

Eldene Surgery

Quality Report

Colingsmead
Eldene
Swindon
Wiltshire SN3 3TQ
Tel: 01793522710
Website: www.eldenesurgery.com

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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

Eldene Surgery is a semi-rural teaching practice providing primary care services to patients resident in Fairford and the surrounding villages Monday to Friday. The practice has a patient population of just over 7,800 patients of which approximately 24% are over 65 years of age.

We undertook a scheduled, announced inspection on 22 October 2014. Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and GP specialist advisor. Additional inspection team members were a practice manager specialist advisor.

The overall rating for Eldene Surgery was requires improvement.

Our key findings were as follows:

- Patients were able to get an appointment when they needed it.
- The practice worked with the multidisciplinary team to support vulnerable patients and their families.
- Carers were well supported.

- Staff were caring and treated patients with kindness and respect.
- Staff explained and involved patients in treatment decisions.
- The practice had the appropriate equipment, medicines and procedures to manage foreseeable patient emergencies.
- The practice managed repeat prescriptions efficiently and effectively.
- The practice met nationally recognised quality standards for improving patient care and maintaining quality.
- The practice delivered an insulin initiation service and worked in conjunction with a hospital consultant to monitor and support diabetic patients.
- The regular review of the health and care needs of frail older adults to update care plans. The service included consultations and home visits on a Saturday.

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

The provider **must:**

Summary of findings

- Ensure patient group directives are completed in line with national guidance.
- Ensure there is a system to log the receipt and issue of prescription pads to GPs.
- Operate a robust recruitment procedure which ensures the appropriate character, qualifications and security checks are undertaken, recorded and monitored.
- Keep accurate staff training records to monitor staff have the appropriate qualifications, skills and knowledge to undertake their role.
- Undertake practice risk assessments such as the control of substances hazardous to health and liquid nitrogen. Implement risk assessment action plans for example, recommendations of the legionella assessment.
- Undertake regular clinical audit and complete clinical audit cycles.
- Undertake an annual infection control audit
- Ensure policies and procedures are up to date and accessible to staff
- Develop a system to enable patient safety alerts to be disseminated to all relevant staff.

The provider **should:**

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?

The practice is rated as requires improvement for safe as there were areas where improvements should be made. Staff understood their responsibilities to raise concerns, and report incidents and near misses. Regular significant event reviews and investigations were thorough and lessons learnt were communicated widely enough to support improvement.

However, the records of the recruitment procedures were not complete. The practice did not check the professional registration status of staff. Although the practice was found to be visibly clean, the practice had not completed annual infection control audits in line with national guidance. We found the practice did not follow national guidance with regards to the management of GP prescription pads, patient group directions. There was no formal system to review patient safety alerts.

Health and safety risk assessments of the environment, such as the Control of Substances Hazardous to Health were not undertaken. The practice had not identified the risks associated with the storage and use of liquid nitrogen.

Requires improvement



Are services effective?

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was used routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. We saw examples of two clinical audits which had been completed in 2012.

Recommendations from the audits had yet to be re-audited to demonstrate that the changes had been implemented and that improvements have been made. Staff told us they had received essential training such as safeguarding and basic life support appropriate to their roles however, the practice did not have documented evidence to confirm this. The practice could identify appraisals and the personal development plans for all staff. However, further training to enable continuing professional development for some staff was not supported by the practice.

Good



Are services caring?

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and

Good



Summary of findings

they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We saw staff communicated with patients with kindness and respect and ensured confidentiality was maintained.

Are services responsive to people's needs?

The practice is rated as good for responsive. Patients reported good access to the practice and continuity of care, with urgent appointments available the same day. The practice had accessible facilities and was well equipped to treat patients and meet their needs. There was a complaints system however; the complaints process was not visible in the practice or readily accessible to patients without their having to ask staff. Evidence we saw demonstrated the practice responded quickly to issues raised.

Good



Are services well-led?

The practice is rated as requires improvement for being well-led. The practice had a clear vision to provide a high quality, caring and comprehensive service to patients in a timely manner. We saw staff applied these values to their practice. There was a leadership structure and overall staff felt supported by management. However evidence gathered through staff interviews, record and policy reviews indicated management did not always lead through learning and development. For example, audit cycles were not completed, access to staff policies and procedures was not well communicated, or policies and procedures were not up to date. The appraisal process did not provide opportunities for staff development. The practice sought feedback from patients and this had been acted upon. The practice had an active patient participation group (PPG). The practice responded to patient suggestions and concerns.

