Taw Hill Medical Practice

Quality Report

Aiken Road, Swindon, Wiltshire. SN25 1UH
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Date of inspection visit: 21 October 2014
Date of publication: 19/03/2015

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

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Inadequate
Are services effective?	Requires improvement
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

Taw Hill Medical Practice is located in purpose built premises in a semi-rural location. It provides services to approximately 12,000 registered patients. The practice dispenses prescriptions to approximately half of its patients.

We carried out an announced, comprehensive inspection on 21 October 2014. We visited the practice location at Aiken Road. Swindon. Wiltshire. N25 1UH.

Overall we have rated the practice as 'Requires Improvement'.

Our key findings were as follows:

- Patients told us they were happy with the care and support provided by the GPs and nurses and their involvement in decision making about their health and wellbeing.
- Aspects of safe practice were not in place. For example, recruitment processes did not include criminal records checks for all nurses and GPs or risk assessments for staff involved in chaperone support. In addition, emergency medicines and associated equipment were not checked to see if they were safe to use.
- Patients' privacy and dignity were maintained and patients' cultural background and human rights were respected
- The practice did not have processes in place which ensured learning was taken from incidents or complaints, audits or the learning and development needs of staff to improve the performance of the practice.
- The practice worked in partnership with other organisations such as the NHS local area team and clinical commissioning group (CCG), the out of hours GP service and other practices to help improve access to GPs for patients in the local area.

Summary of findings

- Governance arrangements were not in place for several areas relating to the management of the practice. There were no clear decision making pathways which enabled all staff to be clear about their role responsibilities and no forum for staff to raise concerns or suggestions for improvements. Risk management took place in regard of the premises but did not include succession planning, performance or quality management and assurance.
- Patients spoke positively about the effectiveness of their treatment and how the GPs and nurses enabled their health to improve or be maintained. Patients told us they could access appointments at a time which suited them and the quality of their treatment was good. However some comments made by other patients using the NHS Choices website indicated they were dissatisfied with access to appointments.

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

Importantly, the provider must:

- Review its recruitment policy and processes particularly in relation to obtaining criminal records checks
- Undertake risk assessments for employee roles which do not require a criminal records check and who may be required to act as a chaperone for vulnerable patients.
- Monitor emergency medicines to ensure they are within expiry dates and equipment, including first aid equipment, is well maintained
- Review its quality assurance processes to ensure there are effective systems in place to monitor and manage the quality of services to patients. For example, significant events, complaints, patient and staff feedback, training, legionella testing and providing support and appraisals to all staff.

In addition the provider should:

- Consider how it manages and provides hand hygiene facilities to its patients.
- The practice should have better systems in place to ensure the day to day stock control of medicines and prescription pads is monitored.
- The practice should establish and develop its patient participation group as a way of gathering patient feedback.

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?

Inadequate

The practice is rated as inadequate for safe. Staff understood their responsibilities to raise concerns and report incidents and near misses. However, when things went wrong, reviews and investigations were not thorough and lessons learnt were not communicated widely enough to support improvement. Risks to patients who used services were assessed but systems and processes to address these risks were not communicated to staff. Criminal records checks through the Disclosure and Barring Service were not always obtained and risk assessments to determine whether these checks were required where not undertaken. The practice did not have adequate arrangements in place to manage emergencies.

Are services effective?

Requires improvement

The practice is rated as requires improvement for effective. Patients stated a high level of satisfaction with the care and treatment they received. Data showed patient outcomes were average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. People's needs are assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Most staff received training appropriate to their roles however further training needs were not clearly identified, planned or recorded. We saw some evidence that audit was used to improve patient outcomes. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice positively for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Data from the national GP patient survey showed the practice was rated in the middle range for patients who rated the practice as good or very good. The practice was also in the middle range for its satisfaction scores on consultations with doctors and nurses.

Are services responsive to people's needs?

Good

The practice is rated as requires improvement for responsive. The practice reviewed the needs of the local population and engaged

Summary of findings

with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice. Patient feedback reported that access to a named GP was not always available, although urgent appointments were usually available the same day.

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

The practice was equipped to treat patients and meet their needs however information about services and opening times was not consistently provided to new patients. Information to help patients understand the complaints system was not easily available. There was limited evidence of shared learning from complaints.

Are services well-led?

Requires improvement

The practice is rated as inadequate for well-led. The practice had a vision and a strategy to deliver well led services, however not all staff were aware of this and their responsibilities in relation to it. There was a leadership structure and most staff felt supported by their peers but at times they were unclear of who in management to go to with issues. Quality assurance processes were not in place to ensure the quality of services provided to patients was regularly monitored and reviewed.

