# Moredon Medical Centre

## Quality Report

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

## Ratings

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

# Summary of findings

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## Overall summary

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

Moredon Medical Centre is a GP practice situated in Swindon and has approximately 11400 registered patients.

We carried out our announced, comprehensive inspection of Moredon Medical Centre on 7 October 2014. During our visit we spoke with a range of staff. These included GPs, nurses, the business manager, administrators and reception staff. We also spoke with patients who used the practice and we reviewed comment cards where patients shared their views and experiences of treatment and care provided by staff.

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. This included the Swindon Clinical Commissioning Group (CCG), NHS England and Healthwatch Swindon.

The overall rating for Moredon Medical Centre is requires improvement. Our key findings were as follows:

- Patients told us they were happy with the care and support provided by the GPs and nurses and their involvement in decision making about their health and wellbeing.
- Patients received care and treatment in a safe environment however, recruitment processes did not include criminal records checks for nurses.
- Patients' privacy and dignity were at the centre of day to day practice and patients' cultural background and human rights were respected by the staff.
- Although the practice reviewed incidents, complaints, and results from audits, there were no processes in place to share learning from these. The leaders in the practice did not have processes in place which ensured learning was taken to improve the practice following incidents, complaints or audits.
- The practice worked in partnership with other organisations such as the CCG, the out of hours GP service and other practices to help improve access to GPs for patients in the practice.

We saw several areas of outstanding practice including:

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- The co-development of the Success urgent illness clinic (A system to provide urgent access to a GP and free up appointments in GP practices for patients requiring longer term care).
- The use of the internationally recognised diabetic passport. (Small credit card size cards that state the type and dose of insulin used by the patient and a picture of the type of insulin used).

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

Importantly, the provider must:

- Ensure their recruitment processes include a risk assessment to identify where a Disclosure and Barring Service check is required.

In addition the provider should:

- ensure significant events are recorded, analysed and lessons learnt are communicated to all staff;
- maintain up to date records of the training undertaken by staff to ensure the practice can demonstrate all staff have the most up to date knowledge and skills relevant to their role;
- undertake cleaning audits to ensure all areas are cleaned to the required standards;
- ensure a risk assessment is undertaken to assess whether legionella testing is required;
- review the telephone system for booking appointments;
- ensure on-going support sessions, one-to-one meetings and general staff or team meetings take place regularly and a record is kept of the meetings; and
- ensure that lessons are learned from concerns and complaints and action is taken as a result to improve the quality of access to care and treatment.

**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?**

**Requires improvement**

The practice is rated as requires improvement for safe. Staff received training in safeguarding vulnerable people and were aware of the types and signs of abuse. Where abuse was suspected the practice took appropriate action and worked in partnership with relevant agencies. Medicines were managed safely and prescribing medicines was monitored in line with current guidance however, stock control of medicines required some improvement to account for medicines used. The practice was clean and tidy. There were arrangements in place to ensure hygiene standards were maintained however, Legionella testing was not routinely carried out. Recruitment processes did not include a disclosure and barring service check for all nursing staff or risk assessments for other staff who provided chaperoning support for patients. There were appropriate arrangements in place to manage emergency situations however, emergency equipment although available was not checked for safe use.

**Are services effective?**

**Good**

The practice is rated as good for effective. Patients we spoke with were pleased with the care and treatment they received. They reported positive health outcomes as their health was improved or maintained by the treatment they received. Patients needs were assessed and treatment was provided in line with expected standards, guidance, and best practice. Best practice guidance was taken into account and the practice ensured all staff had access to information about improving outcomes for patients. Patients told us appropriate health care management plans were put in place to support their health and wellbeing. There were effective working relationships with other providers. Health promotion and prevention information was provided throughout the practice and on the practice's website.

**Are services caring?**

**Good**

The practice is rated as good for caring. Patients told us they were treated with respect, dignity and compassion by all members of the practice team. We heard accounts about how the nurses and GPs supported patients and their partners and about the effective treatment they received. Patients told us their privacy was respected during treatment and when waiting for appointments. All GPs and nurses were aware of the Gillick competency guidelines (a term used in medical law to decide whether a child 16 years or younger is able to consent to their own medical treatment, without the need for

# Summary of findings

parental permission or knowledge). We saw how patients were involved in their care and treatment throughout their visit to the practice. Patients told us how their GP consulted with them about the choices of treatment available to them and how they were asked for their consent about treatment. Accessible information was provided to help patients understand the care available to them. We observed staff treated patients with kindness and respect.

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

Good

The practice is rated as good for responsive. The practice was aware of the different needs of the population it served and provided services to meet the needs of the population. Patients told us they often found they had to wait long periods of time for the telephone appointment system to be responded to, with waits of over 10 minutes. However once through to the practice they told us the system was easy to use and they could get an appointment to see a GP. The practice was currently offering same day appointments only. The practice had a complaints procedure which provided clear statements of how a response would be handled, however the procedure was not actively promoted within the practice. The practice did not have a patient participation group.