Requires improvement



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

The provider was rated as good for caring, effective and responsive overall and this included this population group. The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older patients. The practice provided personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example in end of life care and reducing admissions to hospital. All these patients had a named GP. The practice was responsive to the needs of older patients, including offering home visits and rapid access appointments for those with enhanced needs and home visits. The practice had accessed additional project funds to provide further support for older patients by reviewing their care needs and updating care plans and records.

Requires improvement



People with long term conditions

The provider was rated as good for caring, effective and responsive overall and this included this population group. The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Emergency processes were in place and referrals made for patients in this group who had a sudden deterioration in health. When needed, longer appointments and home visits were available together with structured annual reviews to check their health and medicines needs were being met. For those patients with the most complex needs the GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care. The practice had in place personalised care plans to support patients with long term conditions to improve the quality and coordination of care.

Requires improvement



Families, children and young people

The provider was rated as good for caring, effective and responsive overall and this included this population group. The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Systems were in place for identifying and following-up children who were 'at risk'. For example, the GPs met monthly with the multidisciplinary team to review

Requires improvement



Summary of findings

children and families 'at risk'. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. Women had access to contraceptive services including contraceptive coil insertion and contraceptive implants.

Working age people (including those recently retired and students)

The provider was rated as good for caring, effective and responsive overall and this included this population group. The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice offered online services as well as a full range of health promotion and screening which reflected the needs for this age group. Two flu clinics were held on Saturdays at the beginning of the flu season. The practice did not offer earlier morning or late evening appointments to accommodate the needs of working patients however patients had access to telephone consultations. The practice held a register of patients working in the armed forces and their families.

Requires improvement



People whose circumstances may make them vulnerable

The provider was rated as good for caring, effective and responsive overall and this included this population group. The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice held a register of patients with learning disabilities. The practice had carried out annual health checks for patients with learning disabilities. The practice offered longer appointments for patients requiring more time with their GP. Staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and who to contact within the practice.

Requires improvement



People experiencing poor mental health (including people with dementia)

The provider was rated as good for caring, effective and responsive overall and this included this population group. The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice had started care plans for patients experiencing poor mental health conditions. Quality data demonstrated the practice compared favourably with

Requires improvement



Summary of findings

other practices in the assessment of depression. The practice regularly monitored patients for the side effects of certain medicines used in the treatment of mental health conditions. The practice website included useful links to other information and support services.

Summary of findings

What people who use the service say

On the day of the inspection we spoke with six patients attending the practice. We looked at 23 patient comment cards, feedback from the practice's patient surveys (2013 and 2014), and the GP National Patient Survey 2013/2014. We also spoke with representatives from the practice's patient participation group.

Patients we spoke with and patient comments cards we looked at demonstrated patients were satisfied with the care and treatment received. They described staff as helpful, caring and supportive. This was supported by feedback from the GP National Patient Survey 2013/2014 which indicated 84% of the practice respondents said the last GP they saw treated them with care and concern. 82% of respondents described their experience of the practice as fairly good or very good. Patients we spoke with felt their privacy and dignity were respected by staff. However the GP National Patient Survey demonstrated 25% of respondents were not satisfied they could be overheard in the reception area.

All of the patient feedback told us patients were able to see or speak to a GP if their appointment was urgent. However, patients we spoke with said there could be a wait to see the GP of their choice and it was difficult booking appointments via the practice website. Patients we spoke with were not aware of the complaint process. They expressed confidence in the practice to address concerns when they were raised.

Patients' feedback told us patients were included in their care decisions, able to ask questions of all staff and had treatment explained so they could make informed choices. This was supported by feedback from the GP National Patient Survey 2013/14 which indicated 78% of patients said the last GP they saw was good at involving them in decisions and 81% said the last GP they saw was good at explaining tests and treatments.

Patients told us they were satisfied with the cleanliness of the practice.

