Ashington House Surgery

Quality Report

Ashington Way
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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?	Requires improvement
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 carried out an inspection of this practice on 23 October 2014 as part of our plan of inspections. It was a comprehensive inspection and this practice was chosen because it had not been inspected using our new methodology.

Overall, we found this practice needs improvement. We found the practice worked well with other agencies in order to meet the health needs of patients. There was good analysis and resulting action when significant events occurred and complaints were treated seriously. Most patients were happy with the care and treatment they received and the majority of patients would recommend the practice to others.

Our key findings were as follows:

- There were arrangements in place to respond to the protection of children and vulnerable adults and to respond to any significant events affecting patients well-being.
- The practice worked well with other health care service to enable a multi-disciplinary approach in meeting the health care needs of patients receiving a service from the practice.
- Patients told us they were treated with respect and kindness and staff maintained their confidentiality.
- Most patients were able to have an appointment on the same day unless they wished to see a particular GP. Some patients said if they wanted to see a particular GP for continuity of care and treatment they had to wait. The practice took complaints seriously.
- There was a clear management structure with approachable leadership. Staff were supported and had opportunities for developing their skills. The provider responded to feedback from patients.

There were areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure equipment and services are properly maintained.

Summary of findings

- Ensure there is a full employment history of each person appointed to work in the practice by obtaining two written references before staff commence employment.
- Ensure the premises are safe and access is available in the event of fire.

In addition the provider should:

- Make arrangements for the security of blank prescription forms when not in use.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for safe. There are areas where improvements should be made. There was good analysis and response to actions identified following significant events. There were arrangements in place to respond to any allegation, disclosure or suspicion of abuse and staff received training in this area. The staffing levels were suitable to meet the needs of patients however safe recruitment practices were not always followed. The practice had not ensured the premises and some equipment was safe and which ensured the safety of patients, staff and visitors.

Are services effective?

Good

The practice is rated as good for effective. Patient's needs were assessed and they reported good outcomes following treatment. The practice followed guidance related to meeting patient's healthcare needs and worked with other services to provide a multi-disciplinary approach to supporting patients. People with poor mental health had reviews that included assessment of their physical health along with mental health. Mental capacity assessments were recorded. Clinics were held to support those with long term conditions and patients who required vaccinations. Staff had opportunities for continuing professional development to ensure they were competent to provide services.

Are services caring?

Good

The practice is rated as good for caring. Patients told us they were treated with respect and their confidentiality was maintained. We saw staff treated patients with kindness and patient's cultural needs were acknowledged. Patients told us they had choices about whether to follow treatments and told us they were referred for treatment in a way that ensured they were seen by other services as quickly as possible. The practice website had a page translation feature and could be translated into a range of other languages. The practice had a range of information leaflets that were easy to understand, available for people to take away with them.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. There was effective joint working with other health services. The practice had a system in place to maximise patient's choices. Patients told us they could get an appointment when required although sometimes had to wait to

Summary of findings

see a GP of their preferred choice. Patients said they would report concerns to receptionists initially and we saw that concerns and complaints were taken seriously. Issues identified through the complaints process were actioned within the practice.

Are services well-led?

Good

The practice is rated as good for well led. One of the partners in the practice was registered with the Care Quality Commission as manager of the service. There was a practice manager and assistant practice manager, both of whom had clearly defined roles. All staff had an annual appraisal and meetings were held to engage staff in the operation of the practice. When staff were not involved in meetings they were given copies of the record of the meetings. There was an active patient participation group that sought feedback from patients in collaboration with the practice and issues identified through the patient satisfaction survey were actioned. The provider had a five year action plan that covered all aspects of service provision. The plan extends to 2016 when, we were told, by the practice manager, it will be reviewed.

Summary of findings

What people who use the service say

We sent comments cards to the practice in advance of our visit together with a posting box so patients could give us feedback. We received 26 returned cards with comments from all except one were positive. Comments were made about the difficulty getting a GP of their choice within a short time. All of the comments praised the administrative staff, nurses and GPs for their consideration and friendliness. Patients referred to being treated with dignity and respect and receiving a good service. Some patients said they would recommend the practice to others.

We spoke with seven patients during our visit. Patients said they felt safe at the practice with additional comments made about the relaxed surroundings and professionalism of the staff. Some patients said it was difficult to get an appointment when they wanted although some were pleased they had secured an appointment for the same day.

Patients said they were happy with the care and treatment they received. They told us how the GPs monitored the effectiveness of medicines and referred for specialist treatment if necessary.