**Are services well-led?**

Requires improvement

The practice is rated as requires improvement for well-led. The practice had a vision and a values statement which was displayed in the waiting areas. However reduced staff numbers and a lack of whole practice meetings for over six months meant measuring progress against the values had not been maintained. Senior partners in the practice did not provide continuous monitoring of governance arrangements. This had led to learning from audit cycles being incomplete and policies such as recruitment processes not being reviewed. The practice did not have a patient participation group. There was a suggestion box but patients told us they had not been asked their views about the practice or been encouraged to suggest ideas to improve the services provided. Staff worked towards continuous learning, improvement and innovation through a range of learning opportunities provided by the practice, local professional groups and online learning providers; however a development strategy for the leadership team, which included succession planning had not been put in place.

# Summary of findings

## What people who use the service say

During our inspection all of the 10 patients we spoke with told us the practice and the support they received was good. They were satisfied with all services including those provided by the GPs, the nursing team and the reception and administrative staff. Patients told us they were able to see the GP of their choice at a time which suited them and the treatment they received improved or maintained their health. They also told us they found the environment was always clean and tidy and nurses wore gloves and plastic aprons during personal examinations.

We received comment cards from five patients. All the cards we received provided positive comments about the care provided by the practice. Patients who made negative comments about the practice talked about having difficulties accessing the practice through the telephone system. They described long waits for calls to be answered. Where positive comments were made these highlighted the benefits of evening GP appointments, the management of complex healthcare problems and being treated with dignity and respect.

All the patients we spoke with made positive comments about the accessibility and cleanliness of the practice. Patients told us they felt involved in their treatment, were provided with enough information to understand their health diagnosis and were asked for their consent before physical examinations took place. The patients we spoke with told us they could access emergency treatment on the same day they asked for it and that they received home visits if they became housebound.

## Areas for improvement

**Action the service MUST take to improve**

- Ensure their recruitment processes include a risk assessment to identify where a Disclosure and Barring Service check is required.

**Action the service SHOULD take to improve**

The provider should;

- ensure significant events are recorded, analysed and lessons learnt are communicated to all staff;
- maintain up to date records of the training undertaken by staff to ensure the practice can demonstrate all staff have the most up to date knowledge and skills relevant to their role;
- undertake cleaning audits to ensure all areas are cleaned to the required standards;
- ensure a risk assessment is undertaken to assess whether legionella testing is required;
- review the telephone system for booking appointments;
- ensure on-going support sessions, one-to-one meetings and general staff or team meetings take place regularly and a record is kept of the meetings; and
- ensure that lessons are learned from concerns and complaints and action is taken as a result to improve the quality of access to care and treatment.

## Outstanding practice

- The co-development of the Success urgent illness clinic (A system to provide urgent access to a GP and free up appointments in GP practices for patients requiring longer term care).
- The use of the internationally recognised diabetic passport. (Small credit card size cards that state the type and dose of insulin used by the patient and a picture of the type of insulin used).

# Moredon Medical Centre

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP and a practice manager. All team members had been involved in previous GP practice inspections and had many years' experience in their fields of employment.

## Background to Moredon Medical Centre

Moredon Medical Centre is modern and purpose built with about 11400 registered patients. It is located approximately two miles from Swindon city centre. The practice has nine consulting/treatment rooms on the ground floor, 12 consulting rooms on the first floor and a private chiropractic suite on the second floor. The Swindon CCG has a suite of rooms on the ground floor where it provides a duty doctor service for a number of local GP practices as part of a local 'managing patient demand' service. An independent pharmacy is also located on the premises. The practice is registered as a training practice.

The practice has three partners which includes three GPs, two male and one female, and employs a further three salaried GPs. There are four registered nurses and three health care support workers including a phlebotomist (a worker specialising in taking blood samples). In addition to the healthcare team there are a range of support staff which include a practice manager, business manager, five secretarial and administrative staff and 10 receptionists.

The practice recently had undergone significant changes to its partnership and staffing. At the time of our inspection, the practice was still in the process of recruiting GPs and other staff to vacant posts. Staff told us the transition period had been challenging but that work was underway to bring about improvements in the way services were provided to patients.

The practice has about 11400 patients registered from an area North of the main London to Bristol railway line in Swindon excluding all of the satellite towns & villages close by for example; Blunsdon, Purton, Lydiard Millicent, South Marston. The practice age distribution is broadly similar to the national average with slightly more female patients in the 45 to 49 and 85+ age ranges. Information from our data sources shows the population falls within the fifth least deprived decile (A value that divides sorted data into 10 equal parts). The Quality and Outcomes Framework (QOF) value for the practice is in the middle range and is indicated as being 'OK'.

The practice has opted out of providing out-of-hours services to its own patients.

