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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 27 January 2015 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be good in the safe, effective, caring, responsive and well-led domains. We found the practice provided good care to older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances and people experiencing poor mental health.

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from incidents that occurred. The practice had a system for reporting, recording and monitoring significant events over time.
- There were systems in place to keep patients safe from the risk and spread of infection.
- Evidence we reviewed demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. It also demonstrated that the GPs were caring, good at listening to patients and gave them enough time.
- The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant event meetings.

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 people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were improving and a number were above average for the locality and the practice population. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked well with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect and maintained confidentiality. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieve this.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients told us they could get an appointment with a named GP or a GP of choice, with continuity of care and urgent appointments available the same day.

Summary of findings

Information about how to complain was available and easy to understand and the practice responded quickly when issues were raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff understood 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 promoted quality and caring as its top priority. All practice staff worked together to achieve this. Staff had attended staff meetings and events.

Patients told us that the practice was always supportive, caring and worked hard to make sure they met the healthcare needs of patients. The practice gathered feedback from patients through a patient panel group (PPG). The PPG consisted of patient volunteers who shared their views and responded to surveys through the practice's website. They commented about the services offered and how improvements could be made to benefit the practice and its patients.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people.

The practice offered home visits and fast access appointments for those patients with enhanced needs. Many of the patients had been with the practice for many years and were known to the GPs. As a small practice, relationships had been established over time which patients told us gave them the confidence that the GP knew their medical history and were able to respond to their health needs accordingly.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed.

All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.

Appointments were available around school hours. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly. Child immunisations were carried out and there was a recall system in place to follow up where children had not received their appropriate vaccinations. The practice had taken part in a pilot scheme to offer seasonal immunisations to children in school years seven and eight.

Summary of findings

Working age people (including those recently retired and students)

Good

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

The practice was proactive in offering on-line appointments and repeat prescription services, as well as a full range of health promotion and screening that reflected the needs of this age group. This included health checks for patients aged 40 - 70 years of age.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for patients with a learning disability and most of these patients had received a follow-up. It offered longer appointments for these patients.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It confirmed that vulnerable patients were informed about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in both normal working hours and out-of-hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health. They carried out screening for patients identified at risk and advanced care planning for patients diagnosed with dementia.

Summary of findings

What people who use the service say

We reviewed 25 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that all of these comments were extremely positive. Patients commented that they were impressed with the practice and that they could always see a GP when they needed to. The comments confirmed that GPs were always helpful and that they listened to concerns that patients had. Patients told us that they were really happy with all the staff at the practice and that everyone was courteous, helpful and polite. One patient indicated however, that although they had found their experiences at the practice generally positive they felt that one of the GPs had been disrespectful on one occasion.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP Patient Survey dated July 2014 and a survey of patients undertaken by the practice in 2013/2014. The evidence from these sources showed patients were satisfied with the service they received and that they were treated with compassion, dignity and respect.

The practice was also above average for its satisfaction scores on consultations with GPs and nurses. Data showed that 95% were satisfied with appointment times which was more than the national average of 78%; 100% described their experience of making an appointment as good compared with the national average of 78%; however, only 59% would recommend this practice to someone new to the area which compared with national average of 79%.

Swanswell 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 Practice Nurse specialist advisors.

Background to Swanswell Medical Centre

Swanswell Medical Centre is located in Coventry and provides primary medical services to patients. The practice has two GP partners (one male and one female), two salaried GPs one of whom also takes on the role of practice manager. There is an assistant practice manager, one practice nurse, a health care assistant and administrative and reception staff. There were 1,500 patients registered with the practice at the time of the inspection. The main practice is open from 8.30am to 7pm Mondays, Tuesdays, Wednesdays and Fridays and from 8.30am to 6pm on Thursdays. Home visits are available for patients who are too ill to attend the practice for appointments. The practice has a branch surgery at Hillmorton Road, Coventry. We did not inspect the branch during this inspection. The branch is open for appointments and prescriptions for 2-3 hours per day as required, although patients are being encouraged to attend the main practice at Swanswell Medical Centre for appointments.