Areas for improvement

Action the service **MUST** take to improve

The provider **must**:

- Ensure patient group directives are completed in line with national guidance.
- Ensure there is a system to log the receipt and issue of prescription pads to GPs.
- Undertake a risk assessment for the storage, dispensing and administration of liquid nitrogen.
- Ensure there is a system to check and record staff are registered with the relevant professional body when recruited and annually thereafter.
- Keep accurate staff training records to monitor staff have the appropriate qualifications, skills and knowledge to undertake their role.

Action the service **SHOULD** take to improve

- Undertake practice risk assessments such as the control of substances hazardous to health and implement action plans for example recommendations of the legionella assessment.
- Undertake regular clinical audit and complete clinical audit cycles.
- Undertake an annual infection control audit
- Ensure policies and procedures are up to date and accessible to staff
- Develop a system to enable patient safety alerts to be disseminated to all relevant staff.
- Ensure records of staff recruitment checks are accurate and complete.

Eldene Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and GP specialist advisor. Additional inspection team members were a practice manager specialist advisor inspector.

Background to Eldene Surgery

Eldene Surgery is a small semi-rural teaching practice providing primary care services to patients resident in the village of Eldene in Swindon. The practice is purpose built with most patient services located on the ground floor of the building. The practice has a patient population of just over 7,800 patients of which approximately 24% are over 65 years of age.

The practice has two male and two female GP partners. The male GP partners work full time and the female GP partners part time. They employ three nurses, a practice manager, and nine reception/administration staff.

Each GP has a lead specialist role for the practice and nursing staff have specialist interests such as respiratory disease and infection control. The practice is a training practice for GPs specialising in general practice.

Primary care services are provided by the practice Monday to Friday during working hours (8.30am-12.30pm and 1.30pm - 6pm). The practice has opted out of the Out of Hour's primary care provision. This is provided by another Out of Hour's provider.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

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 are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)

Detailed findings

- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before our inspection, we reviewed a range of information we held about the practice and asked other organisations, such as the NHS England Local Area Team, the Swindon Clinical Commissioning Group and the local Healthwatch to share what they knew.

We carried out an announced inspection on the 22 October 2014. During the inspection we spoke with three GPs, the

practice manager, two nursing staff and four administration staff. We spoke with six patients who used the service. We looked at patient surveys and comment cards. We observed how staff talked with patients.

We looked at practice documents such as policies, meeting minutes and quality assurance data as evidence to support what patients told us.

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.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents, comments and complaints received from patients. There was no formal system to review national patient safety alerts. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Staff also gave examples of reporting patient safeguarding concerns and other incidents.

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 12 months and we were able to review these. Significant events were reviewed regularly. There was clear action planning and learning from the meetings. However, we noted nursing and administrative staff did not attend the meetings which were a source of learning.

We were told by the GPs there was not a formal system to monitor safety alerts from the Medicines and Healthcare Products Agency (MHRA.)

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We were told by the lead safeguarding GP they had completed level three training. Administrative staff had not completed and safeguarding training. Nursing staff told us they had completed safeguarding training however there were no training records to confirm this. The nurses and GPs we asked were able to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information and record evidence of safeguarding concerns and referrals. The practice's safeguarding vulnerable adults policy as guidance for staff did not include contact numbers of external agencies to contact out of normal working hours. The safeguarding lead told us there was a link to the safeguarding website on every practice computer. There was a safeguarding children policy and protocol with information which was out of date with regards to information being available via the Information Safeguarding Authority.

The practice had appointed a dedicated GP as lead in safeguarding and child protection. All staff we spoke with were aware who the lead practitioner was and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example children with child protection plans. There were no children with child protection plans at the time of the inspection. However, we saw from the monthly multidisciplinary team meeting records children subject to child protection plans had been discussed and GPs had made direct contact with health visitors as necessary.

There was a sign to inform patients they could request a chaperone and there was a chaperone policy as guidance for staff.

There was a system for reviewing repeat medicines for patients with co-morbidities/multiple medications. We were told changes to patients' medicines by other healthcare providers were addressed by the GPs. There was an alert on the electronic record to ensure patients received an annual medicines check.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a protocol for ensuring medicines were kept at the required temperatures, and the action to take in the event of a potential failure. Liquid nitrogen used for cryosurgery (freezing of warts) was kept in a well ventilated room however there was no risk assessment for the storage and use of the product.

