharmacy delivery service which delivered over 1310 prescription products per month to over 300 vulnerable, isolated and housebound patients. This service had led to improved communication and feedback between patients and the practice with practice staff being alerted sooner to any special needs of patients. The service had proved popular with patients and meant that very frail patients who had their medicine organised in Dosette boxes were guaranteed a weekly visit from one of the 'Bertie' team. We were given examples of where these visits leading to much earlier clinical interventions and so removing need for hospital admission.
- The practice employed an outreach nurse who had been commissioned by the friends of Wyndham group. Her role was to individually target older, frail, vulnerable or isolated patients to review care plans, conduct risk assessments and provide health care advice; this scheme had helped patients to maintain their independence at home and reduce the need for hospital admission. This opportunistic visiting had led to examples of uncovering social and medical needs which can be tackled proactively and to involve reablement teams, clarify medicines and involve carer support agencies. The scheme also included falls assessments, routine health checks, advice on diet, exercise, mobility etc. The nurse also offered osteoporosis checks, dementia assessments and reviews of care plans. The nurse had also performed checks on the wellbeing of the patient during adverse weather conditions and promotion of, or the gaining of agreement to, the use of the pendant alarm system.

One of the GPs wrote regular columns in two local parish magazines. The monthly articles had included updates on public health or medical education issues. The GP also gave an annual presentations to patients in the town outlining and explaining local healthcare issues. These talks had been attended by over 100 people and have become a part of the annual community calendar.

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

Importantly the provider should:

- Introduce a more formal record to show competency of dispensary staff had been performed in line with the dispensary safety quality scheme (DSQS)
- Records should be kept of safety alerts relating to medicines and the action, if any, that has been taken in relation to these.

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 providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed.

Risks to patients were assessed and well managed.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services.

Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

Wyndham House was ranked in the top three practices in the NEW Devon Clinical Commissioning Group (CCG) for practices in East Devon. The rankings looked at use of emergency care, elective referrals and prescribing budgets demonstrating an efficient and effective practice.

The practice had introduced service to promote positive outcomes for patients and provide information to allow patients to make changes to their lifestyle. For example a healthy lifestyle course for patients at risk of developing diabetes. The course was run by a registered nurse and life coach and involved discussions on diet, weight loss and exercise classes.

One of the GPs wrote regular columns in two local parish magazines. The monthly articles have included updates on public health or medical education issues. The GP also gives an annual presentation to patients in the town outlining and explaining local healthcare issues. These talks have been attended by over 100 people and have become a part of the annual community calendar. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Summary of findings

Are services caring?

Good 

The practice is rated as good for providing caring services.

Data showed that 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 decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Outstanding 

The practice is rated as outstanding for providing responsive services.

It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

The practice had responded to the needs of older people, those with long term conditions and vulnerable patients in this rural community by providing two services. The 'BERTIE' service delivered prescription products and medicines to vulnerable, isolated and housebound patients and had resulted in an improved communication between patients and the practice. The practice also employed an outreach nurse to visit older, frail, vulnerable or isolated patients to review care plans, conduct risk assessments and provide health care advice.

Feedback about access to appointments was good. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care. The practice offered a range of appointment types including 'book on the day,' telephone consultations and advance appointments bookable up to six weeks in advance.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good 

The practice is rated as good for being well-led.

The practice was cohesive and had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure in place and a strong culture of team work. Staff felt supported by management.

Summary of findings

The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk.

The practice proactively sought feedback from staff and patients, which it acted on. The virtual patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice was part of the primary care research network and were involved in recruiting patients for national studies including timings of blood pressure, screening of relatives with rheumatoid arthritis, study of falls and study into medicines to treat a bacteria in the stomach.

Wyndham House actively engaged in pro-actively auditing referrals and showed its success through low referral rates compared to others in the CCG. An analysis of some referral data had led to changes in pathway directions in Mid Devon. The practice had been directly involved in piloting the electronic transfer of information about patients for the CCG and had been instrumental in promoting use of Cardio-call technology to ensure 24 hr ECG taping could move from Secondary Care into the community.

The practice had been involved in medical teaching for many years and feedback from the GP trainees was positive.