Patients felt their complaints would be taken seriously. Most said they would complain at reception initially although one person did tell us they would speak with the patient participation group (PPG). Some patients did not know of the groups existence. Some patients felt the décor of the practice could be improved. All of the patients we spoke with felt the staff were friendly and helpful.

We saw correspondence from patients who wished to thank practice staff. Patients complimented reception staff for their patience, understanding and assistance when dealing with them due to their disabilities.

Areas for improvement

Action the service MUST take to improve

- Ensure equipment and services are properly maintained.
- Ensure there is a full employment history of each person appointed to work in the practice by obtaining two written references before staff commence employment.
- Ensure the premises are safe and access is available in the event of fire.

Action the service SHOULD take to improve

- Make arrangements for the security of blank prescription forms when not in use.

Ashington House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a specialist practice manager and an expert by experience.

Background to Ashington House Surgery

Ashington House Surgery, Ashington Way, Westlea, Swindon, SN5 7XY offers general medical services to approximately 10,300 patients. The majority of patients are of working age and there are under 500 patients over the age of 75 years.

There are six GPs who are partners in the practice, four are male and the other two are female. Three of the GPs are full time and the others work on a part time basis. The practice has a contract with NHS Swindon to provide general medical services.

There is a practice manager and deputy practice manager who are supported by administrative and reception staff. The practice employs three nurses, a healthcare assistance and phlebotomist.

The practice is open Monday until Friday from 8am until 6pm. There are extended hours on three days from 7am on Tuesday and until 7.30pm on Tuesday and Thursday. The practice is closed on Wednesday afternoons except for emergency appointments.

The practice is set over two floors in a detached property. There is a ramp to the front of the building however there are steps down to the reception and main waiting area. To overcome this for those with restricted mobility, there is a bell for patients to alert the reception staff and seating so that they can wait at this level. There is level access to the consulting and treatment rooms. Upstairs there were meeting rooms, offices and staff facilities. There were designated toilet facilities for patients with disabilities and baby changing facilities.

To avoid queuing to speak with the receptionist there is an electronic system to enable patients to inform the practice they had arrived for their appointment. It was situated in the small waiting area inside the front door and was accessible to all patients.

The premises had a security system and the alarm was set by the last person to leave the building. There were arrangements in place for staff to attend the practice if needed, in an emergency.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

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?

Detailed findings

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew.

We met with Swindon Clinical Commissioning Group and the NHS Local Area Team on 26 September 2014.

We contacted the community nursing team and received feedback from Healthwatch Swindon.

We asked the practice to send us information in advance of our visit and looked at the NHS Choices website which was set up to enable patients to make comments about their healthcare services.

We carried out an announced visit on 23 October 2014. During our visit we spoke with two GPs, the practice management team, administration and reception staff, a nurse and healthcare assistant. Our expert by experience spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice had a system in place for reporting, recording and monitoring significant events. When significant events occurred, including any referrals to the child protection or safeguarding teams they were analysed and discussed at the weekly practice meetings. The meeting records showed who was present at the discussion, the initials of the patient, date and description of the event. There was a record of what staff considered had gone well, what could have been done differently and what changes were made following the event.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw one of the significant event records was related to a patient who was prescribed non-steroidal anti-inflammatory drugs (NSAID) without gastro-intestinal medicine which should be considered. An action arising from the event analysis was to carry out an audit of patients over the age of 60 years who had been prescribed NSAIDs to check they had also been prescribed the gastro-intestinal protection. Those patients who regularly took NSAID were sent letters and a prescription for the gastro-intestinal protection medicine. National patient safety alerts and new guidelines were discussed at clinical meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The safeguarding children and vulnerable adults protocol outlined who held lead responsibility within the practice, gave definitions of abuse and described the notifications process if abuse was suspected or disclosed. The contact details for making referrals were included. The practice had a copy of the 'No Secrets in Swindon and Wiltshire' document that outlined the local authority responsibilities and procedures.

We asked two staff what they would do if they had concerns about a child or vulnerable adult. They knew who the practice lead was and said they would report concerns to the practice manager. Staff said they would refer to the practice policy however, they were unable to find it when they looked on the practice computer network. We brought this to the attention of the practice manager who immediately transferred it to an area of the network all staff could access.

The practice maintained a register of vulnerable children and adults. They received reports from Swindon Borough Council of any child protection, safeguarding vulnerable adults or domestic violence case conferences. These were brought to the attention of the patients GP who signed to indicate they had read the report. These were then filed away securely away for safekeeping. The register of those affected included the patients name, date of birth the date then were added to the register and the name of any health visitor involved. The records were discussed in meetings with the health visitor's team and updated as new information was received.

Staff training records showed all staff completed training in safeguarding vulnerable adults and child protection. The practice lead for safeguarding and child protection had completed training at level three, as required.