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 nurses and the health care assistant administered vaccines using directives produced in line with legal requirements and national guidance. We saw overall authorisations of staff to use the patient group direction (a patient group direction is written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation

Are services safe?

for treatment) had been completed with the exception of two vaccines rotarix (for rotavirus) and pneumococcal vaccine (for meningitis). These group directions had not been signed by the GP authorising the nurses to administer the vaccinations. This was not in line with the practice policy or best practice. The nurses told us they received the appropriate training to administer vaccines. We looked at three nurses' personnel files to verify this information. We saw evidence one nurse had received training in the administration of the human papilloma virus (HPV) vaccine to protect against the risks of cervical cancer.

There was a system in place for the management of high risk medicines such as blood thinning agents, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results.

The practice used an electronic prescription system. Prescriptions could be sent to pharmacies directly. All paper prescriptions were reviewed and signed by a GP before medicines were dispensed. Paper prescriptions issued were logged to ensure an audit trail was available for accountability purposes.

GPs told us blank prescription pads were not logged in and out in accordance with national guidance. These were not tracked through the practice and we observed one prescription pad kept in an unlocked GP's bag in an unlocked consulting room.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. There were cleaning schedules in place although these were not regularly monitored by the practice manager. However, we saw there was ongoing communication between the practice manager and the cleaning contractors regarding cleaning issues. Patients we spoke with told us they found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available to which staff could refer. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. There was also a policy for needle stick injury. The practice had a lead practitioner for infection control. Staff told us they received induction training about infection control specific to their role and received updates every one to two years. However, we were not able to see records to confirm this was the

case. We saw an action plan from an infection control audit completed in 2010. The frequency of the audit and staff training was not in line with the practice infection control policy. All action points on the audit had been completed.

Notices about hand hygiene techniques were displayed in staff and some patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a legionella assessment for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw from records the practice had followed through one recommendation required which was to run the shower every week. However, the recommendation to check water temperatures had not been started.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw records demonstrating equipment was tested and maintained regularly. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment, for example, weighing scales.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting GPs, nurses and administrative staff. However, records we looked at did not contain evidence appropriate recruitment checks had been undertaken prior to employment. For example, records did not contain proof of identification, references, qualifications, registration with the appropriate professional body and criminal record checks through the Disclosure and Barring Service (DBS).

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

Staff told us there were usually enough staff to maintain the smooth running of the practice although at times it was very busy.

Are services safe?

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. For example these included maintenance checks of the equipment, dealing with emergencies and staffing levels. However, there were not systems in place to monitor the professional registration requirements of staff. We saw staff recruitment processes were incomplete and staff training records were not kept up to date. We did not see the practice undertook risk assessments such as the control of substances hazardous to health (COSHH).

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Nurses and GPs told us they had received training in basic life support although this could not be confirmed by training records. 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). Members of staff knew the location of this equipment and records confirmed it was checked regularly.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. There were relevant contact details available to which staff could refer.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence for example, care pathways for patients with long term conditions and the use of wound dressings. These were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and palliative care and the practice nurses supported this work. Nursing staff we spoke with told us they could approach the GPs when they had concerns about a patient's condition such as elevations in blood pressure or blood glucose levels. We were told by the nurses every five to six months there was a joint diabetes clinic with a consultant specialist in diabetes.

Quality and Outcomes Framework Data 2013/2014 (QOF is a national performance measurement tool.) demonstrated the practice compared favourably with regional and national results regarding the monitoring and review of patients with a range of chronic conditions including high blood pressure, diabetes and respiratory disease. Patients with complex needs had multidisciplinary care plans documented in their case notes. We saw examples of completed care plans demonstrating they had been shared with and signed by the patient. GPs met every four weeks with community nurses to review the most vulnerable patients with chronic long term conditions who were most at risk of admission to hospital. We were told by the GPs patients were reviewed within three days of discharge from hospital. In addition the GPs had a system to review the health needs of frail patients over 75 years of age. This service was provided either in the practice or at the patients home and was available on Saturdays or during normal practice hours.