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

Outstanding ☆

The practice is rated as outstanding for the care of older people

The practice employed an outreach nurse who was contracted for eight hours per week to visit older patients who were vulnerable patients and unable to leave their home. This 'Elderly Project' had been commissioned by the Friends of Wyndham House to provide limited, non-urgent health support to patients of the Wyndham House Surgery who, through a combination of age and infirmity, had been unable to routinely travel to the practice, with the aim of reducing the likelihood of urgent or emergency intervention. The scheme included falls assessments, routine health checks, advice on diet, exercise, mobility etc. The nurse also offered osteoporosis checks, dementia assessments and reviews of care plans. The nurse had also performed checks on the wellbeing of the patient during adverse weather conditions and promotion of, or the gaining of agreement to, the use of the pendant alarm system.

Older patients at Wyndham House were able to see the same GP for continuity. Pneumococcal vaccination and shingles vaccinations were provided at the practice for older people.

The community nursing team was based within the health centre which helped communication and access to the service.

The practice systematically identified older patients and coordinated the multi-disciplinary team (MDT) for the planning and delivery of palliative care for people approaching the end of life. The practice held regular meetings with community nurses.

The practice also provide a service known as 'BERTIE' which had delivered prescribed medicines to over 300 patients who had been unable to leave their home. BERTIE volunteers had been used to highlight changes in the condition of the patient and had triggered home visits from GPs and medicine reviews.

The practice provided regular balance classes for older patients. The friends group also offered a 'knit and natter' group which helped to reduce social isolation for older patients.

The practice had set up a link up service which put patients in touch with volunteers to offering a befriending service and transport service to the practice and local hospital.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of people with long term conditions.

Summary of findings

The practice had systems to identify patients who might be vulnerable, have multiple or specific complex or long term needs and ensured they were offered consultations or reviews where needed. All patients with long term conditions were offered annual reviews in the month of their birthday.

A system was in place to ensure staff received regular National Institute for Health and Care Excellence (NICE) guidance updates to ensure that clinicians were managing patients with long term conditions in the most current evidence based way.

The practice staff discussed vulnerable patients or those receiving palliative care during the monthly operational meeting to ensure care is coordinated and patients access the health and social care they require.

The surgery ran Balance classes, Lifestyle sessions for patients at risk of Diabetes, Carer Support Clinics and Community activities for patients with dementia (Dementia Carer Group and Knit & Natter weekly event during winter months).

The practice provided a healthy lifestyle course for patients at risk of developing diabetes. The course was run by a registered nurse and life coach and involved discussions on diet, weight loss and exercise classes.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

The practice offered baby and child immunisation programmes so that babies and children could access a full range of vaccinations and health screening.

The local health visitor is based in the practice and has regular safeguarding meetings with the clinical staff. The practice had scheduled visits by the area midwife where she meets with mothers at the practice.

The GPs provided the contraception services and sexual health screening including chlamydia testing. Practice nurses and female GPs offered cervical screening for women. There were quiet private areas in the practice for mothers to use when breastfeeding.

Appropriate systems were in place to help safeguard children or young people who may be vulnerable or at risk of abuse. Vulnerable patients were reviewed at the practice quarterly meeting.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

Patients could book appointments online and order prescriptions online. The practice used a text message reminder service for patients that had signed up to the service and used a social media site to promote lifestyle advice.

There was a virtual patient participation group at the practice which had a high number of working age members. These patients used electronic communication to provide feedback to the practice.

Suitable travel advice was available from the GPs and nursing staff.

The staff took the opportunity to offer health checks to patients as they attended the practice. This included offering referrals for smoking cessation, providing health information, routine health checks and reminders to have medicines reviews. The practice also offered age appropriate screening tests such as prostate cancer screening and cholesterol levels and were actively promoting NHS Health Checks.

The practice had a visiting physiotherapist providing an on-site service via referral from the GPs.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice had a vulnerable patient register. These patients were discussed at the monthly operation meetings if relevant.

There were a very small number of patients whose first language was not English. Practice staff said these patients had a good understanding of English but knew they had access to an interpretation service.

The practice employed an outreach nurse who visited any vulnerable patients to assess and facilitate any equipment, mobility or medicines needs they may have.

All of the patients with learning disabilities had been offered a health check within the last year when their long term care plans were discussed with the patient and their carer if appropriate.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people living with dementia).

Summary of findings

A register at the practice identified patients who had a mental illness or mental health problems. Patients had access to one of the GPs who offered in-house counselling. The practice had links with the local depression and anxiety service.