Some staff had received training so they could act as chaperone, if requested. The names of staff were listed in the chaperone policy that outlined the guidelines for how to act as chaperone and confidentiality.

Medicines management

Each day there was a dedicated member of staff to deal with repeat prescription requests. Patients requested them on line, or in writing and the prescriptions were prepared ready for the GP to sign.

We asked one of the GPs what happened if patients did not attend for health, disease or medicines review. They explained how this was difficult as there were a few patients who were reluctant to attend reviews for a variety of reasons. They told us how attaching reminders to prescriptions encouraged patients to come in.

A GP told us there were no designated prescribing leads within the practice and all GPs attended prescribing meetings three or four times each year with the NHS Clinical Commissioning Group (CCG).The meetings with the CCG considered clinical effectiveness of medicines and cost effective prescribing and local initiatives such as, which statin to use.

Requires improvement

Are services safe?

The practice used national and local guidance for prescribing medicines and were supported by a pharmacist.

Prescriptions were printed and stocks of blank prescriptions were kept in a locked cupboard, for security. However, the stock of prescriptions in use, were left in the printer overnight and this may pose a risk. The practice should look to improve the way they manage prescription pad security.

The practice held a small stock of pain relief and other medicines to administer to patients as needed. Vaccines were stored in fridges and the temperatures were recorded to ensure the vaccines were kept at the correct temperature. There were no medicines held in the practice that required special storage arrangements. Medicines and vaccines were checked monthly to ensure they had not passed their expiry date.

Cleanliness and infection control

We saw all areas of the practice were clean and tidy. The practice had a cleaning contract with an external contractor. We saw a cleaning schedule which included the frequency for cleaning but, there was no record to show this was followed. Staff who worked in the practice told us they did visual checks of the cleanliness and the contractor did regular spot checks.

Health and safety was discussed at staff meetings and risk assessments were in place. The clinical waste policy outlined the practice responsibilities in this area including the training of staff. The policy referred to the segregation and handling of waste including sharp instruments. We saw that waste was appropriately managed.

We saw the infection control policy statement referred to management of risk associated with healthcare procedures, decontamination arrangements and waste. We did not see an audit of infection control arrangements.

Hand washing guidance was displayed in the practice and anti-bacterial gel was available at the reception desk. There were adequate supplies of soap and hand towels available in all of the rooms we looked in. We saw staff using personal protective equipment. We saw paper covering was used on examination couches and curtains around them were disposable.

The practice did not have a policy relating to spillage of bodily fluids. The practice manager said that if there was a spill in the reception or waiting area they would clean up and ask the cleaner to thoroughly clean the area that evening. The cleaner received training provided by their employer.

The water system was checked for legionella in May 2014.

Equipment

We saw staff attended training in fire safety in March 2014 and we were told they participated in fire drills however; there was no record of this. The fire alarm system was checked weekly and records of tests were maintained. The fire alarm system had not been serviced since August 2013 and was overdue. We saw there was equipment at the bottom of the stairs adjacent to the fire exit and could present a trip hazard in an emergency situation. We were also told by staff that sometimes the gate outside of the fire exit leading to the car park was locked.

We also noted the heating and hot water system boiler was overdue for its annual service although the hot water temperatures were checked monthly. The electrical installation was due to be checked in 2013 and this had not been done. We saw a broken electrical socket cover in the reception area. These placed staff at potential risk of harm due to poor maintenance and repair schedules.

Portable electrical appliances had recently been tested and all equipment used in the practice had been calibrated in April 2014 to ensure it was functioning properly. Staffing and recruitment

The practice had a stable staff group. There were six GPs who were supported by three practice nurses, a phlebotomist and health care assistants along with management, reception and administrative staff.

The recruitment policy stated “the practice has a responsibility to ensure that all employees are treated fairly and equitably, and to ensure that all appropriate current legislation is followed. In order to carry out this responsibility to the highest standard it is essential that recruitment is consistent and managed in the most effective and efficient manner”.

We looked at the records for the four most recently recruited staff and found recruitment procedures had not been followed. All staff had criminal records checks with the Disclosure and Barring Service (DBS) and evidence of their identity and immunisation status.

Requires improvement

Are services safe?

Applicants for employment completed an application form where they were required to record their full employment history. In one of the records we looked at we saw one member of staff had left school in 1973 but only recorded their employment from 2001. The practice manager said this would have been checked at interview.

The recruitment policy outlined that references should be taken but did not specify how many. It stated "when satisfactory references have been received, confirm to candidate that the job offer is firm and unconditional". We saw two references were requested but they were not always received. We saw there were no references confirming the work history and character of the applicants on two of the files we looked at.