The practice treats patients of all ages and provides a range of medical services. The practice provides a number of clinics such as chronic disease management which includes asthma, diabetes, heart disease and stroke, chest, and mental illness. It offers child and travel immunisations. The practice does not provide an out-of-hours service but has alternative arrangements in place for patients to be seen when the practice is closed.

Swanswell Medical Centre has a Personal Medical Services (PMS) contract. The PMS contract pays GPs on the basis of meeting set quality standards and the particular needs of their local population. Swanswell Medical Centre will however, be changing to a General Medical Services (GMS) contract in April 2015. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

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 was 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.

The practice was inspected by CQC in September 2013 as part of a routine inspection programme and they were compliant with all of the areas inspected. This inspection report is available on our website www.cqc.org.uk.

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

Before our inspection of Swanswell Medical Centre we reviewed a range of information we held about this practice and asked other organisations to share what they knew. We contacted Coventry Clinical Commissioning Group (CCG) and the NHS England area team to consider any information they held about the practice. We also supplied the practice with comment cards for patients to share their views and experiences of the practice.

We carried out an announced inspection on 27 January 2015. During our inspection we spoke with a range of staff that included four GPs, the assistant practice manager and reception staff. We also looked at procedures and systems used by the practice.

We observed how staff interacted with patients who visited the practice. We spoke with one patient and reviewed 25 comment cards where patients and members of the public shared their views and experiences of the practice.

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People whose circumstances may make them vulnerable
- People experiencing poor mental health

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. We reviewed safety records, incident reports and minutes of meetings where these were discussed. We saw for example, that alerts were printed out and kept in the practice manager's office to show what action had been taken in response to these alerts. A recent alert about the use of a medicine showed that a patient search had been carried out to identify any patients who were prescribed this medicine. We saw that appropriate clinical action had been taken and recorded accordingly. These records showed the practice had managed patient safety consistently over time.

Staff told us they were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were a standing item on the practice meeting agenda. We saw that minutes of the meetings were circulated to relevant staff and staff we spoke with confirmed this.

We saw examples where near misses had been investigated and the learning from these had been shared with all clinicians. Changes had been made to reduce the risk of this recurring. For example, we saw that a patient referral request had been lost in the hospital system. The practice had investigated this. As a result they made changes to their protocols to ensure that requests were followed up if no appointment had been received by the patient within two to four weeks of the request being made. The practice confirmed that the changes made to the protocols had seen improvements to the referral process. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. GPs we spoke with confirmed this. Staff told us they knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts, medical devices alerts and other patient safety alerts were printed off and shared by the practice manager with relevant practice staff. Staff told us that alerts were discussed at practice and business meetings to ensure everyone was aware of any issues relevant to the practice and what action, if any, needed to be taken. National patient safety alerts are issued when potentially harmful situations are identified and need to be acted on. We saw that any action taken had been recorded appropriately. The practice manager told us that the local pharmacist helped them with alerts that involved medicines. For example, we saw where a recent alert had been received regarding a medicine for the treatment of epilepsy. We saw that a patient search had been carried out and appropriate clinical action had been taken and recorded.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training for safeguarding adults and children. We asked members of staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out-of-hours. Contact details for relevant agencies were easily accessible to staff.

The practice had a dedicated GP appointed as the lead for safeguarding vulnerable adults and children. The GP had been trained to an appropriate level and demonstrated they had gained the necessary knowledge from this training to enable them to fulfil this role. Staff confirmed they knew who the safeguarding lead was and that they were able to access the policies and procedures we saw available in the practice. Staff explained to us the processes they would follow in the event they became concerned that

a patient may be at risk of harm. The lead safeguarding GP was aware of vulnerable children and adults registered with the practice and records demonstrated good liaison with partner agencies such as health visitors.

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 such as vulnerable patients or children who may be subject to child protection plans. GPs appropriately used the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed.