The clinical IT software flagged up when a patient was at risk of dementia and appropriate screening was offered by the GP. 100% of patients experiencing poor mental health had received an annual physical and mental health check.

Patients living with dementia had care plans which were reviewed regularly. In-house mental health reviews were conducted to ensure patients received appropriate doses of medicines and had their physical health assessed. Blood tests were performed on patients receiving certain mental health medicines to check that optimum levels were prescribed

There was communication, referral and liaison with the psychiatry specialist. Staff appreciated the advice and support provided.

Staff were aware of the Mental Capacity Act and deprivation of liberty and were in the process of organising further training on the subject.

Patients with mental illness and those living with dementia were discussed and reviewed during safeguarding meetings where appropriate.

Summary of findings

What people who use the service say

The national GP patient survey results published on July 2015 showed the practice were rated higher by patients for 19 out of 23 questions compared the CCG and national averages. There were 56 responses which represents approximately 1.6% of the practice population.

- 100% said they found it easy to get through to this practice by phone compared with a CCG average of 84% and a national average of 73%.
- 94% find the receptionists at this practice helpful compared with a CCG average of 91% and a national average of 87%.
- 92% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 72% and a national average of 60%.
- 96% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 91% and a national average of 85%.
- 100% say the last appointment they got was convenient compared with the CCG average of 95% and a national average of 92%.
- 99% describe their experience of making an appointment as good compared with a CCG average of 83% and a national average of 73%.
- 88% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 71% and a national average of 65%.
- 81% feel they don't normally have to wait too long to be seen compared with a CCG average of 64% and a national average of 58%.

As part of our inspection we also asked for patient feedback prior to our inspection. We received 22 comment cards which were all positive about the standard of care received. Comments from patients were detailed and referred to staff as being kind, caring, respectful and helpful. Patients said the treatment they received was excellent, good and caring and stated that they appreciated the clean and tidy facilities. Patients said the staff went out of their way when care was needed and appreciated the same day appointment service.

On the day of our inspection we spoke with 15 patients, a co-ordinator of the friends of Wyndham surgery group and with a representative from the patient participation group (PPG). We also received email responses from six virtual PPG members. This feedback and found their views aligned with findings from comment cards. For example 10 patients referred to the ease of seeing a GP on the same day. Patients were positive about the practice and the treatment they received. Patients appreciated the service from the dispensary team and referred to a 'one stop shop' where staff were able to dispense medicines and make follow up appointments. Patients said they had enough time with the GPs and nurses and said they were listened to and involved in their care. Patients were satisfied with the cleanliness and facilities at the practice and had not found any need to complain.

We saw the results from the practice friends and family test carried out between the end of February 2015 and end of July 2015. There were 46 results of which 40 respondents were extremely likely to recommend the practice. Five respondents were likely to, and one neither likely nor unlikely. Comments linked to the neutral response included suggestions to make the waiting area less dark. Positive comments included prompt answering of telephones, the onsite dispensary service and ease of getting appointments.

Areas for improvement

Action the service SHOULD take to improve

- Introduce a formal record to show competency of dispensary staff had been performed in line with the dispensary safety quality scheme (DSQS)
- Records should be kept of safety alerts relating to medicines and the action, if any, that has been taken in relation to these.

Summary of findings

Outstanding practice

- The practice had two schemes in place that particularly supported older frail patients. A pharmacy delivery service which delivered over 1310 prescription products per month to over 300 vulnerable, isolated and housebound patients. This service had led to improved communication and feedback between patients and the practice and practice staff being alerted sooner to any special needs of patients.
- The practice employed an outreach nurse to visit older, frail, vulnerable or isolated patients to review care plans, conduct risk assessments and provide health care advice; this scheme had helped patients to maintain their independence at home and reduce the need for hospital admission.

Wyndham House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor, a practice manager specialist advisor, a practice nurse specialist advisor and an expert by experience. Experts by Experience are people who have experience of using care services.

Background to Wyndham House Surgery

Wyndham House Surgery was inspected on Wednesday 26 August 2015. This was a comprehensive inspection.

The main practice is situated in the rural village of Silverton, Devon. The practice provides a primary medical service to approximately 3,600 patients of a diverse age group. The practice was a training practice for doctors who are training to become GPs and for medical students from the local medical school. Two of the GPs also taught at the medical school.

