Taw Hill Medical Practice

Quality Report

Aiken Road
Swindon
Wiltshire
SN25 1UH
Tel: 01793 709500
Website: www.tawhillsurgery.nhs.uk/

Date of inspection visit: 5 August 2015
Date of publication: 03/09/2015

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced focussed inspection at Taw Hill Medical Centre on 5 August 2015 to follow up on actions identified during out previous inspection in October 2014. Aspects of the practice we asked the provider to improve which were covered during our inspection included; staff recruitment, the safety and availability of equipment, medicines management and quality assurance processes. We saw the provider had made improvements to their service; overall the practice is rated as good.

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

- 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, with improvements to those relating to recruitment checks, medicines management and emergency equipment.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- 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.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice sought feedback from staff and patients, which it acted on and quality assurance processes had improved.

We saw one area of outstanding practice:

- The phlebotomist's role had been extended to improve outcomes for patients. Alongside blood tests they took the patient's blood pressure, measured their weight, recorded their body mass index and recorded their smoking status. Where concerns were noted the

Summary of findings

GP was informed and a further appointment was made. This helped the practice to proactively work towards preventing patients acquiring longer term conditions.

However there were areas of practice where the provider could make improvements. Importantly the provider should;

- Ensure all newly appointed staff have their induction training prioritised so that key subjects such as safeguarding and mental capacity are covered earlier in their induction.
- Ensure more frequent supervision of nurse prescribers is arranged and implemented.
- Ensure monthly infection control checks are recorded to evidence the work carried out.

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. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good 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 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. 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.

Are services well-led?

Good

The practice is rated as good for being well-led. It 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 and staff felt supported by management. 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 patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

What people who use the service say

We spoke with 15 patients who attended the practice for appointments during our inspection. We looked at data the Care Quality Commission holds about this practice, the practice website and their NHS Choices website to look at comments made by patients and gather other information (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent NHS GP patient survey where 83.3% of patients who responded had described their overall experience at the practice as good.

The majority of comments made by patients during our interviews were positive and praised the treatment they received. For example, comments were made about receiving the right treatment at the right time, about seeing a gender specific GP and about being involved in the care and treatment provided. We heard patients generally found access to the practice via the telephone system time consuming but once through appointments were generally easy to get.

The most recent GP survey showed 79.2% of patients said the last appointment they received was convenient compared to a Clinical Commissioning Group average of 89.6% and a national average of 91.8%. Patients said they were usually seen promptly when attending appointments, with 67.8% being positive about appointments compared to a Clinical Commissioning Group average of 65% and a national average of 65.2%.

Patients told us the environment was always clean and tidy, that their privacy and dignity was respected during consultations. They also found the reception area was sufficiently private for most discussions they needed to make. The GP survey showed 93.9% of patients said they had confidence and trust in the last GP they saw or spoke with compared to a Clinical Commissioning Group average of 94.6% and a national average of 95.3%. Almost half the patients we spoke with were unaware of the practice's website and online booking facilities. Positive comments included receiving prompt referrals to other services, approachable staff and not having any concerns about the safety of the practice.

Areas for improvement

Action the service SHOULD take to improve

- Ensure all newly appointed staff have their induction training prioritised so that key subjects such as safeguarding and mental capacity are covered earlier in their induction.
- Ensure more frequent supervision of nurse prescribers is arranged and implemented.
- Ensure monthly infection control checks are recorded to evidence the work carried out.

Outstanding practice

We saw an area of outstanding practice;

The phlebotomist's role had been extended to improve outcomes for patients. Alongside blood tests they took the patient's blood pressure, measured their weight, recorded their body mass index and recorded their smoking status. Where concerns were noted the GP was informed and a further appointment was made. This helped the practice to proactively work towards preventing patients acquiring longer term conditions.

Taw Hill Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead Inspector; the team included a GP, a practice manager and a practice nurse**.** The team also included an Expert by Experience. Experts by Experience are a part of the inspection team and focus on patients experiences of the practice; they are granted the same authority to enter the registered persons' premises as the CQC inspectors.

Background to Taw Hill Medical Practice

Taw Hill medical centre is a large modern purpose built medical centre located approximately two miles from Swindon town centre. The practice has 13 consulting/ treatment rooms on the ground floor and first floors. Some of these were used by other service providers or were not in use. There are large management, meeting and training areas on the first floor. The practice is registered as a training practice.

There are two partner GPs, one partner is male and the other is female. Additionally there are seven salaried and locum GPs in the practice. The majority of locum GPs were regularly employed to cover GP absences such as maternity leave and clinical commissioning group commitments. The GPs provide an average of 33 patient sessions each week and collectively are the equivalent to 4.5 whole time employees. A team of four nurses, a health care assistant nurse and a phlebotomist provide a range of nursing services and clinics over the five days of the week which the practice is open. In addition there are administrative and reception staff including a practice manager who support the day to day running of the practice.