National data showed the practice was in line with referral rates to hospital and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients for example, with suspected cancer. We saw records which demonstrated peer reviews of hospital referrals. GPs told us referral letters were countersigned by another GP before the referral was made as part of the peer review process.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice showed us two examples of clinical audits undertaken in 2012. One was to review the management of contraceptive implants and the other the management of patients with pulmonary disease. Recommendations from the audits had yet to be re-audited to demonstrate that the changes had been implemented and improvements made. There was no clinical audit schedule.

We saw evidence the practice nurse undertook regular audits of the system to manage the follow up of patient results from cervical smear results. When the practice did not receive results the practice nurse contacted the hospital. Patients who did not attend for their cytology appointment were followed up by the practice nurse.

The GPs told us some audits were linked to medicines management information for example diabetes monitoring and prescribing for osteoporosis (bone thinning condition).

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, we were told an average of 99.97% of patients with diabetes had an annual medicines review. QOF data 2013/2014 demonstrated the practice compared favourably with regional and national results regarding the monitoring and review of patients with a range of chronic conditions including high blood pressure, cancer and respiratory disease. The average practice QOF result for all conditions monitored was 99%-100%. This practice was not an outlier for any QOF (or other national) clinical targets.

There was a protocol for repeat prescribing which was in line with national guidance. There was an alert on the patient record for six monthly to annual reviews of medicines. Health checks were completed for long-term

Are services effective?

(for example, treatment is effective)

conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

New patients with repeat prescribed medicines had their medicines reviewed by a GP within three months of registration at the practice.

The practice had achieved and implemented the Gold Standards Framework for end of life care. It had a palliative care register and had regular informal meetings with community staff as well as multidisciplinary meetings every month to discuss the care and support needs of patients with palliative needs and their families. This included a review of the patients' end of life care plan decisions and wishes.

Effective staffing

The practice did not keep records of staff training or professional registration requirements. This meant we were not able to confirm GPs were up to date with their yearly continuing professional development requirements necessary for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council). The practice did not keep up to date records of the practice nurses' professional registration status. However, the practice checked their registration details during the inspection and we saw they were in date with their professional registration requirements.

All staff told us they had an annual appraisal and professional development plans. However, the staff we spoke with said staff shortages meant the development plans were not achieved and the process was not fulfilling.

The practice was a training practice, trainee GPs offered extended appointments and had access to a senior GP throughout the day for support.

Practice nurses told us they were trained to fulfil defined duties for example, administration of vaccines, cervical cytology and monitoring blood clotting times for patients taking blood thinning medicines. Those with extended roles for example sexual health and contraception advice and monitoring had relevant qualifications. We could not confirm this as staff training records were not kept.

However we looked at three nurses files'. There was evidence to confirm one nurse had attended basic life support in 2014 and another nurse safeguarding training in 2013.

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, and Out-of-Hours GP services both electronically and by post. The GP who saw these documents and results was responsible for the action required.

The practice held monthly multidisciplinary team meetings with community staff and other members of the multidisciplinary team to discuss the needs of complex patients, or patients with long term conditions. For example, those at risk of emergency admission to hospital or patients with palliative care needs.

One GP had undertaken insulin initiation training to support patients with diabetes transfer to insulin treatment. Joint clinics were held with the diabetic hospital consultant to review and monitor diabetic patients treatment plans.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local pharmacy and one with a 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, and the practice made a range of referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained to use the system. The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

The practice had a comprehensive consent policy as guidance for staff. Nurses and GPs told us most procedures required the patient to give verbal consent. This was recorded on the patients' record.

GPs and nurses understood the general principles of the Mental Capacity Act 2005. Nurses we spoke with gave us examples of how they explained that for patients with impaired capacity they would take extra time to explain treatment and involve carers with the patient's permission. Nurses documented and referred patients back to a GP when they refused treatment which nurses considered to be in the patient's best interest. Staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

GPs told us patients with learning disabilities 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).

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant / practice nurse. The GP was informed of all health concerns detected and these were followed-up. If the patient was taking prescribed medicines we were told they would be seen by the GP.

Nursing staff used their contact with patients to help maintain or improve mental and physical health and wellbeing. For example, offering smoking cessation advice to smokers and weight management programmes to overweight patients. There was a comprehensive range of health promotion information in the practice some of

which was specific to certain cultural groups. However the information was not available in other languages. There were links on the practice website which included mental health and sexual health advice.