## 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.

Please note that when referring to information throughout this report for example, any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

# 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?

We also looked at how well services were 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 living in vulnerable circumstances

People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We asked the provider to send us information about their practice and to tell us about the things they did well. We carried out an announced visit on 7 October 2014.

We talked with the majority of staff employed in the practice. This included six GPs and a registrar GP, two practice nurses, a phlebotomist, two health care assistant, the business manager and six administrative/reception staff. We spoke with 10 patients and received comment cards from a further five patients.

Requires improvement

# Are services safe?

## Our findings

### Safe Track Record

Staff understood their responsibilities in relation to raising concerns, recording safety incidents, concerns and near misses, and reporting them internally and externally where appropriate. Staff told us about three significant events involving patients which had occurred this year. We found two of these incidents were not recorded however, staff were aware of the incidents and measures to ensure they did not occur again were put I place. For example the patient record system had updated tasks added to ensure blood test results were communicated to patients promptly. All GPs and nurses received NHS National patient safety alerts and the practice manager received medicines and healthcare products regulatory agency alerts. We heard from staff that they were informed about these alerts and relevant checks were made in the practice.

### Learning and improvement from safety incidents

Where safety incidents were reported, they were investigated. Patients who were notified when they were involved in an incident and how they were given an apology and informed of actions taken as a result of the investigation. For example where a scan result was entered onto the wrong patient recording system. Minutes of the investigation provided to us showed appropriate action had taken place. However staff told us there was no formal structure for learning from incidents. They said learning was shared among staff verbally.

The Practice told us they would review the systems they had in place for reporting, recording and monitoring significant events.

### Reliable safety systems and processes including safeguarding

The lead GP had attained level three safeguarding training and had made safeguarding information available to all staff. Staff demonstrated a clear understanding of the signs and symptoms of abuse and were aware of who to report concerns to within the practice. Where there were concerns about a vulnerable adult or child, information was recorded as an alert on the patient record system. We saw information on staff notice boards which identified vulnerable patients which were known to the local safeguarding team.

The staff we spoke with told us they had received training in safeguarding vulnerable adults and children. However, the training records we saw were not up to date and did not reflect the training undertaken by staff. GPs and nurses were aware of the Gillick competency guidelines (a term used in medical law to decide whether a child, 16 years or younger, is able to consent to their own medical treatment, without the need for parental permission or knowledge).

The practice had a chaperoning policy and there were signs which indicated to patients that chaperones were available on request. The staff we spoke with told us that the nurses acted as chaperones if required or, if they were unavailable, reception or admin staff stepped in. However we were told by reception staff they had not been Disclosure and Barring Service checked and that there were no risk assessments for them acting as chaperones.

### Medicines Management

There were safe systems in place for obtaining medicines, storage was secure and access was limited to GPs and nurses. Medicines were stored at the correct temperatures and a daily log was kept to ensure medicines such as vaccinations were safe to use. The amount of medicine in stock was regularly audited and the amount of stock available at the time of the audit recorded.

The practice had implemented a recognised computer based prescribing system. Where medicines were prescribed these were recorded on the patient record and the prescription was sent to the pharmacy chosen by the patient. This is in line with current agreed guidance. Where paper prescriptions were used these were held securely and accounted for by the practice manager. The patients we spoke with commented positively about the way their prescriptions were managed and how repeat prescriptions were obtained.

### Cleanliness & Infection Control

Standards of cleanliness and hygiene were maintained by the practice. All areas of the practice appeared to be clean and tidy. Clinical areas of the surgeries had designated clinical spaces with surfaces which could be wiped clean or washed. Personal protective equipment such as examination gloves, plastic protective aprons and surface cover sheets were available. There were separate hand and instrument washing facilities, and alcohol-based hand gels were available throughout the practice.

Requires improvement

# Are services safe?

A cleaning contractor provided cleaning services and the practice made visual checks of the cleaning carried out. However the provider did not carry out their own cleaning audits to ensure all areas had been cleaned to the required standards. Nursing staff ensured the treatment rooms were cleaned in between each patient.

The practice did not carry out Legionella testing to ensure water systems were free of harmful bacteria, particularly in areas not frequently used. This was contrary to general health and safety law which places a responsibility on the employer to identify and assess sources of risk; prepare a scheme or course of action for preventing or controlling the risk; implement and manage the scheme. They should also appoint a person to be managerially responsible, sometimes referred to as the 'responsible person'; keep records and check that what has been done is effective.

Clinical waste was managed in accordance with infection control guidance. Waste was appropriately segregated and held securely until it was collected by a recognised waste disposal contractor.