The practice has approximately 12,500 patients registered from an area immediately surrounding the practice and nearby villages. The practice age distribution is very different to the national average with most patients being under the age of 60 years. There are relatively few patients with long term conditions, with health conditions which affect their daily lives or who have a caring role when compared to national averages. Information from our data sources shows the population falls within the least deprived in the country. Life expectancy for male patients is equal to the national figure of 79 years with female life expectancy being 89 years which is above the national average of 83 years. The Quality and Outcomes Framework (QOF) value for the practice is in the middle range and is indicated as being average.

The practice has opted out of providing Out of Hours services to its own patients, this service is provided by SEQOL. Information about Out of Hour's services is available on the practices website and on their telephone answering service.

Why we carried out this inspection

We carried out a focused 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 follow up on whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

How we carried out this inspection

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

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

The focus for this inspection was specifically around the safe, effective and well-led domains and the regulations which underpin these domains. The main regulations concerned requirements relating to workers; the safety, availability and suitability of equipment; management of medicines and assessing & monitoring the quality of service provision.

Before visiting, we reviewed a range of information we hold about the practice and looked at information from other sources. We carried out an announced visit on 5 August 2015.

We talked with a small number of staff employed in the practice including; two GPs, the lead nurse and one practice nurse, the practice manager and six administrative/reception staff. We looked at a range of information provided to us by the practice including, policies, audits and staff files We also spoke with 15 patients who visited the practice during our inspection.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, reporting and responding to an incident where a young patient had caught their hand in the reception area automatic opening doors.

We reviewed safety records, incident reports and minutes of meetings where these incidents had been discussed for the period since our last inspection in October 2014. These showed the practice had managed safety consistently over time and so could show evidence of 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, incidents and accidents. We reviewed records of four significant events that had occurred during the last year and saw the system was followed appropriately. The practice had a significant event email address to facilitate easy, confidential reporting of adverse events.

Significant events were a standing item on the practice meeting agenda and a meeting was held annually to review actions from past significant events and complaints. There was evidence that the practice had learned from these incidents and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and stated they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked four incidents and saw records had been completed appropriately and in a timely manner. We saw evidence of action taken as a result and that the learning had been shared; for example, increased vigilance when prescribing medicines from consultants' letters. When patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the partners and practice manager to relevant practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, advice about prescribing and supply of antiviral medicines. They also told us alerts were discussed at practice meetings and informally to ensure all staff were aware of any which were relevant to the practice and when they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all but the three recently appointed staff had received relevant role specific training about safeguarding and had access to update their knowledge through online learning. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and most staff knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. The nurses and GPs we spoke with were clear about their reporting responsibilities and who to speak with. We saw staff had been provided with access to safeguarding training via an online system and that safeguarding information was available to all staff via policies. However, some non-clinical staff we spoke with were unaware who the lead staff were or where further information could be found.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example, children subject to

child protection plans and patients regarded as being most at risk of hospital admissions. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors, community services and the local authority.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff had been trained to be a chaperone. Reception staff undertook the role of a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS 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). A risk assessment was in place for all staff who undertook chaperone responsibilities. The practice also had a staff chaperone register clearly visible in the administration office so that GPs and nurses could clearly see who was fully trained and checked by the practice. This ensured GPs and nurses didn't ask any untrained staff to help them and helped ensure patient safety.

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 policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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 also noted that medicines stock control was more closely monitored and regular stock rotation was applied to ensure medicines did not go out of date.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. Both types of directions had been updated recently, most recently a PGD on 27th July 2015. A member of the nursing staff was qualified as an independent prescriber had not received regular supervision but was supported in her role by a mentor GP and a prescribing colleague.

Cleanliness and infection control

We observed the premises to be clean and tidy with all treatment areas having clear surfaces. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, during intimate patient examinations or when providing new dressings to patients.

The practice had a lead for infection control. All staff received induction training about infection control specific to their role and received annual updates. The lead nurse described how they carried out monthly infection control audits and that any improvements identified for action were completed on time. We noted these checks were unrecorded and raised this with the nurse, they responded positively to our observation and arranged for future checks to be recorded.

In response to our observations at our last inspection in October 2014 notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks

with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Additional hand gel dispensers and hand hygiene advice and signage had been provided in all patient areas including adjacent to signing in screens and the reception area.