The practice offered NHS Health Checks to all its patients aged 40-75.

The practice had ways of identifying patients who needed additional support. For example, the practice kept a register of all patients with learning disabilities and dementia. All these patients were offered an annual physical health check. This involved a 20 minute appointment with the practice nurse for general questions related to the patient's health and then 20 minutes with their GP. There was a recall system for patients who did not attend.

The practice's performance for cervical smear uptake was 77.8% which was above the Swindon Clinical Commissioning Group (CCG) average. The practice performance for national mammography (in last three years prior to 2013) was also above Swindon CCG average (75.4% and 74.9% respectively). The uptake for national bowel screening (over six months 2013) was about average for the Swindon CCG area (50.9% and 53.3% respectively)

The practice offered a full range of immunisations for children, older adults and travel vaccines. Flu vaccinations were administered in line with current national guidance. Patients identified as carers were offered flu vaccinations. Patients over the age of 75 years were also able to have a shingles injection.

The GPs and practice nurses provided a combined clinic every Thursday morning for all pre-school children. The services included immunisations and development checks. Overall last year's performance for all immunisations was above average for the CCG.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national patient survey and a survey of 49 patients undertaken by the patient participation group in 2013 and 59 patients in 2014. The evidence from these sources demonstrated 75% described their experience of the practice as good, very good or excellent. This was confirmed by data from the GP National Patient Survey 2013/2014 which showed 82% of respondents described their overall experience as good with 78% respondents who would recommend the practice. 90% described the receptionists as helpful. The GP National Patient survey demonstrated overall the practice scored lower than the Clinical Commissioning Group (CCG) average for most questions. However, 84% of patients in the GP National Patient Survey said the last GP they saw was good at treating them with care and concern.

Patients completed CQC comment cards to provide us with feedback about the practice. We received 23 completed cards and all gave positive comments about the service experienced. Patients said they felt the practice offered a good service. The staff were described as excellent, supportive and caring. For example, one patient gave feedback about the excellent support provided by the GPs following a bereavement. The comments said staff treated them with dignity and respect. All the patients we spoke with on the day of our inspection told us they were satisfied with the care provided by the practice and said their dignity was respected.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. Results from the GP National Patient Survey (2013/14) indicated 25% of patients said they could be overheard and were not happy with it. We observed the reception area

was shared with a service delivered by another provider and open to the waiting area. The practice had started to address the concern. For example, there was a patient self-check in system.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients' responses to questions about their involvement in planning and making decisions about their care and treatment was higher than the clinical commissioning group average. Patient comment cards and the patients we spoke with on the day of inspection said their health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Nursing staff gave examples of how patients were involved in their treatment. For example, patients with diabetes setting personalised achievable goals and keeping a log of their dietary habits.

The GPs told us they supported patients and their carers to consider their end of life care choices. For example, decisions about do not attempt cardio pulmonary resuscitation. This information was shared with the other healthcare providers to enable patients' wishes to be respected

Staff told us translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 84% of respondents to the GP National Patient Survey (2013/2014) said the last GP they saw treated them with care and concern. 94% said they had confidence and trust in the last GP they saw. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff did not rush patients, and were supportive

Are services caring?

and helpful. One patient gave feedback on the excellent support provided by the GPs following a bereavement. Staff told us if families had experienced a bereavement, their usual GP contacted them and a visit was arranged.

Information in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice had a

comprehensive carers' policy and a lead member of staff for carer support. We were told carers meetings were held at the practice and the carer lead practitioner met with the group. We saw new patients were offered a carers pack if relevant on registration at the practice. The practice's computer system alerted GPs if a patient was also a carer. Main carers were also offered flu vaccinations.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Overall we found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided.

There had been little turnover of staff which enabled continuity of care and accessibility to appointments with a GP of choice. This included appointments with a named GP or nurse.

The practice was not open outside the hours of 8.30am to 6.00pm to accommodate patients not able to attend the practice during routine practice hours. However, patients were able to arrange telephone consultations during practice hours. Standard appointments of 10 minutes were provided to patients however, longer appointments were also available for people who needed them and those with long-term conditions. There were arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information about the out-of-hours service was provided to patients.