When staff accepted an offer of employment they were issued a contract which outlined the terms and conditions of their employment. One of these conditions was that staff were to maintain patients confidentiality and they signed a statement to indicate this. Induction training was recorded and signed off as completed.

The qualifications of nurses were checked and evidence of these and their registration with the nursing and midwifery council were in place. To ensure the needs of patients were met the practice increased the number of nurses from two to three.

We were told the practice rarely used Locum GPs.

Monitoring safety and responding to risk

The practice had a policy indicating there was a 'zero tolerance' to violence. Reception staff had 'emergency' buttons to summon assistance if needed. Staff who had been working in the practice for a number of years had received training in responding to aggression. The practice manager told us this would be arranged again for newer staff.

The practice whistle–blowing policy provided guidelines for staff for what to do if they felt a colleague was acting inappropriately. It gave the procedure to follow and outlined the practice duty to protect staff who reported colleagues.

Arrangements to deal with emergencies and major incidents

All staff attended training in cardio-pulmonary resuscitation (CPR) and the practice had medicines and equipment as recommended by the Resuscitation Council UK. We saw all of the medicines were within their use by date and checked monthly with a record of the check maintained. If emergency medicines were used this was recorded and the health care assistant who checked medicines asked for replacements to be ordered through the local pharmacy.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

When new clinical guidelines were issued they were given to the GP with a lead interest in the subject. They took responsibility for disseminating the guidelines to other staff in the practice at practice meetings.

The practice manager told us that instead of sending letters to invite patients into the practice for influenza vaccination, staff telephoned them. They said this had reduced the number of patients who did not arrive for their appointment. There were similar arrangements for patients who were given cardio-vascular health checks to ensure the appointment was at a convenient time.

In order to reduce unplanned hospital admissions the practice ensured patients with the most unstable conditions were monitored. One of the GPs told us in line with the enhanced service contract for reducing unplanned admissions to hospital, they had in depth care plans for the most vulnerable 2% of its patients some of which were shared with the community matron. The care plans helped to keep conditions and medicines under review. The GP told us there was good liaison with the community matron. The practice had not signed up to the enhanced service contract for patients with dementia. They told us they were considering resource implications before making a decision.

We saw no evidence of discrimination when making care and treatment decisions.

Management, monitoring and improving outcomes for people

To meet Quality and Outcomes Framework (QOF) targets the practice maintained registers and there was a recall system in place which ensured that people on the registers were seen. The practice nurse ran clinics for people with diabetes, asthma, chronic obstructive pulmonary disease (COPD) and vascular disease. If patients did not attend for regular checks the practice would add a note to any repeat prescription or telephone them to remind them to book a review appointment.

The practice aimed to meet the target for QOF by ensuring over 95% of children received immunisation. Reminders were sent for children under five years of age. Immunisation for older children was carried out by school nurses who maintained good liaison with the practice and communicated when immunisation had taken place.

Clinical audits were carried out in line with appraisal and revalidation of GPs. Revalidation is the process GPs go through to demonstrate they have the knowledge and skills to continue to practice. One of the GPs told us that when appropriate additional audits were conducted. We saw there were audits carried out in respect of cancer, heart failure, osteoporosis and hypertension.

The audit of patients with a diagnosis of osteoarthritis (degenerative condition affecting cartilage and the underlying bone) in March 2014 was carried out by an external agency. The audit report made recommendations for the practice and projected the costs and financial benefits of interventions. The practice manager told us the results of the audit were to be discussed at a future educational event for GPs.

The audit of patients diagnosed with hypertension (high blood pressure) considered whether National Institute for Health and Care Excellence (NICE) guidelines had been followed. NICE recommended that patients who were suspected to have hypertension should have an electrocardiogram (ECG) and a check on the albumin/ creatinine ratio (ACR) as part of the initial assessment. The audit identified that 17% of patients had both tests and 17% of patients had neither test. 70% patients had an ECG and 27% patients had the ACR test. We asked the practice manager what actions were taken in response to the audit findings. They spoke with the GP who conducted the audit who said the audit was undertaken to inform all GPs and to raise their awareness. Patients were not contacted directly but when patients attended for appointments the GPs were able to bear the audit results in mind.

When patients needed to be recalled for a blood pressure check a note was added to their prescription. Reception staff were able to carry out the check and sign post patients to a GP, practice nurse or the healthcare assistant. Effective staffing

Training records showed one of the GPs had attended training in minor surgery and an update on diabetes care and treatment. There were records to show nurses had attained further qualifications such as diplomas in diabetes care, asthma care and nurse prescribing. Other training had

Good

Are services effective?