Medical equipment used in patient examinations were mainly single use items which were then disposed of appropriately. Where equipment could be used again we saw equipment was stored appropriately until it was cleaned by the nurse after the patient left. Cleaned equipment was hygienically packaged and date stamped to indicate when it should be used by. Waste bins were foot operated and lined with the correct colour coded bin liners. We saw waste was stored in locked bins until it was regularly collected by a recognised waste disposal contractor. Clinical sharp objects such as needles were disposed of in recognised sealed containers and disposed of in line with current guidance.

All cleaning materials and chemicals were securely stored in line with Control of Substances Hazardous to Health (CoSHH) guidance. We were told surgeries were deep cleaned as required and at least annually.

### Equipment

The design, maintenance and use of facilities and premises kept patients safe. The building was constructed about five years ago and provided easy patient access to all areas. Staff only areas such as offices, medicines stores, cleaning stores and equipment areas were fully secured and only accessible with electronic key fobs.

### The maintenance and use of equipment kept patients safe.

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatment. They told us that all equipment was tested and maintained regularly and we saw records which confirmed this. All portable electrical equipment was routinely portable appliance tested (PAT) and displayed stickers indicating testing dates. A schedule of re-testing was in place and was carried out by one of the trained administrators.

### Staffing & Recruitment

The practice had considered how staffing levels and skill mix were planned and reviewed. A rota was in place which showed planned sessions for each GP as well as their on call days and administrative time. A similar rota arrangement was in place for the nursing team and reflected the sessions and clinics they were involved in. The number and skill mix of staff on the day of our inspection was consistent with the rota provided to us. Staff told us these staffing levels were the normal day to day levels.

The practice used locum GPs to cover absence and annual leave. We were told that the same locums were requested where possible to support continuity of patient care.

Recently appointed staff we spoke with told us about their induction to the practice and about how other staff supported them in the early days of their employment. Information was available for new staff about the practice, the systems in daily use and the roles of all the staff. A recruitment policy was in place which covered all aspects of recruitment, except criminal records checks through the Disclosure and Barring Service (DBS). The Disclosure and Barring Service helps employers make safer recruitment decisions and prevent unsuitable patients from working with vulnerable groups, including children. All the nursing staff told us they had not had a criminal records check.

Staff told us that criminal records checks were carried out for GPs only. There were no risk assessments in place to assess the risks of not carrying out criminal records checks.

### Monitoring Safety & Responding to Risk

Staff identified and responded to changing risks to patients. For example where a patient's health had deteriorated, health review appointments were made to monitor their condition. If patients were at risk of hospital admissions, their information was recorded and passed on

to the Out of Hours service. Where there were concerns about the wellbeing of a patient, referrals were made to specialist services such as counselling or social wellbeing groups to encourage social inclusion. The practice held a risk register for the 2% of most vulnerable patients, this was reviewed by the GPs when changes were identified.

Staff were able to seek support from senior staff where there were concerns. An informal system of support was in place where staff could discuss issues and the practice's intranet system allowed email communication between the staff. However, staff meetings had not taken place since early in the year and there was no formal mechanism to allow staff to share concerns about safety and address them. Records of safety concerns and responses to them were not routinely maintained. Where there were staff meetings, staff told us they were often missed and sometimes resulted in poor communication between staff at all levels of the practice.

The provider's computer based records system had an alerting system in place which indicated which patients might be at risk of medical emergencies. This alerted GPs to possible risks to patients. Potential risks were shared with the reception team where patients were vulnerable, for example through poor mobility or where complex health needs were diagnosed.

### Arrangements to deal with emergencies and major incidents

The provider had arrangements in place to manage routine emergencies. Staff had completed basic emergency first aid training and were able to tell us the locations of all emergency medical equipment and how it should be used. However training records relating to emergency cardiopulmonary resuscitation (CPR), were not up to date with about half the staff not having completed annual update training. We checked the medical equipment and found it to be in good working order, had recently been checked and was accessible. Equipment was available in a range of sizes for adult and children.

Emergency medicines were available in a secure area of the practice. All medicines were in date, fit for use and were routinely checked by the practice nurse. The practice held a list of the expiry dates for different medicines and had a procedure for replacing medicines when they expired.

Emergency appointments were available each day both within the practice and for home visits. Out of Hours emergency information was provided in the practice, on the provider's website and through their telephone system. The patients we spoke with told us they were able to access emergency treatment if it was required.

The practice had a business continuity plan which explained what to do in the event of an emergency such as a power failure or major fire. However, some elements of the plan such as business contact numbers were incomplete. There was no evidence the plan was regularly reviewed or tested.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The main partner GP ensured all relevant information from organisations such as the National Institute for Health and Care Excellence (NICE) was put onto the practice's intranet and shared with all staff. Patients' needs were assessed and their care planned and delivered in line with evidence-based guidance, standards and best practice. For example, the way patients at risk of having diabetes were diagnosed, assessed and referred to other services within and outside the practice was in line with professional guidance. Those patients diagnosed with diabetes were provided with an internationally recognised diabetic passport. These plastic cards stated the type and dose of insulin used by the patient and had a picture of the type of insulin used. The passport could be handed to any pharmacy in the world and the recognised medicines could be provided.