A chaperone policy was in place and information about the service was visible on the waiting room noticeboard and in consultation rooms, although this information was not included on the practice's website. 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. The policy included details about who was able to act as a chaperone, confidentiality and the procedure to follow including recording information in patients' notes post examination. Staff told us that they always asked patients whether they required a chaperone when they received any intimate treatment. Nurses and GPs carried out chaperone duties when required.

Medicines management

We saw that the practice had policies and procedures in place for the management of medicines dated September 2014. This included safe stock control, dispensing medicines to patient, disposal and safe storage of vaccines. Staff told us they were aware of these policies and procedures and confirmed they were able to access these as required.

We saw that there was a protocol for repeat prescribing which was in line with national guidance. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. We saw however, that there were five blank prescriptions kept in the GPs visit bag. Although the visit bag was kept securely we found there were no logs, audits or tracking system in place for these blank prescriptions. The practice addressed this and put these processes in place for prescriptions held in the GP visit bag during the inspection.

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

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

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

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients commented that they always found the practice clean and had no concerns about cleanliness or infection control. We saw from the comment cards that patients always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role. We saw evidence that the lead had carried out clinical audits on 23 September 2014 and 16 November 2014. Results of these audits were shown in the practice's action plan with completed actions recorded. For example, the audit identified that the practice needed to put a formalised cleaning schedule in place. We saw that the cleaning schedule was in place and daily cleaning had been recorded when completed. Areas identified for action from the audits were also discussed at team meetings. Minutes of practice meetings showed that the findings had been discussed.

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

Good

Are services safe?

gloves, aprons and coverings for couches 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.

We saw that staff had access to the infection control policy and posters were displayed in consultation rooms. 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.

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company. There were guidelines informing staff what to do in the event of a needle stick injury. Staff confirmed to us that they knew what action to take in the event they or a colleague sustained such an injury. We saw clear guidelines displayed in the treatment and consultation rooms to guide staff.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice carried out regular checks in line with this policy to reduce the risk of infection to staff and patients. For example, we saw that a recent legionella check had been carried out on 24 January 2015.

Equipment

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

We saw maintenance records which showed equipment at the practice was being serviced. Calibration stickers were seen on relevant equipment including weighing scales and blood pressure machines. This helped ensure they were fit for use. For example, we saw that annual calibration (testing for accuracy) of relevant equipment such as weighing scales, nebulisers and blood pressure monitoring machines had been carried out during 2014.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at 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 criminal records checks as required through the Disclosure and Barring Service (DBS). We spoke with newly recruited staff who confirmed that all the checks had been carried out prior to their employment.

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 to ensure that enough staff were on duty. Staff told us they worked additional hours to cover sickness and annual leave within the practice.

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 were in line with 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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The GPs and practice manager informed us there were sufficient appointments available for high risk patients, such as patients with long term conditions, older patients, and babies and young children. Patients were offered appointments that suited them, for example same day, next day or pre-bookable appointments with their choice of GP. There was a system in place that ensured patients with long term conditions were invited for regular health and medicine reviews and followed up if they failed to attend.

We saw that the practice had identified and monitored patients with long term conditions who were at high risk of an unplanned hospital admission. The practice completed

care plans with patients and ensured that these were followed up and reviewed every month. The practice manager managed these patients in conjunction with the GPs and called them when their review was due.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage medical emergencies. We saw records that showed all staff had received training in basic life support and staff confirmed they knew how to respond to a medical emergency should one occur.

We saw that a kit was available for the emergency treatment of allergic reactions that may occur at the practice. However, this kit contained limited supplies of the type of medicines that could be used. We saw that no risk assessment had been completed by the practice to show their rationale for the limited stock of emergency medicines held. The practice addressed this following the inspection and sent us details of the completed risk assessment and confirmed that all medicines were now stocked, as recommended by professional bodies such as the British Medical Association (BMA). Processes were also in place to check whether the emergency medicines were within their expiry date and suitable for use.

All the medicines we checked were in date and fit for use. Staff confirmed that any instances where emergencies had occurred would be discussed at the practice's significant event meetings.

Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We found however, that not all emergency equipment was available at the surgery and that some equipment such as oxygen was accessed from the nearby Anchor Centre and the Coventry City Health building. We found there was no formal risk assessment or written guidance in place for staff to follow in the event an emergency occurred and oxygen would be needed. The practice manager sent us a copy of the risk assessment and procedure they had completed immediately following the inspection. These clearly outlined the identified risks and the formal procedure in place for staff to follow to manage this. For example, the risk assessment showed that the practice considered the risk related to the location of oxygen was acceptable as this could be accessed within one minute that any emergency arose. Both the Anchor Centre and the Coventry City Health building were accessible during the practice opening times.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, loss of main surgery building, loss of medical records, staff shortage and access to the building. The plan provided actions to take and important contact numbers for staff to refer to which ensured the service would be maintained during any emergency or major incident. For example, contact details of an electrical company to contact in the event of failure of the electricity supply. We saw there was a procedure in place to protect computerised information and records should there be a computer systems failure. The practice manager and GPs confirmed that copies of this plan were held off site with designated management staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs 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. We saw minutes of practice meetings where new guidelines had been discussed and shared. We saw copies of the guidance that had been circulated to clinical staff by email.

We saw that the implications for the practice's performance and patients were discussed and required actions agreed during these meetings. Staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs that thorough assessments of patients' needs were completed in line with NICE guidelines and these were reviewed when appropriate.

GPs told us they each led in specialist clinical areas such as diabetes, lung disease, dementia and heart disease. Two GPs were lead specialists for mental health. The GPs attended educational meetings facilitated by the Clinical Commissioning Group (CCG), and engaged in annual appraisal and other educational support. The annual appraisal process required GPs to demonstrate that they had kept up to date with current practice, evaluated the quality of their work and gained feedback from their peers. GPs told us they ensured best practice was implemented through regular training, networking with other clinical staff and regular discussions with the clinical staff team at the practice. We were told that GPs were very approachable and that staff felt able to ask for support or advice if they felt they needed it.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and ethnicity was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff throughout the practice had key roles in monitoring and improving outcomes for patients. These roles included infection control, scheduling clinical reviews, managing medicine alerts and medicines management.

We looked at clinical audits carried out by the practice. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through systematic review of care and the implementation of change. It includes an assessment of clinical practice against best practice such as clinical guidance to measure whether agreed standards are being achieved. The process requires that recommendations and actions are taken where it is found that standards are not being met.

GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. Following the audits, the GPs shared their findings with relevant staff and looked at ways to make improvements where these had been identified. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice showed us three clinical audits that had been completed recently with further audits that were on-going. Two of these were completed audits where the practice had demonstrated the changes resulting since the initial audit. For example, we saw that audits dated May 2013 and December 2014 had been completed to inform and provide data to demonstrate the evolving practice action plan for patients with long term conditions. One audit showed that the practice was providing the best treatment for patients who required regular blood monitoring. Further audits had been completed and were on-going to ensure this position had been maintained. Another audit carried out in December 2013 and February 2014 considered appropriate prescribing of medicines for a particular population group. This audit identified 12 patients whose prescribed medicines were to be reviewed. Information was shared with GPs and patients concerned. Reviews were completed and changes were agreed with patients where this was considered to be appropriate. The practice had carried out re audits on a regular basis to ensure that prescribing continued to be appropriate for each patient by all GPs at the practice.

Good

Are services effective?

(for example, treatment is effective)

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 100% of patients with dementia had received an annual medicine review which was significantly higher than the national average of 84%. In some areas the practice had reached performance levels that were slightly lower than the national average. The practice had carried out an audit to identify these areas and a rationale had been established. For example, low performance rates in the elderly population when the practice population consisted of mainly younger and working age population.

The performance data that showed that the practice had however achieved 98% for their total QOF points compared with a national average of 96%.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for patients with long-term conditions, such as diabetes and that the latest prescribing guidance was being used. The computer system flagged up relevant medicines alerts when the GP prescribed specific medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe this outlined the reason why they had decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patients' needs.