(for example, treatment is effective)

been completed including ear care, contraception, child health, immunisation, cardio vascular disease risk assessment and using equipment to test foot pulses. The practice manager had formal recognised qualifications in management and business administration and finance and had attended training in human resources, employment law, pensions, appraisal and practice management.

We observed how the delegation of tasks to the reception team was efficient in dealing with patients requests. Each of the team stepped in to answer calls for appointments when the practice was busy.

Working with colleagues and other services

The practice worked with other service providers and was supported by community health services to meet patients' needs and to manage complex cases. There were two midwives a community matron and district nurses. The practice manager met with the community matron monthly and information about the patients seen was fed back to staff at practice meetings.

We contacted the community nursing team. They gave positive feedback about working with the practice. They told us there was good two way communication so patients got the correct services. They supported patients with complex health conditions so that unplanned hospital admissions could be avoided.

A community psychiatric nurse was attached to the practice and assessed patients who needed support with their mental health. They referred people for counselling where this was felt to be appropriate. The practice was able to offer patients appointments for counselling with the 'Lift' counselling service, a specialist service for patients in the Swindon and Wiltshire area.

There was a dedicated nurse for carrying out health care reviews for patients with learning disabilities.

There were clinics for minor operations and cryotherapy (wart treatments). In addition a visiting pharmacist ran clinics twice each week for minor ailments.

The practice was part of the 'Navigator' scheme operated by the NHS Swindon Clinical Commissioning Group. A pilot scheme to provide support from various sectors and agencies to deliver a package of assistance to patients locally. A 'Navigator' was employed in the practice. Their role was to liaise with GPs in order to support patients with complex needs following an holistic assessment. They were trained to assess patient's equipment needs and refer to the continence advice service or dietician. One of the aims of the role was to reduce unnecessary hospital admissions.

We met with Swindon Clinical Commissioning Group and the NHS Local Area Team on 26 September 2014. They told us they had no concerns about this practice.

Information sharing

Patients said they were happy with the information provided about the care and treatment they received. They told us how the GPs monitored the effectiveness of medicines and referred them for specialist treatment if necessary. The practice used electronic systems to communicate with other service providers and to ensure timely sharing of patient information.

The practice ran specific clinics for people with long term conditions such as asthma and diabetes. Information packs were available for those with a diagnosis of diabetes.

To ensure patients received their preferred care the practice maintained a register of those with end of life care needs in line with the 'Gold Standards Framework'. It recorded the patient's name, diagnosis and any concerns. There were quarterly meetings that included staff from the local hospice so that information could be shared. The deputy practice manager spoke of good communication and positive relationships with staff from the hospice.

Consent to care and treatment

We saw written guidance on assessing mental capacity in one of the GPs consulting rooms. The GP told us they used their judgement when assessing capacity and would seek advice from the local community mental health team. They were aware of the referral pathway for patients with dementia. We saw there was a dedicated nurse who held reviews for patients with learning disabilities. There was a clinic protocol outlining how these review appointments should be held and what should be checked during them. The practice linked with the community matron to support people with learning disabilities.

We saw there was guidance for staff relating to 'Gillick competence'. This was used to decide whether a child (16 years or younger) is able to consent to his or her own

Good

Are services effective?

(for example, treatment is effective)

medical treatment, without the need for parental permission or knowledge. This was when children who were deemed to be competent to make decisions relating to their care were supported to do so.

Health promotion and prevention

We saw a range of information posters and leaflets displayed in the reception and waiting areas. The practice manager told us the practice encouraged patients to be proactive regarding their own health care and the provision of information was one of the ways the practice achieved this.

When new patients registered with the practice their notes were summarised within eight weeks and they were offered a health check however, not all new patients attended.

The practice nurses ran women's health clinics for contraceptive implants and intra-uterine devises. We saw a log of implants and intrauterine devices and that staff had regular update training.

When appropriate, GPs could prescribe to the 'steps to health' programme, slimming services and respiratory rehabilitation group.

Older people

The practice environment had some limitations for patients with restricted mobility however, there were arrangements in place to ensure they could inform the practice they had arrived for their appointment and to request assistance. When home visits were requested they were logged and a GP contacted the patient to determine if it was necessary. Seasonal vaccinations were offered to older and vulnerable patients to give them protection. The practice worked closely with other services which ensured the needs of patients were met including, at the end of their life.

People with long term conditions

A range of clinics were held which ensured the health care needs of patients with long term conditions were monitored. The practice recognised that some patients had more than one condition affecting their health and was considering how to address this. Audits were conducted to review the care of patients and actions were taken in response.