Patients with long-term or chronic conditions, including terminally ill patients were routinely monitored through planned recall appointments. Risk profiling was used to ensure that patients had their needs assessed and care was planned and delivered proactively. This was particularly the case for the most vulnerable patients in the practice. Patient information was also shared with the Out of Hours team to ensure continuity of patient care. The patients we spoke with reported that they did not feel they were discriminated against when decisions were made about their care. They spoke positively about the treatment they received from all the GPs and nurses and told us their health was improved or maintained following prescribed treatment.

### Management, monitoring and improving outcomes for people

Information about the outcomes of patients' care and treatment was routinely collected and monitored. This included the assessment and diagnosis of patients' health needs and how often patients were referred to other services. This information was used by the practice to ensure other services such as the Out of Hours GP service was informed of patients at risk of hospital admissions.

Management of patients' long-term or chronic conditions was co-ordinated by the GPs. Patients were referred to clinics within the practice or to consultants in other locations, when required. For example when a patient's condition indicated a possible diagnosis of cancer, the patient was referred to the local hospital for more detailed investigation and clarity about treatments which may provide clear outcomes for the patient. A patient we spoke with told us this type of referral took place quickly and the consultant and GP communicated effectively in regard of the treatment the patient required.

Outcomes for patients using this practice compared favourably to other similar practices. For example, access to same or next day appointments and child immunisations was similar to other practices. Clinical audits were carried out by all relevant staff.

The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. The findings were used to improve the way services were provided and to improve the quality of care provided to patients. However the outcomes of audits were not communicated to all staff through meetings or records of discussions and could result in staff not having information relevant to their role.

### Effective staffing

The practice had recruitment processes which ensured staff had the right qualifications, skills, knowledge and experience to do their job. The practice manager checked that GPs and nurses were registered and that they maintained their continuous professional development. There were opportunities for staff to take on new responsibilities, for example phlebotomy (a process to draw blood from a patient for clinical or medical testing) and to enhance their current learning.

However the learning needs of staff for routine annual updates, for example cardio pulmonary resuscitation (CPR) were not robustly managed and the record of training undertaken by staff was poorly maintained. Staff told us they had not completed updated emergency resuscitation training for over a year. This could result in patients being assisted by staff who did not have the most current knowledge to support them. We spoke with the business manager about his and they reassured us that CPR training had been arranged for those who had missed their updates. They also told us the training records would be updated.

All GPs were up to date with yearly continuing professional development requirements and all were revalidated (Every GP is appraised annually and every five years undertakes a

Good

# Are services effective?

## (for example, treatment is effective)

fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice). GPs and nurses told us they had appropriate training to meet their learning needs and to cover the scope of their work. Their learning and continuous professional development was checked during their annual appraisal. Nurses told us there was protected time for training.

The practice was a registered training practice and registrar GPs received regular appraisals, coaching, mentoring and clinical supervision from the lead training GP.

The telephone system for booking appointments was a barrier for some patients. Our contacts with the practice resulted in waiting times of over 10 minutes, patients reported similar waiting times. We observed the staff responding to calls to the practice and saw that the volume of calls exceeded the staff capacity to respond quickly to all calls. Patients who worked who had appointments during our inspection told us of having to try for several days to get appointments. The main problem in regard of answering telephones promptly at busy times had still to be addressed by the practice.

### Working with colleagues and other services

All staff were involved in assessing, planning and delivering patient care and treatment. There were arrangements within the practice to ensure care was coordinated between members of staff, for example GPs referring patients to nurses and nurses referring patients to GPs when required. Care and treatment was coordinated when different services were involved including GP Out of Hours care and the urgent illness clinic.

Staff worked together to assess and plan ongoing care and treatment in a timely way when patients moved between services. The practice had integrated IT systems with other services which allowed information sharing and which provided daily information about patients who were admitted or discharged from hospital. Information about patients who were at high risk of hospital admission was shared between relevant services. There were systems in place for managing blood results and recording information from other health care providers. The practice nurse co-ordinated blood test results and carried out audits to ensure the results were being used to inform patient care and treatment. The patients we spoke with told us about prompt and joined up referrals to hospital.

### Information Sharing

The practice used a recognised computer based patient records system. All the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the system. This included care and risk assessments, care plans, case notes, test results and alerts to indicate where a patient may be at risk or vulnerable. When patients moved between teams and services including at referral and transition, all the information needed for their ongoing care was shared. Paper documents were scanned into the system so they could be easily accessed and the information shared.

### Consent to care and treatment

The patients we spoke with told us their consent to treatment was always taken before examinations or treatment. The staff we spoke with were able to demonstrate they understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. All GPs and nursing staff had undertaken training in this subject as part of their safeguarding and children in need training. Where there was doubt about a patient's capacity to make decisions about their care individual GPs and nurses sought advice from a colleague within the practice. Staff explained to us that where patients lacked capacity to make decisions about their care, they would involve partners and carers in decision making.