The practice had a palliative care register and had regular contact with multidisciplinary teams and attended relevant meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with training such as annual basic life support. We noted a good skill mix among the doctors who collectively had additional diplomas in psychological medicine, diabetes and mental health. Two GPs were planning to complete additional diplomas in paediatrics and contraception. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans had been documented. Staff confirmed that the practice provided training and funding for relevant courses. For example, staff told us they were able to access on line training courses as well as vocational courses as these became available.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, ear syringing, smoking cessation programme and lifestyle advice.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, x-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice participated in multidisciplinary team meetings when required to discuss the needs of complex patients, for example those with end of life care needs or children who were considered to be at risk of harm. These meetings included health visitors and palliative care nurses. Decisions about care planning were documented in each patient's record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. GPs told us that they worked closely with the team to make sure patients' needs were met and that important information was shared.

Good

Are services effective?

(for example, treatment is effective)

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record system was used (EMIS) by all staff to coordinate, document and manage patients' care. All staff were trained to use the system and told us they found it easy to use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. The practice made referrals directly and through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

Consent to care and treatment

The practice had a consent to care and treatment policy which identified all the practice leads for specific areas, such as vulnerable adults lead GP This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Two GPs at the practice were specialists in mental health. We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

The GPs also demonstrated a clear understanding of Gillick competencies. These were used to help assess whether a child had the maturity to make their own decisions and understood the implications of those decisions.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The specialist learning disability team provided support and advice to the practice when this was required.

The practice had not needed to use restraint in the last three years, but staff we spoke with were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the GPs, health care assistant or practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by carrying out opportunistic medicine reviews, offering lifestyle advice, or to review the patient's long term condition.

The practice also offered NHS Health Checks to all its patients aged 40-75 years of age. The NHS Health Check programme was designed to identify patients at risk of developing diseases including heart and kidney disease, stroke and diabetes over the next 10 years. GPs and clinical staff showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice also kept a register of all patients with learning disabilities and these patients were offered annual physical health checks. Similar mechanisms were in place to identify patients at risk such as those who were likely to be admitted to hospital and or patients receiving end of life care. These patient groups were offered further support in line with their needs.

Up to date care plans were in place that were shared with other providers such as the out-of-hours provider and with multidisciplinary case management teams. Patients aged 75 or over and patients with long term conditions were provided with a named GP.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice offered flu vaccinations to patients over the age of 65 and to patients with chronic diseases such as asthma, diabetes, heart disease, and kidney disease. For example, last year's performance for patients with diabetes who had received the flu vaccine at 97% was higher than the national average of 93%.

Good

Are services effective?

(for example, treatment is effective)

Last year's performance for cervical smear uptake was 80%, which was slightly lower than the national average of 81%. There was a policy to offer telephone reminders for patients who had not attended for cervical smears and the practice carried out annual audits for patients who failed to attend.

We saw that a range of health promotion leaflets were available in the reception area, waiting room, treatment rooms and on the practice's website. Clinical staff we spoke with confirmed that health promotion information was available for all patients. They told us that they discussed health issues such as smoking, drinking and diet with patients when they carried out routine checks with patients. Staff confirmed that patients were given information to access other services as was needed, such as the bereavement service Cruse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP Patient Survey dated July 2014 and a survey of patients undertaken by the practice in 2013. The evidence from these sources showed that patients were satisfied and felt they were treated with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated above average for its satisfaction scores on consultations with GPs and nurses. Data showed that 83% were satisfied with appointment times which was slightly more than a national average of 80%; 85% described their experience of making an appointment as good compared with a national average of 75%; however, according to the data available only 59% would recommend this practice to someone new to the area which compared with a national average of 79%.