Families, children and young people

The practice worked closely with community midwives to ensure care and monitoring of expectant mothers. Infants had an initial appointment with a GP for inoculation and were seen in routine appointments for follow up monitoring. Parents praised the way the practice responded to the needs of their child and we saw a child who was unwell being given access to priority treatment. The practice recognised that some children had the ability to consent for treatment and their confidentiality was respected.

Working age people

The appointment system and pre-bookable appointments during the extended hours of opening enabled patients within this group to access a GP at a time which suited them. The practice provided a range of information leaflets to give health and lifestyle advice which enabled some patients in this group to manage their own health.

People whose circumstances may make them vulnerable

There was signposting to other services and the implementation of the Navigator scheme was beginning to enable support to the most vulnerable. The Navigator scheme was introduced by the Clinical Commissioning Group to direct patients to appropriate support services with the aim of reducing hospital admissions. The needs of patients whose first language was not English were understood and the practice provided information on it's website in a range of languages. Staff were observed being patient and helpful with patients who had difficulty understanding because of the language barrier. Whilst the practice was not fully accessible to patients with impaired mobility there were systems in place to accommodate them.

People experiencing poor mental health

The practice liaised with the community mental health team and made referrals for counselling where appropriate. A community psychiatric nurse assessed patients with mental health needs and signposted them to other services. The Navigator scheme was available to support patients.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The practice was 'signed up' to the NHS 'six c's culture of compassionate care'. These were listed as care, compassion, competence, communication, courage and commitment to engage in training. The practice manager told us all staff in the practice treated patients with dignity, respect, empathy and understanding. They said they listened to patients needs and referred to alternative health care providers when appropriate.

Over 80% of patients said they would recommend the practice to others in 2013 National Patient Survey. There were 179 responses to the practice survey conducted by the patient participation group (PPG). The majority of patients rated their experience of privacy and confidentiality at their last visit as 'excellent' or ''very good'. A similar response was received in respect of the warmth of greeting from practice staff.

We observed reception staff during the morning of our visit. There was a calm atmosphere as staff responded to telephone calls regarding appointments. Staff were polite and friendly as they checked patient's details and offered several appointment times until a suitable arrangement could be made. We saw that patient's confidentiality was respected at all times.

We saw the practice website was translated into a range of different languages. We observed reception staff speaking with patients whose first language was not English. They ensured patients understood what was being said in a kind and respectful way.

There was a ramp to the front of the building however there were steps down to the reception and main waiting area. To overcome this, for those with restricted mobility, there was a bell for patients to alert the reception staff and a patient required assistance. Seating was provided so that patients could wait at this level until assistance arrived. There was level access to the consulting and treatment rooms. The patient participation group (PPG) purchased a wheelchair to assist those with restricted mobility inside and outside of the practice. There was a designated toilet facility for patients with disabilities.

The practice had a portable induction loop at the reception desk for patients with hearing impairment who wore hearing appliances that could be switched to the loop facility. Patients with learning disabilities were given longer appointments in recognition of them needing more time to communicate and understand information about diagnosis and treatment.

We saw correspondence from patients who wished to thank practice staff for the way they were treated. Patients complimented reception staff for their assistance, patience and understanding when dealing with them due to their disabilities.

We sent comments cards to the practice in advance of our visit together with a posting box so patients could give us feedback. We received 26 returned cards with comments from all except one to be positive. One question asked patients if they were treated with dignity and respect. The comments praised the administrative staff, nurses and GPs for their consideration and friendliness. Patients referred to being treated with dignity and respect and receiving a good service. Some patients said they would recommend the practice to others.

Care planning and involvement in decisions about care and treatment

We spoke with the GP with a special interest in mental health. They told us the GPs discussed the mental well-being of individual patients as appropriate and would consult with the Community Mental Health Team if needed. Some of the GPs used an assessment tool to assess and diagnose depression. To encourage patient involvement in decisions about their care and treatment they encouraged patients to complete the tool themselves to assess their own mental health within the area of depression.

There were 85 patients on the practice register of people with a diagnosis of poor mental health.

Patients with this diagnosis were invited to the practice clinics for health reviews. Each appointment slot included 20 minutes with the nurse where height, weight, blood pressure and pulse were checked. Patients were asked about smoking and alcohol intake and given advice on health promotion. This was followed by a ten minute appointment with a GP. The health review encouraged patients to become involved in decisions about their care and treatment.

The practice used counsellors from the 'Lift' community psychology service and appointments were made available

in the evenings. Patients could be referred to the service or refer themselves if they preferred and they were seen within two weeks. A GP told us they could also refer to a charity that supported people with poor mental health. A patient who completed a comment card in advance of our visit told us how they appreciated the referral for counselling.