There was a team of five GPs, three male and two female. There were two GP partners and two salaried GP within the organisation. Partners hold managerial and financial responsibility for running the business. There was also a GP registrar (A qualified doctor training to become a GP). The team were supported by a practice manager, two practice nurses, a dispensary team and additional administration staff, some of whom also work in the dispensary. The practice employ an outreach nurse who visits people in their own homes and use the services of a physiotherapist.

Patients using the practice also had access to community nurses and health visitors who are based at the practice. Other health care professionals visit the practice on a regular basis. For example podiatrists and midwives.

The practice is open from Monday to Thursday – 8.30 to 6pm and Friday – 8.30 to 5pm. The GP manages calls on a Friday between 5pm and 6pm. The dispensary is open all day. Outside of these times there is a local agreement that the out of hours service take phone calls and provide an out-of-hours service.

The practice offered a range of appointment types including 'book on the day,' telephone consultations and advance appointments bookable up to six weeks in advance.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?

Detailed findings

- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We also received four responses from members of the patient participation group.

We carried out an announced visit on 26 August 2015. During our visit we spoke with a range of staff and spoke with 15 patients who used the service, a representative from the friends group and a representative from the patient participation group. We observed how people were being cared for and talked with carers and/or family members. We reviewed 22 comment cards where patients and members of the public shared their views and experiences of the service

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff told us they would inform the practice manager of any incidents. The staff were then asked to make a record of the event after which action was taken and an analysis of the significant event performed and reviewed.

We reviewed significant event registers and saw that trends were monitored and lessons shared to make sure action was taken to improve safety in the practice. For example, a complaint had been received when a patient could not contact the practice after the practice had closed but before the out of hours service had taken over. This had been managed as a significant event and resulted in an apology to the patient and an investigation which had revealed there was no mobile phone coverage where the GP had been located. A change of policy had been introduced where the GP taking the calls was located at the practice.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety. The practice used the National Reporting and Learning System (NRLS) eForm to report patient safety incidents.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. For example, the policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs met with the health visitors on a regular basis to discuss any child safeguarding issues. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. The GPs had trained to level 3 to ensure that they all had suitable knowledge.
- A notice was displayed in the waiting room, advising patients that chaperones were available if required. All staff that acted as chaperones had been trained for the role and had received a disclosure and barring check (DBS - these checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Recruitment checks were carried out and the two files we reviewed showed that appropriate checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. Assurances that suitable pre-employment checks had been performed were also obtained for locum staff.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Administration staff told us they used a rota system to cover their work and ensure they maintained skills in more than one area.

The practice was clean and tidy. There was an infection control protocol in place and training had been planned for new staff. The new lead practice nurse and practice manager had just completed an infection control audit which had identified a need to introduce infection control training at induction and to introduce a clinical cleaning schedule for staff use. Further environmental actions included the introduction of foot operated bins in one consulting room and introduction of wall mounted soap dispensers. We were informed that replacement of carpets in a treatment room and replacement of some taps in consulting rooms was already part of a business plan.

The arrangements for managing medicines within the practice, including emergency drugs and vaccinations, kept patients safe. This included obtaining, prescribing, recording, handling, storing and security of medicines. There were systems in place to ensure medicines requiring refrigeration were stored at the correct temperatures. These systems included daily fridge temperature

recordings and policies to maintain the cold chain so that medicines were safe to be given to patients. The practice used prompts for prescribing and regular medicine audits were carried out to ensure the practice was prescribing in line with best practice guidelines for safe prescribing, for example, for antibiotic prescribing. Prescription pads were securely stored and there were systems in place to monitor their use.

The practice offered a full range of primary medical services and was able to provide pharmaceutical services to those patients who lived more than one mile (1.6km) from their nearest pharmacy premises.

The practice had a dispensary that was open Monday to Friday. The dispensary was open between 8:15am to 6:00pm Monday to Thursday and 8:30 to 5:00 on Friday for patients to collect their prescriptions. There was a system in place for medicines to be delivered to patients who were housebound and could not come to the surgery to collect them. This service was run by volunteers who had received recruitment checks.