Where a patient's mental capacity to consent to care or treatment had been assessed, this was recorded in the patient's record. The nurses we spoke with told us that where they provided care and treatment for children and young people they carried out assessments of their capacity to consent in line with Gillick competencies (a framework for deciding whether a child 16 years or younger is able to consent to his or her own medical treatment). When patients lacked the mental capacity to make a decision staff made 'best interests' decisions in accordance with legislation.

### Health Promotion & Prevention

The practice had a range of information displayed around the practice to support patients to live healthier lives. Patients were given advice or referred to other services to support them to live healthier lives. For example, where a patient was overweight they were provided with advice about diet and exercise and, if appropriate, were referred to

Good

# Are services effective?

## (for example, treatment is effective)

a weight loss clinic provided by the practice nurse. There was a separate noticeboard which provided carer specific information which included signposting to support organisations.

A range of screening programmes were provided by the practice. Where patients did not attend screening appointments the practice had systems in place to follow up on and arrange further appointments. There was a comprehensive and effective vaccination programme in place which matched or exceeded the national average for providing vaccinations to children. Patients at risk of developing a long-term condition were included in the practice's seasonal flu vaccination programme alongside those patients from other vulnerable groups.

All new patients were invited to attend a health assessment check once registered with the practice. A wellbeing clinic provided routine health checks for patients aged 40–74. The practice ensured appropriate follow-up actions were taken following the outcome of health assessments. The practice provided a fitness for work service and advice to promote patient recovery and return to work.

Care of older patients was tailored to individual patients needs and circumstances. We heard from patients visiting the practice how consideration of carers' needs was included. There was a specific noticeboard for carers in the practice which provided information on support services and other organisations related to carers' need. Staff told us about regular patient care reviews for all patients over the age of 75 years which involved patients and their carers. Where the most vulnerable elderly patients were identified, the practice ensured patients received appropriate coordinated, multi-disciplinary care. This was achieved through sharing patient information with services such as the Out of Hours GP service. Unplanned admissions and re-admissions for this group of patients was regularly reviewed.

Staff demonstrated the knowledge, skills and competence to respond to the needs of patients with long term conditions. For example, when providing clinics to support patients with chronic obstructive pulmonary disease (COPD) or through routine or recall appointments. Conditions supported by the nursing team included vaccinations, asthma, diabetes, heart disease, weight management and phlebotomy (blood tests). Patients we spoke with told us about referrals to specialists which they felt were made in an appropriate and timely way. Patients were signposted to patient groups and other support networks in the locality, through leaflets and posters available in the practice.

Nurses, health visitors and a GP saw mothers and their children for postnatal checks, childhood immunisations, developmental checks and any other health related matters. For pregnant women much of the care was provided by a midwife, however the GPs were available to see women if requested. Women considering pregnancy were encouraged to take folic acid each day to help the development of a healthy foetus. The community midwives, midwives who are not employed directly by the practice but who sometimes provide services for women from the practice, held clinics in conjunction with the practice and were considered an integral part of the joined up service. Children and pregnant women who were eligible for flu immunisation were invited to attend the practice for vaccination. Information, including lifestyle advice on healthy living, was available to pre-expectant mothers, expectant mothers and fathers.

The practice had varied opening times and provided appointments from 7:30 in the morning for blood tests to bookable evening appointments up to 8pm. Six patients told us the appointment system enabled them to access appointments suitable to their needs but that getting through on the telephone was currently difficult. The practice offered patients, who were unable to attend the practice due to work commitments, telephone consultation appointments. 'Well-person' clinics were available with a health care assistant for patients in this category for advice on general health and a basic health check. The practice provided self-certification forms on their website for patients who were unwell and who needed the form to submit to their employer. The practice provided appointments for patients who required fit notes for their employer if they were unwell for longer than seven days.

The practice supported patients in vulnerable circumstances and put measures in place to promote access to services. Their website explained where the practice catchment area was, its opening hours, and how to register. There were protocols for enabling patients who were temporarily resident in the area to see a GP. Information sign posted patients to specialist support groups and services in the locality. The practice had

Good

# Are services effective?

## (for example, treatment is effective)

information sharing arrangements with the Out of Hours service so that they were aware of patients from this group and continuity of care and treatment was maintained. The practice supported patients with learning disabilities who lived locally as well as those with drug and alcohol addictions. Where patients had received support from drug and alcohol services the practice provided prescriptions for medicines to support these patients.

The practice monitored patients with mental health needs shared information with relevant services when patients were at risk of harm. GPs recognised and managed patients with complex mental health problems and referred them to specialist services. Care was tailored to patients' individual needs and circumstances. This included annual health checks for those with serious mental illnesses.