Patients were invited to complete CQC comment cards to provide us with feedback on the practice. We received 24 completed cards from patients and all gave positive feedback about the service they experienced. Patients commented that they felt the practice offered an excellent supportive service and that staff were kind, courteous, helpful and caring. They noted that staff treated them well, politely and with respect. One patient indicated that although they had found their experiences at the practice generally positive they had commented that one experience they had they felt was less positive. They felt the GP had not been respectful, but no details were provided to enable any response or opportunity to explore this further.

Staff and patients told us that all consultations were carried out in the privacy of a consultation room. Disposable curtains were provided in consultation rooms so that patients' privacy and dignity was maintained during examinations and investigations. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could on some occasions be overheard. We saw that following feedback from patient surveys the practice had responded to concerns that conversations taking place in these rooms could be overheard. Some alterations had been carried out to the premises to reduce this possibility. The GPs at the practice told us that further work was needed and had been planned to further reduce this risk.

Staff told us they offered a chaperone service if patients preferred. Clinical staff confirmed they had received chaperone training. They told us that information was made available to patients to inform them that a chaperone option was available to them. We saw information displayed in the reception area that confirmed this.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

Patients told us on the comment cards that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also commented that they felt supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions. For example, data from the national patient survey 2014 showed 80% of practice respondents said the GPs were good at involving them in decisions about their care which compared slightly lower than the national average of 82%. We saw however, that other data compared more favourably with the national average for patients who stated that the last time they saw or spoke with a GP, the GP was good or very good at involving them in decisions about their care; and the number of patients who stated that the last time they saw or spoke with a GP, the GP was good or very good at treating them with care and concern.

GPs and staff demonstrated knowledge regarding best interest decisions for patients who lacked capacity. They told us that patients were always encouraged to be involved in the decision making process. They told us that they always spoke with the patient and obtained their agreement for any treatment or intervention even if a patient had attended with a carer or relative.

Good

Are services caring?

The practice was able to evidence joint working arrangements with other appropriate agencies and professionals. For example, palliative care was carried out in an integrated way. This was done using a Multidisciplinary Team (MDT) approach with district nurses, palliative care nurses and hospitals.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients that this service was available. The GPs told us that their practice population was mainly Asian and that most of their patients spoke English. GPs told us they could speak with patients in their own language where they preferred or where they did not speak or understand English, to ensure they fully understood discussions about their health needs.

Patient/carer support to cope emotionally with care and treatment

Comment cards completed by patients were positive about the emotional support provided by the practice. For example, comments confirmed that staff responded compassionately when they needed help and provided support when required. Patients commented that the staff had been always supportive of them and their family, and that they were very friendly and caring.

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

We saw that regular multi-agency meetings were held and recorded. End of life care and bereavement information was available to patients and their relatives or carers in the waiting rooms and on the practice website. Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and or signposting to a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. Staff told us the practice population consisted of a high number of people who experienced deprivation. For example, national patient data showed that the practice population for the unemployed population group was 13% compared with the national average of 6%; and the practice working population group was 69% compared with the national average of 60%. The data showed however, that the patients who experienced deprivation was 43% compared with the national average of 24%. For the remainder of the population groups the practice population compared with or was slightly lower than the national average.

We saw minutes of meetings that showed the practice engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to discuss local needs and service improvements that needed to be prioritised. The minutes of meetings showed discussions that had taken place and actions agreed to implement service improvements and manage delivery challenges to its population. For example, we saw that an investigation had been carried out by a public health consultant because CCG data showed the practice had low prescribing rates in some areas such as chronic heart disease and antibiotic medicines. The results of the investigation identified that the low prescribing rates were probably linked to a number of factors. These included the younger population groups served by the practice and the greater use of interventions for people with mental health problems rather than medicine prescribing. Two GPs were specialists in mental health care provision.

We saw there was a system in place that ensured patients with long term conditions such as asthma and diabetes received regular health reviews. Clinical staff told us they carried out regular and routine blood tests for patients with diabetes. They explained they also used these sessions to give dietary advice and support for patients on how to manage their conditions. Longer appointments were available for patients who needed them such as patients with mental health concerns, learning disabilities and long term conditions.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient panel group (PPG). This group was made up of a group of patient volunteers and members of the GP practice team. The purpose of the panel group was to discuss the services offered and how improvements could be made to benefit the practice and its patients. For example, the latest patient survey feedback had suggested that a range of health books were provided in the waiting room that were suitable for different age groups. The suggestions had been added to the action plan and were scheduled for discussion at the next PPG meeting.