Medicines in the dispensary were stored securely and were only accessible to authorised staff. The dispensary did not feel excessively hot but there were no records of room temperature monitoring kept to show that medicines were stored at appropriate temperatures, however this was introduced by the end of the inspection visit. Systems were in place to check that medicines were within their expiry date and suitable for use. Expired and unwanted medicines were disposed of in line with waste regulations. Systems were in place to deal with any medicines alerts or recalls, and records kept of any actions taken.

The practice had written operating procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately reflected current practice. Systems were in place to make sure that prescriptions were signed by the prescriber, before medicines were dispensed or handed out to patients. Medicines were scanned using a barcode system to help reduce any dispensing errors. Some medicines were dispensed into a dosette box to help some patients take their medicines correctly, and these were always dispensed and checked by two trained staff. There were arrangements in place to ensure that patients were given all the relevant information they required.

The practice was signed up to the Dispensing Services Quality Scheme (DSQS) to help ensure processes were suitable and the quality of the service was maintained. Dispensing staff had all completed appropriate training. However, there was no evidence to show staff had had their competency formally reviewed. Staff explained that this process was done informally throughout the year.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Safety incidents relating to the dispensary were reported to the practice manager and the GP responsible for the dispensary. Staff told us these were discussed in the weekly dispensary meetings. We saw an example of action taken to reduce the risk of one recent reported error recurring.

The dispensary staff told us they received medicines safety alerts and checked whether these were relevant to make sure appropriate action was taken. However they did not keep records of these alerts or any action they had taken in response to them.

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.

There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the staff common room. The practice had up to date fire risk assessments. All electrical equipment was checked to ensure the equipment was safe to use. For example, the last PAT (portable electrical safety testing) had been performed at the beginning of August 2015. Clinical equipment had been tested on the same day for safety and performance as part of a rolling maintenance programme. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health (COSHH) and infection control and legionella. The last legionella risk assessment was performed in June 2015 with monthly testing also in place. The cleaning cupboard was secured with a bolt but no lock. The practice manager was in the process of replacing this with a secure lock.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

There were panic systems on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training.

The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

Wyndham House had been ranked in the top three practices in the NEW Devon Clinical Commissioning Group (CCG) for practices in East Devon. The CCG rankings looked at use of emergency care, elective referrals and prescribing budgets demonstrating an efficient and effective practice.

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results had achieved 97.5% of the 100% of the total number of points available, with 0.1% exception reporting. This practice was not an outlier for any QOF (or other national) clinical targets. Data from the health and social care information centre showed;

- Performance for diabetes related indicators was similar to the CCG and national average. For example, the practice explained that all QOF markers had been achieved apart from one where the practice was marginally below target, with plans to increase this.
- The percentage of patients with hypertension having regular blood pressure tests was better than the CCG and national average of 86%.
- Performance for mental health related and hypertension indicators were similar to the CCG and national average.

The practice had also introduced service to promote positive outcomes for patients and provide information to allow patients to make changes to their lifestyle. For example a healthy lifestyle course for patients at risk of developing diabetes. The course was run by a registered nurse and life coach and involved discussions on diet, weight loss and exercise classes.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. We were shown five clinical audits completed in the last two years. All of these were completed audits where the improvements made were implemented, repeated and monitored. The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services and monitor effectiveness. For example, an audit of patients being referred for plastic surgery was performed after the GPs had noted the practice referral rates for plastic surgery had been uncharacteristically very high compared to rates in other specialities during 2014. The GPs had reviewed and recorded the reason for each referral. The GPs had concluded that almost all referrals had been appropriately directed and discussed the findings with the Clinical Commissioning Group (CCG) who found the data useful and planned to investigate further. The plan was to repeat the audit following the introduction of a GP dermatology service which had started in July 2015.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality. Clinical staff and locum GPs were also supported according to their need and ability. All staff were informed how to access practice policies and were issued with contract which contained detailed information.
- Staff told us they felt supported and had access to further education and training. Learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. Staff explained there was mutual respect shown at the practice and all colleagues were supportive and offered guidance where required. All permanent staff had

received an appraisal within the last 12 months. However, dispensary staff had not formally had their competency assessed. Dispensary staff said this had been done informally throughout the year.

- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Registered nurses had received further education to keep their skills and knowledge up to date.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available within treatment rooms and waiting areas. All relevant information was shared with other services in a timely way, for example when patients were discussed at the operational meetings.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patient needs and to assess and plan on-going care and treatment. This included when patients moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that the practice held a range of meetings to discuss patients. These included daily clinical meetings, weekly dispensary meetings, monthly safeguarding meetings, monthly GP meetings and monthly operational meetings where vulnerable patients and care plans were reviewed and updated.

Consent to care and treatment

The practice used prompts when gaining consent for procedures including ear syringing, cervical smears and child immunisations. Patients gave written consent before undergoing minor surgical procedures. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance.

Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. We were provided with examples where this had been performed.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last stage of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and those at risk of developing diabetes. Patients were then signposted to the relevant service.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 80%, which was comparable with the national average of 77%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable than CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds was 94.82% and for five year olds who were fully immunised was 90% which were also comparable to CCG and national averages.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

Wyndham House was ranked in the top three practices in the NEW Devon Clinical Commissioning Group (CCG) for practices in East Devon. The rankings looked at use of emergency care, elective referrals and prescribing budgets demonstrating an efficient and effective practice.

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results had achieved 97.5% of the 100% of the total number of points available, with 0.1% exception reporting. This practice was not an outlier for any QOF (or other national) clinical targets. Data from the health and social care information centre showed;

- Performance for diabetes related indicators was similar to the CCG and national average. For example, the practice explained that all QOF markers had been achieved apart from one where the practice was marginally below target, with plans to increase this.
- The percentage of patients with hypertension having regular blood pressure tests was better than the CCG and national average of 86%.
- Performance for mental health related and hypertension indicators were similar to the CCG and national average.

The practice had also introduced service to promote positive outcomes for patients and provide information to allow patients to make changes to their lifestyle. For example a healthy lifestyle course for patients at risk of developing diabetes. The course was run by a registered nurse and life coach and involved discussions on diet, weight loss and exercise classes.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. We were shown five clinical audits completed in the last two years. All of these were completed audits where the improvements made were implemented, repeated and monitored. The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services and monitor effectiveness. For example, an audit of patients being referred for plastic surgery was performed after the GPs had noted the practice referral rates for plastic surgery had been uncharacteristically very high compared to rates in other specialities during 2014. The GPs had reviewed and recorded the reason for each referral. The GPs had concluded that almost all referrals had been appropriately directed and discussed the findings with the Clinical Commissioning Group (CCG) who found the data useful and planned to investigate further. The plan was to repeat the audit following the introduction of a GP dermatology service which had started in July 2015.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality. Clinical staff and locum GPs were also supported according to their need and ability. All staff were informed how to access practice policies and were issued with contract which contained detailed information.
- Staff told us they felt supported and had access to further education and training. Learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. Staff explained there was mutual respect shown at the practice and all colleagues were supportive and offered guidance where required. All permanent staff had

received an appraisal within the last 12 months. However, dispensary staff had not formally had their competency assessed. Dispensary staff said this had been done informally throughout the year.

- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Registered nurses had received further education to keep their skills and knowledge up to date.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available within treatment rooms and waiting areas. All relevant information was shared with other services in a timely way, for example when patients were discussed at the operational meetings.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patient needs and to assess and plan on-going care and treatment. This included when patients moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that the practice held a range of meetings to discuss patients. These included daily clinical meetings, weekly dispensary meetings, monthly safeguarding meetings, monthly GP meetings and monthly operational meetings where vulnerable patients and care plans were reviewed and updated.

Consent to care and treatment

The practice used prompts when gaining consent for procedures including ear syringing, cervical smears and child immunisations. Patients gave written consent before undergoing minor surgical procedures. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance.

Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. We were provided with examples where this had been performed.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last stage of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and those at risk of developing diabetes. Patients were then signposted to the relevant service.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 80%, which was comparable with the national average of 77%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable than CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds was 94.82% and for five year olds who were fully immunised was 90% which were also comparable to CCG and national averages.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area. For example, the practice was involved in two initiatives set up by GPs in the town and the CCG.