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

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. On our previous inspection we found out of date equipment. In response to this the practice had undertaken a review of equipment and we saw a range of new equipment had been purchased. For example, new defibrillator pads and batteries, spirometers, blood pressure monitors, oxygen saturation monitors and ear thermometers. The practice was in the process of reviewing other equipment with a view to further improvements. The new equipment could help facilitated more accurate tests for patients through improved technology and easier use and supported improved emergency procedure responses through safer equipment.

Staff told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date being May 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment for example, weighing scales, spirometers, blood pressure measuring devices and fridge thermometers.

Staffing and recruitment

On our previous visit we found the practice did not always follow safe recruiting practices. In order to address this the practice had updated their recruitment policy setting out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at for three recently appointed staff contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (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).

The recruitment checks were completed for locum staff. We found in the records we checked evidence of DBS checks, registration status, identity including a photograph, training certificates and immunisation status. These checks helped ensure patient safety was maintained by the practice.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see in key areas around the practice and there was an identified health and safety representative. Regular maintenance and security checks of the premises were carried out by practice staff.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the log. We saw an example of

Good

Are services safe?

this for example, covering GP absences and the mitigating actions that had been put in place. The meeting minutes we reviewed showed risks were discussed at practice meetings and within team discussions.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date and noted they were. The notes of the practice's significant event meetings showed that staff had discussed the new equipment provided since our last inspection.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of utility companies to contact if the heating, lighting or water systems failed. The plan was last reviewed in January 2015

The practice had carried out a fire risk assessment in early 2015 which included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills and testing.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners through online resource libraries. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms. We discussed with the practice manager and GP how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a clear level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with asthma were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required in a timely way.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Management, monitoring and improving outcomes for people

Information about patients' care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us four clinical audits which had been undertaken in the last few months. All of these were first cycle completed audits, subject areas included, gestational diabetes, type 2 diabetes, antibiotic prescribing and weight loss medicines prescribing. The practice had a system in place for completing clinical audit cycles. The practice provided us with clinical audits that had been completed and the improvements made for example, medicines reviews and recall appointments. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, inviting two patients diagnosed with epilepsy for consultations as they had not received contraception advice for up to six years and who had not received previous recall appointments. Other examples included antibiotic prescribing and retrospective audits and reflections on clinical sessions.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The practices patient demographic, with most patients being under the age of 60 years, influenced these scores. Specific 2013 to 2014 examples to demonstrate this demographic included:

- Performance for diabetes related indicators was below the national average.
- The percentage of patients with hypertension having regular blood pressure tests was below the national average
- The dementia face to face review rate was comparable to the national average

The practice was aware of all the areas where performance was not in line with national or Clinical Commissioning Group (CCG) figures and we saw action plans setting out how these were being addressed. The action plan included named GPs and nurses taking responsibility for individual

Good

Are services effective?

(for example, treatment is effective)

aspects of QOF and regularly reporting back to the clinical team on improved progress in achieving better outcomes for patients. QOF was a standing agenda item on practice meetings.

The practice's prescribing rates were similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. The practice was focusing on ensuring routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

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.
- The 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. This included ongoing support during sessions, one-to-one meetings where appropriate, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors via the partners. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

The practice held monthly staff training meetings on the last Wednesday of every month for 1 hour between 13:00 and 14:00. Reception staff and a duty doctor covered this period on rotation to allow all staff to attend the meetings.

The practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. The most recent trainee had very recently completed their training and the practice was awaiting a foundation training doctor to arrive at the practice (Doctors are known as foundation doctors while on the training programme. Depending on the year of the programme they are on, they are known as foundation year 1 doctors (F1) and foundation year 2 doctors (F2)).

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results and letters from the local hospital including discharge summaries, Out-of-Hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of Hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

Emergency hospital admission rates for the practice were 9.17% compared to the national average of 14.4%. The senior partner explained these positive figures were due to the work the practice carried out and the partnership they had with the urgent care 'Success' service which provided Swindon wide support to GP practices. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the process for actioning hospital communications was working well in this respect.

Good

Are services effective?

(for example, treatment is effective)

The practice held multidisciplinary team meetings monthly to discuss patients with complex needs. For example, those with multiple long term conditions, patients from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by community nurses, palliative care nurses where their involvement was relevant and decisions about care planning were documented in a shared care record. The meetings would also involve social workers and the local safeguarding team if there were concerns about children or other vulnerable patients. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP Out-of-Hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record and had this operational by Spring 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff such as GPs were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. Most clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. However two staff we spoke with lacked a clear understanding of the Act and had not completed training on the subject. We raised this with the practice manager and lead GP who responded positively and informed us they would arrange for staff to complete the training and also for it to be discussed in a forthcoming staff meeting.

There was a practice process for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent. We had previously been shown an audit that confirmed the consent process for minor surgery had being followed in all cases and were assured by the lead nurse these processes were still followed.