Home visits were made to a local care home by a named GP and to those patients who needed one. Patients who were too unwell to attend the practice could request a home visit.

The patient website enabled patients to order a repeat prescription and book an appointment via the practice website. Patient feedback indicated it was not easy to book an appointment via the website.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). For example, increasing the use of telephone triage of patients requiring an appointment.

The practice had implemented the Gold Standards Framework for end of life care. It had a palliative care register and held monthly multidisciplinary meetings in addition to community nurses meetings every month to discuss patients' and their families' care and support needs.

The practice delivered an enhanced service (locally developed service over and above the essential/additional services normally provided to patients) to co-ordinate and manage the care of frail older patients and those with long term conditions to avoid unplanned admissions to hospital.

The practice demonstrated their achievement of the enhanced service by regular monthly meetings with other health care providers such as the community nurses and community matron, the development of patient care plans and the identification of the most vulnerable patients.

The practice offered a range of contraceptive services including contraceptive coil insertion and contraceptive implants.

The practice undertook minor operations and joint injections for patients who had been assessed as suitable for the treatment.

One GP had undertaken insulin initiation training to commence patients with diabetes onto insulin treatment. Joint diabetes clinics were held with a hospital diabetes consultant every five to six months to review patients' diabetes management.

Tackling inequity and promoting equality

The practice premises were purpose built with patient services on the ground floor. The building enabled patients with mobility needs to gain access without assistance. The practice had an induction loop system for patients with hearing difficulties.

The practice waiting area was large enough to accommodate patients using wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. There were designated chairs in the waiting room with high backs and arms to enable patients to sit down and get up safely. Patient examination couches were adjustable height operated.

Accessible toilet facilities including baby changing facilities were available in the reception area.

The practice had access to a translation service for patients where English was not their first language.

Access to the service

Appointments and telephone consultations were available from 8.40am to 6.00pm on weekdays. Patients were able to request a repeat prescription via the practice website.

Are services responsive to people's needs?

(for example, to feedback?)

Information was available to patients about appointments on the practice website and in the practice booklet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. 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 which they should ring depending on the circumstances. Information about the out-of-hours service was provided to patients.

Patients stated they were generally satisfied with the appointments system. Information from the GP National Patient Survey 2013/2014 demonstrated 83% of respondents said their last appointment was convenient. Although all of the patient feedback told us patients were able to get to see or speak to a GP if their appointment was urgent, there was a wait of up to two weeks to see a GP of their choice.

Patients told us their appointment times were usually on time. This was confirmed by the GP National Patient Survey 2013/14 where 70% of patients said they waited less than 15 minutes for their appointment. This was also confirmed by our observations on the day of the inspection.

Longer appointments were available on request by patients with more than one area of concern and for annual checks for patients with learning disabilities and dementia.

Listening and learning from concerns and complaints

The practice had a system for handling formally recorded complaints and concerns. Its complaint policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

We looked at the complaints summary from the last three years. There had been no complaints recorded in 2014. We saw past complaints had been managed in line with the practice policy. Patients were informed of the outcomes of complaint investigations and in some instances had a meeting with the GPs. Feedback from patients told us they had no complaints about the practice. Patients we spoke with said they were confident any concerns would be managed appropriately.

There was information available to patients in small print in the back of the practice leaflet about who to contact in the practice if they wanted to make a complaint. The practice leaflet did not include information about other organisations to contact if the patient was not satisfied with the way the practice handled their complaint. Further information about how to make a complaint was not clearly visible in the practice.

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 to provide a quality, caring and comprehensive service to patients in a timely manner.

Staff we spoke with gave examples of how team work and knowledge of their patients, enabled a high standard of care and treatment. Nursing staff told us they were well supported by the GPs.

Governance arrangements

The practice had a range of policies and procedures in place to govern activity and we were told these were available to staff via any computer within the practice. However, on the day of the inspection we checked the whistleblowing policy was available electronically and found it had been overwritten by the recruitment policy. We looked at a range of paper copies of policies and procedures. Although they were dated as reviewed some included out of date information for example in the safeguarding policy. In addition there were two different versions of some policies.