Tackling inequity and promoting equality

The practice proactively removed any barriers that some people faced in accessing or using the service. Staff we spoke with told us they would arrange for an interpreter if required and that information could also be translated by GPs at the practice. Three female GPs worked at the practice and were able to support patients who preferred to have a female doctor. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

There were arrangements in place to ensure that care and treatment was provided to patients with regard to their disability. For example, the practice was on one level and there were no steps to access. Doors were wide enough for patients in wheelchairs to gain access. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

The practice had recognised the needs of different groups in the planning of its services such as carers and vulnerable patients who were at risk of harm. The computer system used by the practice alerted GPs if patients had a learning disability, or if a patient was also a carer so that additional appointment time could be made available. For example, where patients were also identified as carers we saw that information was provided to ensure they understood the support that was available to them should they need it.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a policy in place and provided equality and diversity training through e-learning. We saw records that confirmed staff had completed this training, for example in July 2014. Clinical staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was discussed at staff team meetings. We saw training records that confirmed this training had been completed.

Access to the service

Comprehensive information was available to patients about appointments on the practice leaflet and through their website. This included details on how to arrange urgent appointments, home visits and how to book appointments through online. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided in leaflets, through information displayed in the waiting room and on the practice website.

The practice was open from 8.30am to 7pm Mondays, Tuesdays, Wednesdays and Fridays; and from 8.30am to 4pm on Thursdays. The practice was closed at weekends. The branch surgery at Hillmorton Road was open for limited appointments from 10.30am to 12.30pm and 2.30pm to 5.30pm on Mondays, Wednesdays and Fridays. On Tuesdays and Thursdays the branch was open from 10.30am to 12.30pm only and patients were encouraged to attend the main practice where possible. Home visits were available for patients who were too ill to attend the practice for appointments. Longer appointments were also available for patients who needed them. This also included appointments with a named GP or nurse.

Patients confirmed on the comment cards that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Patients commented that they had always been able to make appointments when they were in urgent need of treatment on the same day of contacting the practice. A patient we spoke with told us they had always been able to get an appointment when they had needed one at either the branch or the main practice.

GPs told us the practice's extended opening hours until 7.30pm on Wednesdays and Fridays had become increasingly popular clinics and were particularly useful to patients with work commitments. This was confirmed by comments made by patients on the comment cards.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We found that there was an open and transparent approach towards complaints. We saw that the practice recorded all complaints and actions had been taken to resolve each complaint as far as possible. We tracked two complaints and found these had been handled in accordance with their policy, in a timely way with learning identified where appropriate.

We saw that two complaints, one written and one verbal had been logged for the previous 12 months. The method of complaint received by the practice had indicated patients knew how to complain. We saw that both informal and formal complaints had been recorded. Both complaints received had been looked at and actioned. For example, we saw where a complaint had been made by a patient who was unhappy about what they considered to be a breakdown in communication between them and a GP. We saw evidence that the practice had responded to the patient's concerns and an apology had been made. As a result of this complaint the practice had made changes to the way in which information about health conditions and appointments were communicated with patients.

Accessible information was provided to help patients understand the complaints system through a poster on the practice's waiting room wall and in the practice's leaflet. Patients recorded on comment cards that they were aware of the process to follow should they wish to make a complaint. None of these patients had ever needed to make a complaint about the practice. Staff told us that they were aware of what action they would take if a patient complained. Staff confirmed that complaints were discussed at practice clinical meetings and they were made aware of any outcomes and action plans.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. Evidence showed that lessons learned from individual complaints had been acted on.