A community psychiatric nurse (CPN) was attached to the practice and assessed those who needed support with their mental health. They referred people for counselling where this was felt to be beneficial or to the Community Mental Health Team (CMHT) if their mental health was more complicated.

The practice developed care plans for patients with poor mental health or followed those devised by the CMHT and liaised with the CPN or community team as appropriate. For those who were seriously unwell the practice referred to the 'crisis team'.

Patients were encouraged to have their blood pressure monitored and reception staff received training to enable them to do the checks. There was a small private area behind the reception area desk where the checks were carried out. The reception staff could sign post patients to other services if the check indicated this was appropriate.

Another patient who completed a comment card in advance of our inspection referred to how their asthma was reviewed regularly and of the benefits this had for them..

Patient/carer support to cope emotionally with care and treatment

There was a peer support group for those patients who had been recently diagnosed with diabetes.

The practice manager and chair of the patient participation group told us there had been carers meetings held and these were successful. They told us there were plans for this monthly support group to be re-introduced. A new member of staff was identified to arrange future meetings and was liaising with the Swindon Carer's Group for support in this area.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The majority of patients registered with the practice were of working age, recently retired or students. In order to meet the needs of those who worked the practice operated extended opening hours in the morning and evening on some days. Most patients who responded to the practice survey knew about the extended opening hours.

One patient attended the practice with an urgent request for a repeat prescription. The patient was satisfied when the receptionist told them they would arrange for a prescription to be ready for them to collect in the afternoon.

Patients with learning disabilities were invited to the practice clinics for annual health checks. Each appointment slot included 20 minutes with the nurse where their height, weight, blood pressure and pulse were checked. They were asked about smoking and alcohol intake and given advice on health promotion. This was followed by a ten minute appointment with a GP.

We spoke with the health care assistant. They ran phlebotomy clinics each day, cardio vascular health checks, routine injections, immunisations, ear syringing and also gave anti-smoking advice. They told us they could redress wounds to support the practice nurse. They told us they attended updates in tissue viability and wound care to keep up to date

We saw the neighbouring pharmacy called to collect prescriptions throughout the day. This meant patient's medicines were dispensed in a timely way. For patients whose medicines were dispensed in a monitored dose pack there was a dedicated member of staff who liaised with the pharmacist.

We received feedback from Healthwatch Swindon. There were mixed views. Some patients from the practice told Healthwatch about positive experiences for them and their children. Others told of difficulty getting an appointment. We did not share these comments with the provider as they were received after our visit.

The patient participation group (PPG) consisted of about eight patients who held monthly meetings. The practice manager was invited to the meetings and was consulted about how the PPG could support the practice. The PPG raised funds for equipment and had purchased items including a wheelchair to assist patients with restricted mobility and an oximeter (for checking a patient's oxygen saturation). The PPG chairperson told us they had asked the practice manager for guidance on how they should spend the funds they had recently accumulated and were waiting for feedback.

Members of the PPG assisted practice staff during the influenza vaccination clinics. We were told this allowed face to face meetings with patients and provided an 'interface' between patients and the practice. The chairperson told us how they met with a patient who was unhappy and relayed information to the practice.

The chairperson of the patient participation group (PPG) told us how the group had put pressure on the practice to improve waiting times. Patients who arrived for their appointment and checked in using the electronic system could now see how many patient appointments were ahead of them.

Tackling inequity and promoting equality

The reception team were organised so they were responsible for various tasks. This included face to face interaction with patients, repeat prescription requests, same day enquiries and dealing with appointment bookings. The member of the team who booked appointments was away from the reception desk which offered patients privacy when discussing their health needs.

Appointments could be booked up to four weeks in advance. If patients telephoned the practice for an appointment on the same day, the receptionist asked them which type of appointment they needed. If all appointments were booked patients could wait to be seen at the end of the day. The practice manager told us they recognised most patients would prefer to see the same GP for continuity of care and wherever possible the practice aimed to accommodate this. The practice was closed for routine appointments on Wednesday afternoons for staff meetings and training but GPs were available in case of emergency.

Some patients said it was difficult to get an appointment when they wanted although some were pleased they had secured an appointment for the same day.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Less than 5% of the patients registered with the practice were aged over 75 years. Some of them lived in sheltered accommodation. Any requests for home visits were listed in a designated book. Requests were taken by reception staff and a GP would call the patient to check the necessity for a home visit. A GP told us there were no issues regarding accessing appointments for older people and most were able to be seen on the same day.

The receptionist who dealt with same day enquiries liaised with GPs throughout the day so they could relay information back to patients. They were able to give patients results of any tests they had and dealt with hospital discharge information.