Good

# Are services caring?

## Our findings

### Respect, Dignity, Compassion & Empathy

The patients we spoke with made positive comments about the caring and supportive nature of all the staff within the practice. The nursing team was particularly highlighted as being professional, knowledgeable and caring.

All the staff we spoke with understood and respected patients' personal, cultural, social and religious needs and took these into account when interacting with them. Where possible, the GP or nurse of choice was made available to patients, and if requested a chaperone was provided. We observed interacting with patients in a respectful and considerate manner.

Staff showed an encouraging, sensitive and supportive attitude to patients. When booking appointments the reception staff were polite and greeted patients by name where these were known. Where a GP spoke additional languages this was explained on the provider's website. The computer based patient signing in system was available in a range of languages which were spoken locally.

GPs and nurses ensured patients' privacy and dignity was respected during physical or intimate examinations by closing consulting room doors and using screens where needed. The waiting area was located away from reception desks so private conversations could not be overheard. Separate rooms were available for private discussions. We observed that staff respected patient confidentiality, including in the reception area.

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

The patients we spoke with told us staff communicated well with them and ensured they understood their care, treatment and diagnosis. One patient's carer explained how staff recognised when they needed additional support to understand their partner's care and treatment. They told us they were provided with information to understand the condition and were enabled to access support through an external organisation.

Patients who used the practice and those close to them told us they were routinely involved in planning and making decisions about their care and treatment. For example, in managing their diabetes. They told us they felt listened to and supported by staff and had sufficient time during consultations to make informed decisions about the choice of treatment they wished to receive. Patient feedback on the comment cards we received also reflected this view.

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

Staff understood the impact that a patient's care, treatment or condition would have on their wellbeing and on those close to them. For example, a patient told us about gaining additional support following bereavement through a referral to the counselling service provided in the practice. There was a specific area set aside for carers' information which also included information about other services such as self-help groups which staff could refer patients to.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

Information about the needs of patients who used the practice was used to inform how services were planned and delivered. For example, in response to the high number of patients who required urgent appointments, the practive collaborated with another GP practice and the clinical commissioning group (CCG) to set up an urgent illness clinic to which patients needing to be seen urgently could be referred.

The practice had been involved in the co-development and piloting of the Swindon area 'Success' urgent care centre booking system. This system provided urgent care appointments to patients between 8:00am and 8:00pm seven days a week located in a near by practice. Use of this service was hoped to create additional appointments for all local practices once fully implemented.

Where the practice recognised that patients of working age and school children needed blood tests but found it difficult to make day time appointments, an early morning clinic was provided once a week so patients could attend before work or school.

The services provided reflected the needs of the population and promoted flexibility, choice and continuity of care. This included longer appointments for those who needed them, for example, for patients who had long-term or multiple conditions and those with a learning disability. The practice also included, where possible, appointments with a named doctor or nurse, a male or female doctor and home visits.

The majority of patients we spoke with told us they could get an appointment when they needed one. However, some patients told us they could not always get through to the practice on the phone when they needed to make an appointment or required advice. The practice had recognised this issue but had not implemented measures to resolve this.

There were facilities for patients with reduced mobility or who used a wheelchair to mobilise. There was a range of modern equipment available in the clinical areas.

The practice did not have an active patient participation group. Staff told us the practice had been trying to improve patient involvement for several months. Limited patient feedback had been gained from a suggestion box located in a reception area. None of the patients we spoke with said they had been asked to complete patient satisfaction surveys or other forms to gain their feedback about the services provided.

The staff we spoke with told us about language line interpreters, a loop system used to help patients with hearing loss and specialist advice and advocacy services available locally.

### Tackling inequity and promoting equality

The practice had a number of services and clinics in place to take account of the needs of the different patients it served. There were services such as annual assessments and medication reviews for patients over the age of 75 years; early morning phlebotomy clinics for working and school age patients; contraceptive services for teenagers; and maternity clinics for women. Other services and clinics were available for patients who had long term or multiple illnesses, for example asthma and chronic bronchitis clinics, cardiovascular screening clinics and epilepsy clinics.

The practice maintained a list of its most vulnerable patients and those with complex needs, for example, those living with dementia, or those with a learning disability. Information about these patients was shared with the Out of Hours service to ensure care plans were shared.

The practice engaged with patients who were in vulnerable circumstances, for example by visiting elderly patients in local residential and nursing homes. Patients with learning disabilities living in the community were provided with home visitswhen they required it. Patients with a mental health diagnosis were seen in the surgery and were promptly referred to other community based support services including those specifically for children.

### Access to the service

Patients had timely access to appointments for an initial assessment or diagnosis, and for treatment or on-going management of chronic conditions. The practice implemented an appointments system which allowed telephone, online and in person appointment bookings. At the time of our visit however, the practice was not using the online system and was only providing same day

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

appointments. Many patients told us the telephone appointment system was easy to use once the telephones had been answered and it supported patients to access appointments at a time to suit them.