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example;

- Patients told us they were able to see a GP on the same day, often within hours of requesting the appointment.
- There were longer appointments available for people with a learning disability.
- Home visits were available for older patients or for patients who would benefit from these.
- There were disabled facilities and translation services available.
- The practice ensured any patients with mobility issues could be seen in a ground floor consulting room. All treatment rooms were situated on the ground floor.
- This rural practice, through a trust fund, provided a 'BERTIE' service which delivered prescription products and medicines to vulnerable, isolated and housebound patients. This service had provided a service to over 300 patients and an average of 1310 products being delivered per month. The benefits of the service had included an improved communication and feedback between patients and the practice and practice staff being alerted to any special needs of patients.
- The practice employed an outreach nurse to visit older, frail, vulnerable or isolated patients to review care plans, conduct risk assessments and provide health care advice.

Access to the service

The practice was open from Monday to Thursday – 8.30 to 6pm and Friday – 8.30 to 5pm. The GP managed calls on a Friday between 5pm and 6pm. The dispensary is open all day. Outside of these times there is a local agreement that the out of hours service take phone calls and provide an out-of-hours service.

The practice offered a range of appointment types including 'book on the day,' telephone consultations and advance appointments bookable up to six weeks in advance.

All of the patients we spoke to on the day were able to get appointments when they needed them and seven patients commented that they had made their appointment on the same day, often within hours of phoning. Comment cards contained positive feedback about getting appointments. One patient said their relative had been visited in the GPs lunch hour and another patient said they were always slotted in.

Results from the friends and family test results contained positive comments about the appointment system and access. The national GP patient survey also showed that patient's satisfaction with how they could access care and treatment were either comparable with local and national averages. For example:

- 89% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and national average of 75%.
- 97% patients said they could get through easily to the practice by phone compared to the CCG average of 80% and national average of 73%.
- 93% patients described their experience of making an appointment as good compared to the CCG average of 81% and national average of 73%.
- 88% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 72% and national average of 65%.

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 the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. For example, we saw posters and leaflets displayed in waiting areas and information on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint, although none of the patients had made a complaint.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

We saw a complaints spread sheet which was used to monitor any trends and used to raise any lessons and identify any action to improve the quality of care. For example, one complaint about dispensing medicines raised by a patient had resulted in an apology to the patient and change of practice policy.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice was well led and had a cohesive team. This practice had a mission statement which was displayed on the website and in the practice and included a commitment to high quality, accessible, community based healthcare. The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. Staff were trained in more than one area of work which promoted a sense of team work.
- Practice specific policies had been implemented since the arrival of the practice manager a year ago and were available to all staff on the intranet. Staff explained that any changes, alerts or updates were discussed at their daily clinical meetings.
- A comprehensive understanding of the performance of the practice was communicated to all staff at the weekly meetings and quarterly staff meetings.
- A programme of continuous clinical and internal audit which is used to monitor quality and to make improvements. For example, audits of the use of medicines used for depression.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, annual environmental risk assessments were performed.

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. Systems were in place to prioritise safe, high quality and compassionate care, through structured meetings, IT systems and information gathering. The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness and honesty.

Staff told us that there was a non-hierarchical and open culture within the practice. Staff explained that they had the opportunity to raise any issues informally or at the formal team meetings and felt confident in doing so and were supported if they did.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. The practice also gathered feedback from patients through the virtual patient participation group (PPG) and through surveys and complaints received. For example, patients had requested extended opening times for the dispensary, which had been done.

The PPG representatives we spoke with or received feedback from told us the practice staff were receptive and open to suggestions.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice was part of the primary care research network and were involved in recruiting patients for national studies including timings of blood pressure, screening of relatives with rheumatoid arthritis, study of falls and study into medicines to treat a bacteria in the stomach.

Wyndham House actively engaged in pro-actively auditing any areas of referral that seem to be outliers. The referral rates were low compared to others in the CCG and an analysis of plastics referral data had led to changes in pathway directions in Mid Devon. The practice were directly involved in piloting the electronic transfer of information about patients for the CCG and had been instrumental in promoting use of Cardio-call technology to ensure 24 hr ECG taping could move from Secondary Care into the community.

The practice had been involved in medical teaching for many years and had a GP registrar working (GP registrars are fully qualified doctors with hospital experience who are training to become a GP). Patient participation with

Are services well-led?

Good

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

registrars was entirely voluntary; patients were notified and able to decline the appointment at any time. Feedback from the GP trainee was positive and confirmed there was support from all GPs and staff at the practice.

Two of the GPs were GP trainers and also taught medical students from the Peninsula Medical School. The practice had received a positive re-accreditation report from the university deanery in July 2013 and was due another visit in the near future.