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

Swanswell Medical Centre was a close knit family practice of four related GPs with an aim to continue as a small practice to provide health care for their local community. GPs told us their aim for the practice was to provide a family run, caring, professional and high quality service to its patient population. The practice considered that to be able to deliver this service they needed to be knowledgeable, caring, competent and compassionate at all times. The practice aimed to ensure patients had easy access to the services they required and that they understood the care and treatment they were offered. We spoke with three members of staff and they all demonstrated that they understood the vision and values for the practice. They knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in hard copies and on the computer within the practice. We looked at seven of these policies and procedures. We saw plans were in place to ensure these were reviewed annually or sooner if required.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF is a scheme which rewards practices for providing quality care and helps to fund further improvements. We saw that QOF data was regularly discussed at monthly practice meetings and action plans were produced to maintain or improve outcomes. The practice had completed a number of clinical audits which included audits for medicines prescribed to thin blood and medicines prescribed to prevent the loss of bone mass.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a GP lead for infection control and another of the GPs was the lead for safeguarding. We spoke with three members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw that performance data was regularly discussed at weekly practice meetings and action plans were produced to maintain or improve outcomes. We found there was a culture of transparency at the practice and a constant review and audit of working processes and change being undertaken to ensure the most effective and efficient working.

Leadership, openness and transparency

There was a clear and visible leadership and management structure in place. Staff told us that there was a positive culture and focus on quality at the practice. We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings and through individual appraisals. We spoke with all four GPs and three staff who confirmed that there was an open and transparent culture of leadership, encouragement of team working and concern for staff well-being.

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and the senior management team were visible and accessible. Records showed that regular staff and clinical meetings took place at the practice. The practice manager told us that they met with the GPs each week and information from those meetings was shared with staff. Staff told us that the GPs and the practice manager were very supportive.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, an induction policy and a recruitment and equal opportunities policy which were in place to support staff. Staff we spoke with knew where to find these policies if required.

We saw from minutes that team meetings had been held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that protected time for individual and team training and development was made available to all staff on a monthly basis.

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

The practice had an active patient panel group (PPG). This patient panel was made up of a group of patient volunteers and members of the GP practice team. The purpose of the panel was to discuss the services offered and how improvements could be made to benefit the practice and

Are services well-led?

Good

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

its patients. We saw reports from the last two years where the group had met and had discussed a range of topics. This included the results of the patient surveys that had been completed during the years 2013 and 2014.

The results of the survey of patients had identified areas that would help to improve the service provided by the practice. For example, in the 2013 survey patients had commented the practice should open at the weekend. The practice had responded to this in the report by stating weekend hours were covered by the out-of-hours service. We saw that an action plan had been produced from the issues discussed in the reports and timescales were given for the actions to be taken. For example, consultation rooms required sound proofing. The action plan indicated that this would be completed by December 2014. We saw evidence to show that work had been carried out in the practice to address this, with further work identified and planned.

Staff told us the practice shared the survey results with the whole team for discussion at their staff meetings. This gave staff the opportunity to give feedback on any of the findings from the survey report. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

We saw from minutes that staff meetings usually took place every month. Practice discussions and information sharing took place during these meetings. Staff told us that they felt able to make contributions and suggestions at all times, and their views were actively sought and acted upon. 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

The practice held regular meetings that ensured continued learning and improvements for all staff. We saw minutes of staff meetings and management team meetings that showed discussions had taken place on a range of topics. This included significant events, complaints and palliative care for patients, with actions to be completed where appropriate.

The practice was able to evidence through discussion with the GPs and via documentation that there was a clear understanding among staff of safety and learning from incidents. Concerns, near misses, significant events (SEs) and complaints were appropriately logged, investigated and actioned. For example, we saw that significant event reporting had been discussed at the practice meetings held throughout 2014. We saw that the details of the incidents, who was involved and that action taken had been discussed.

GPs told us that the practice supported them to maintain their clinical professional development through training, clinical supervision and mentoring. Staff told us that the practice was very supportive with training and that they had regular protected time provided for learning. Staff told us that information and learning was shared with staff at practice meetings.