Patients told us they had to wait long periods to have their call answered and some were not aware of the on line booking system.

The practice prioritised patients with the most urgent needs through a triage system. This is a system to prioritise patients for medical treatment. Telephone consultations were available where appropriate. Patients who needed to be seen urgently were referred to the urgent illness clinic.

Patients told us appointments were rarely cancelled and appointments usually ran on time. Were we observed delays in patients receiving their appointment on reception staff did not always inform patients how long their appointment might be delayed. Patients told us they understood why appointments might be delayed but felt they could be better informed.

### Listening and learning from concerns & complaints

The majority of patients we spoke with knew how to make a complaint or felt able to raise concerns with the practice.

The practice had a system in place for handling complaints, concerns and comments. This was supplemented by a policy document, invitations for patients to make comments via the practice's website as well as through a suggestion box in the reception area. There was a designated responsible person who handled all complaints in the practice.

There were 24 complaints in the summary, almost half related to telephoning to make appointments. Complaints were handled effectively, with a response for the complainant and a formal record kept. The outcomes of complaints were explained appropriately to patients.

Patient views were not routinely gathered and used to inform services provided. Where patient views were received through complaints the information was not always used to inform practice improvements, for example in improving the telephone answering responses. Where complaints were made about staff interactions with patients, how behaviour should change was not shared or went unrecorded so staff, not present, could respond accordingly. Where audits were carried out, for example with medicines management. The audits were not reviewed to identify how improvements could be made and action taken to improve performance.

# Are services well-led?

Requires improvement

(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 and a set of values statement which was displayed in the waiting areas. The main value areas were, caring for wellbeing in body, mind, spirit and relationships; respecting all; working as a team; integrity and learning and improving. The statement placed patient welfare at the heart of the practices values. Staff were aware of the vision and values. However a lack of whole practice meetings for over six months meant measuring progress had not been maintained.

The practice recognised that difficulties with recruitment and loss of staff earlier in the year had created difficulties in meeting their objectives, particularly in relation to the statement on working as a team. The practice was currently advertising for more staff and was using locum GPs to cover vacant posts. Practice staff told us they did not have an established patient participation group to gain patient feedback on the application of the practice's values. However the patients we spoke with told us they felt staff worked well together in coordinating their care and treatment.

Staff told us that the practice manager was due to leave their role after a notice period and another key member of the administrative team was also due to leave their post shortly. With several staff having worked for the practice for many years it was likely further retirements might take place. A development strategy for the leadership team, which included succession planning, was not in place.

### Governance Arrangements

There was a governance framework in place which supported the delivery of the strategy and good quality care, however, governance arrangements were not always monitored. We found audits were not always completed; for example, in regard of staff training, policies were not reviewed and communication between the staff teams did not take place effectively.

Where significant events were reported, the outcomes and learning were not routinely shared amongst the staff.

### Leadership, openness and transparency

The culture of the practice centred on the needs and experience of patients who used the practice. Patients we spoke with told us they felt they were valued and listened to. Staff in leadership roles understood the challenges to good quality care and could identify the actions needed to address them once they had adequate staffing levels.

Feedback from the staff we spoke with indicated that senior staff were not always visible but were approachable. They said senior staff encouraged cooperative, supportive and appreciative relationships between staff but felt communication required further development. Staff told us they felt supported, respected and valued by their peers but would value more opportunities to meet as a whole practice team. However, the arrangements for supporting and managing all levels of staff to deliver effective care and treatment was not in place. On-going support sessions, one-to-one meetings and general staff or team meetings had not taken place for over six months.

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

The practice did not have a patient participation group at the time of our inspection. The practice sought patient views and experiences through suggestion boxes and a comments section on their website. The staff we spoke with were not able to tell us how comments were acted on to shape and improve the service and the culture of the practice.

Staff told us they felt engaged with at the level they worked at but felt their views were not always reflected in the planning and delivery of services or in shaping the culture of the practice.

### Management lead through learning & improvement

Staff worked towards continuous learning, improvement and innovation through a range of learning opportunities provided by the practice. Local professional groups and online learning providers were used for this purpose. However, learning from complaints and safety incidents had not been fully considered or undertaken by the practices management.

The practice had developed a central library and learning resource on its intranet which enabled staff to have timely access to learning materials, journals and current guidance from professional organisations and research resources. Each GP and nurse took responsibility for their own continuous professional development and this was

# Are services well-led?

Requires improvement

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

monitored during annual reviews. The nursing staff we spoke with told us about attending specialist training to enhance their role, for example in diabetes treatment and support.

This section is primarily information for the provider

# Compliance actions

## Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers<br>**Patients who used services were not protected against the risks of harm caused by inadequate employment checks. Regulation 21 (1) (b)** |