Health promotion and prevention

The practice used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering chlamydia screening to patients aged 18 to 25 years, offering smoking cessation advice to smokers and signposting patients to counselling services. We saw health promotion information was available in the patient waiting area with a wider range of information available from nurses and GPs as required.

We saw the phlebotomist (a person trained to take blood samples) role had been extended to improve outcomes for patients. Alongside blood tests they took the patient's blood pressure, measured their weight, recorded their body mass index and recorded their smoking status (if not already gained). This information was recorded on the patient's record and where concerns were noted the GP was informed and a further appointment was made. This helped the practice to proactively work towards preventing longer term conditions.

Good

Are services effective?

(for example, treatment is effective)

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of the majority of patients over the age of 16 and actively signposted patients to the NHS 'Smokefree' smoking cessation clinics. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care or who were recently bereaved. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 78.55%, which was similar to the national average of 81.88%. There was a process to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening; the latter being provided in a mobile screening unit at a nearby GP practice.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was slightly above or similar to the Clinical Commissioning Group average for the majority of immunisations where comparative data was available. For example:

- Data about flu vaccination rates for the over 65s were unavailable for this practice.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 96.6% to 98.6% and five year olds from 93.9% to 98.1%. These were comparable to local CCG averages.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We spoke with four members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them. We found details of the vision and practice values were part of the practice's strategy and included, to;

- offer skilled care to enable patients to achieve their optimum state of health and well-being;
- treat all patients with respect at all times;
- uphold the human and citizenship rights of all who receive treatment, work and visit the practice;
- support individual choice and personal decision-making as the right of all patients. Respect and encourage the right of independence of all patients;
- recognise the individual uniqueness of patients, staff and visitors, and treat them with dignity and respect at all times;
- respect individual requirement for privacy at all times and treat all information relating to individuals in a confidential manner.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at four of these policies as they were highlighted as having been reviewed in response to our last inspection. Recently reviewed policies included, health and safety, fire, recruitment and medicines cold chain management. The policies and procedures reflected current guidance and best practice and included processes which would ensure patient safety within the practice. The practice manager acknowledged that other policies would require reviewing shortly and planned to review these in the coming months.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with six members of staff about the staff structure and they were all clear about their own roles and responsibilities. They all told us there had been improvements in this aspect of the practice since our last inspection; they said they felt valued, well supported and knew who to go to in the practice with any concerns. They told us communication within the practice had improved.

The GP and practice manager took an active leadership role for overseeing the systems in place to monitor the quality of the service were consistently being used and were effective. These included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data was incomplete for this practice and had not been weighted for the patient age profile however; the data showed it was performing broadly in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings, staff had lead responsibilities for QOF areas and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, for improving hygiene standards around the practice and monitoring medicines and emergency equipment. Evidence from other data from sources, including individual incidents and complaints was used to identify areas where improvements could be made. The practice regularly submitted governance and performance data to the Clinical Commissioning Group.

The practice identified, recorded and managed risks. Risk assessments had been carried out where risks had been identified and action plans had been produced and implemented, for example, for legionella testing and infection control. The practice monitored risks on a monthly basis to identify any areas that needed addressing. We noted some systems needed further embedding; for example, checks made by a nurse were carried out but not recorded in detail. This could make carrying these checks out difficult for other staff if the nurse was absent or unavailable. The nurse responded positively to this when we discussed it with them and they told us they would arrange for the checks to be recorded.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

Are services well-led?

Good

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

Leadership, openness and transparency

The partners in the practice were more visible in the practice since our last inspection and staff told us that they were approachable and always took the time to listen to all members of staff. One of the partners had reduced their time commitment to the Clinical Commissioning Group by two days a week to help refocus the practice and to bring about changes. We saw improvements had been made and how all staff were involved in discussions about how to run the practice and how to develop the practice. The partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held every month. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff including nurses, administrators and receptionists said they felt respected, valued and supported by the partners and practice manager in the practice.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. A patient participation group had been formed (PPG - A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care) which included representatives from various population groups including younger adults, patients from the working population and patients with long term conditions. The PPG was due to hold its first meeting on 10 September 2015 and planned to meet two or three times a year. The practice had actively promoted the PPG on their website and in the practice to encourage participation. The practices website had been significantly improved and provided information to patients about how to feedback comments about the practice.

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice, particularly through the 'Friends and Families' survey and the new PPG.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they felt more empowered to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that appraisals had taken place since our last inspection in October 2014 which included a personal development plan. Staff told us that the practice was very supportive of training and that they had improved access to training and meetings where they could discuss concerns or issues relating to their role.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example, ensuring patient codes on the patient record system are periodically audited to ensure they reflect the current patient situation.