Access to the service

The practice was open on weekdays from 8.00 am until 6.00 pm. In addition there were pre-bookable appointments on Tuesday evening from 6.30 pm until 7.30 pm and on Wednesday and Friday mornings from 7.00am until 8.00 am. The practice closed at 12.30 pm on Wednesdays except for emergencies.

There were steps to the reception area which restricted access to patients with limited mobility, those who used a wheelchair or mobility scooter or mothers with pushchairs. There was an electronic appointment arrival system and a bell for patients who needed assistance. There was a small seating area at the top of the steps for people to use while they waited for assistance.

One of the GPs we spoke with told us some patients with long term conditions may have multiple conditions and be required to attend several clinics. They told us they were contemplating the introduction of a 'one stop' clinic so patients would not have to return to the practice more than once in each period.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints 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.

The complaints policy was available on the practice website and copies of the complaints procedure were available in the waiting area. It gave a declaration that complaints would be handled positively and in a friendly way. The timescales for responding to complaints were listed along with, contact details of NHS England and reference to the Health service Ombudsman.

A record of complaints was held along with an overview summary. We saw appropriate responses were made. The summary of complaints listed patient details and a summary of the complaint and significant dates.

Patients we spoke with felt their complaints would be taken seriously. Most said they would complain at reception initially although one person told us they would speak with the patient participation group (PPG). Some people did not know of its existence.

Are services well-led?

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

Our findings

Vision and strategy

The practice statement of purpose stated "Ashington house will endeavour to provide quality medical services to its practice population within the local community". It went on to say it would meet the needs of patients in an equitable way, in order to promote better health and prevent illness.

The record of the staff meeting held on 22 October 2014 outlined how the practice was changing to meet patient' needs, including additional clinics and rearranging appraisals for next year.

Governance arrangements

The practice was established 25 years ago and the GP partnership had been stable for 15 years. One of the GPs told us they were cohesive and worked well as a team. Each of the partners in the practice had a special interest. These included diabetes, care of older people, asthma and chronic obstructive pulmonary disease, hypertension, epilepsy, heart disease and mental health. One of the GPs interests were epilepsy, weight management and contraception.

A range of meetings were held. There were meetings between the practice manager and partners and general staff meetings. In addition there were meetings between the practice and community teams. The practice manager told us nursing staff attended the multi-disciplinary team meetings and were sent minutes of other meetings as soon as possible afterwards.

There were quarterly meetings to discuss clinical issues with hospital consultants. We were told during these meetings any new clinical guidelines were discussed.

The practice manager was supported by a deputy manager, reception team and administration staff. Staff described good team working referring to colleagues as supportive.

Leadership, openness and transparency

Staff we spoke with told us they felt supported and described a staff team where everyone got along well together.

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

The PPG and practice jointly carried out a survey of patients. The questionnaires were available at the reception desk and were handed to patients who attended vaccination clinics last winter. The findings of the survey were discussed at various meetings and displayed on the practice website in January 2014. Overall there was generally positive feedback about the practice.

Actions arising from the survey related to communication, appointments, reception and the environment. Some of the actions had been achieved including increasing the frequency of issuing a practice newsletter and the recruitment of an additional nurse. In addition the practice was now messaging patients with appointment reminders to reduce the number of patients who failed to attend appointments. This had increase appointment availability for other patients.

We looked at the NHS Choices website which was set up to enable patients to make comments about their healthcare services. There were 22 reviews the practice manager had responded to in the last 12 months. They were variable with some patients making positive comments about their experiences while others were negative about the practice.

Management lead through learning and improvement

The GPs had regular educational sessions with consultants to review practice and update their knowledge where appropriate. There was a system of appraisal for staff who told us they found them to be useful. Staff meetings were used to identify where improvements could be made and the patients survey also led to actions for the practice.

The practice had developed over time and had a five year strategy that was due for renewal in 2016. We saw the business plan set out the core values and business objectives of the practice. They were concerned with providing a quality service, good financial management and equitable working in the partnership. It recognised that valuing staff was important as was continuous improvement. The practice goals included improving communication, the environment and facilities and maintaining good working partnerships.

We saw the imminent installation of a new, improved information technology system was a major development that would enable the practice system to be compatible with and allow access to systems operated other relevant agencies in the Swindon area.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15 (1) (c).**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment **People who use services and others were not protected from the use of unsafe equipment because equipment was not suitably maintained. Regulation 16 (1)(a).**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **People who use services were not protected because the provider had not ensured the information required to be kept was in place. Regulation 21 (b) Schedule 3 (3)**