The practice held two weekly practice meetings. We looked at minutes from the meetings and found performance, quality and risks had been discussed.

Significant events were reviewed regularly. There had been four recorded in 2014. We saw from the significant event register there was clear action planning and learning from the meetings. However, we noted nursing and administrative staff did not attend the meetings which were a resource of learning.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. Not all staff we spoke with were informed of the QOF results as a resource for learning.

We saw the GPs had undertaken a small number of clinical audits. For example, an audit of contraceptive implants and the management of patients with chronic obstructive airways disease (a chronic condition of the lungs). Recommendations from the audits had yet to be re-audited to demonstrate that the changes had been implemented and improvements made. There was no clinical audit schedule. The last infection control audit we saw was in 2010.

Leadership, openness and transparency

There was a leadership structure which had named members of staff in lead roles. For example there was a nurse with lead responsibilities for infection control and one GP had lead responsibilities for safeguarding. Staff we spoke with were clear about their own roles and responsibilities. Most staff we spoke with said the practice worked well as a team and most staff felt supported.

There were whole practice meetings approximately every three months. Staff from all departments

were invited. Staff said these were helpful. We were told meetings within individual departments were informal and records were not kept.

Overall quality monitoring records were up to date for example, emergency equipment and maintenance of the building and equipment. We saw evidence for example of changes to practice resulting from learning from incidents and significant events. For example, the recording of when patients are told test results so if appropriate an appointment with a GP can be made. The practice had not evaluated the effectiveness of the changes made.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of the processes in place. These included the recruitment processes and records of nurses' professional registration and GPs' validation requirements. We found records were incomplete and did not contain sufficient information to ensure patients were protected from risk.

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

The practice gathered feedback from patients through patient surveys, complaints and the patient participation group. The results and actions agreed from these surveys were available on the practice website. The practice had an active patient participation group (PPG) which had steadily increased in size. The PPG mostly contained representatives from patients not working or retired. The PPG met every two months with practice staff.

We looked at the results of the PPG annual patient surveys (2014 and 2013) and questions raised by patients to the group. The practice had responded to a range of comments including requests for example an increased use of triage to determine the appropriate level of patient support. Minutes of meetings demonstrated the survey results were discussed at PPG meetings. The results and actions agreed

Are services well-led?

Requires improvement 

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

from these surveys were available on the practice website and as a hardcopy on request. In addition the GPs worked with the PPG to explore specific concerns. For example, establishing why patients queued outside the practice each morning before the building opened. The practice leaflet did not include information about other organisations to contact if the patient was not satisfied with the way the practice handled their complaint. Further information about how to make a complaint was not clearly visible in the practice.

We were told the practice had a whistle blowing policy on the intranet which was available for staff to read as guidance. However, on the day of the inspection the policy was not available as it had been 'overwritten' by another policy.

Management lead through learning and improvement

Staff told us they completed on-line mandatory training and attended annual basic life support training. However, this could not be confirmed by training records as the practice did not keep a record of who had attended

training. GPs told us there had been clinical meetings to discuss patient case studies which had recently stopped. Staff told us they missed them as they were good for learning.

Staff told us they had an annual appraisal which included a personal development plan. However, the staff we spoke with said staff shortages meant the development plans were not completed and the appraisal process was not rewarding.

Evidence gathered through staff interviews and record and policy reviews indicated management did not always lead through learning and development. For example, audit cycles were not completed, access to staff policies and procedures was not well communicated, or policies and procedures were not up to date. The appraisal process did not provide opportunities for staff development.

The practice was a GP training practice for medical students and GP registrars specialising in primary medical care. The practice was involved in a clinical research programme.

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

Diagnostic and screening procedures
Family planning services
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers

Patients who used the service and others were not protected because the provider did not keep appropriate records of the recruitment process or ensure staff employed were registered with the relevant professional body.

Regulated activity

Diagnostic and screening procedures
Family planning services
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

The provider did not keep accurate staff records of the mandatory training and the continuing professional development training undertaken by staff to monitor they have the appropriate qualifications, skills and knowledge to undertake their role.

Regulated activity

Diagnostic and screening procedures
Family planning services
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

The registered provider must protect service users against the risks associated with the unsafe use and management of medicines.