The practice had a number of policies and procedures to govern activity however, the recruitment policy was new and incomplete. Governance meetings were inconsistently held and feedback from these meetings was not communicated to all staff in the practice. The practice did not have a system for getting feedback from patients and did not have a currently active patient participation group (PPG). All staff had received basic inductions but did not have access to regular staff meetings and events.

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

Requires improvement

The practice is rated as requires Improvement for the care of older people. The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as inadequate for safety and requires improvement for effective 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 average outcomes for conditions commonly found amongst older people. The practice offered personalised care to meet the needs of the older people in its population and had a range of services, for example in dementia and health and wellbeing. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Requires improvement

The practice is rated as requires Improvement for the population group of people with long term conditions. The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as inadequate for safety and requires improvement for effective 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 that had a sudden deterioration in health. When needed, longer appointments and home visits were available. All these patients had access to a named GP if requested and annual reviews were being planned to check their health and medicines needs were being met. For those people with the most complex needs the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Requires improvement

The practice is rated as requires Improvement for the population group of families, children and young people. The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as inadequate for safety and requires improvement for effective and for well-led. The concerns which led to these ratings apply to everyone using the

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practice, including this population group. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances.

Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that 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. We were provided with positive examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires Improvement for the population group of the working-age people (including those recently retired and students). The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as inadequate for safety and requires improvement for effective and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering some online services such as prescription requests as well as a health promotion and screening which reflected the needs of this age group. However some comments made by patients using the NHS Choices website indicated they were dissatisfied with access to appointments.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires Improvement for the population group of people whose circumstances may make them vulnerable. The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as inadequate for safety and requires improvement for effective 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 living in vulnerable circumstances including those with learning disabilities. The practice had carried

Summary of findings

out annual health checks for people with learning disabilities and the majority of these patients had received a follow-up appointment. The practice offered longer appointments for people with learning disabilities if required.

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

People experiencing poor mental health (including people with dementia)

Requires improvement 

The practice is rated as requires Improvement for the population group of people experiencing poor mental health (including people with dementia). The provider was rated as good for caring and responsive overall and this includes for this population group. The provider was rated as inadequate for safety and requires improvement for effective and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The majority of patients experiencing poor mental health had received an annual physical health check. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place care planning for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and local organisations including MIND and similar local services. The practice had a clear system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs.

Summary of findings

What people who use the service say

During our inspection all of the 14 patients we spoke with told us the practice and the support they received was good and they had a high level of satisfaction with all services, whether provided by the GPs, the nursing team or from the reception and administrative staff. Patients told us they were mostly able to see the GP of their choice at a time which suited them for non-urgent appointments and the treatment they received was provided in a safe and effective way. They also told us they found the environment was always clean and tidy. They said GPs and nursing staff, particularly nurses, wore protective equipment such as gloves and plastic aprons during personal examinations.

We received comment cards from 17 patients. All the cards we received provided positive comments about the practice. Patients talked about exceptional GPs who they felt listened to them and put patients first. They also highlighted how access to consultants and specialists was done promptly and how staff worked hard to keep them informed.

A 'friends and family test' survey had recently commenced to find out if patients would recommend the practice to other people. This survey showed 96% of patients were 'extremely likely' or 'likely' to recommend the GP practice. A similar percentage of patients also rated the treatment received from the GP they saw as 'very good'.

Where comments were made about less satisfactory aspects of the practice, for example, the telephone appointment system, we saw these had been responded to by the practice manager. We heard how the practice explained to patients the reasons why a change to a new system was required before the system was implemented. Practice staff recognised that some patients found the system unsatisfactory and patients were invited to speak with the practice about the system.

Areas for improvement

Action the service MUST take to improve

- Review its recruitment policy and processes particularly in relation to obtaining criminal records checks
- Undertake risk assessments for employee roles which do not require a criminal records check and who may be required to act as a chaperone for vulnerable patients.
- Monitor emergency medicines to ensure they are within expiry dates and equipment, including first aid equipment, is well maintained
- Review its quality assurance processes to ensure there are effective systems in place to monitor and manage the quality of services to patients. For example, significant events, complaints, patient and staff feedback, training, legionella testing and providing support and appraisals to all staff.

Action the service SHOULD take to improve

- Consider how it manages and provides hand hygiene facilities to its patients.
- The practice should have better systems in place to ensure the day to day stock control of medicines and prescription pads is monitored.

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Outstanding practice

- The co-development, through the senior partner's role in the clinical commissioning group, of the Swindon area dashboard, DASH reports for patient activity following patient contact with the accident and emergency department and out of hours service.

Taw Hill Medical Practice

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 practice manager and two practice nurses.

Background to Taw Hill Medical Practice

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

There are two partner GPs, one of which worked in the practice one day a week due to their clinical commissioning group commitments. Additionally there are three salaried GPs and six locum GPs in the practice. The majority of locum GPs are regularly employed to cover GP absences such as maternity leave and clinical commissioning group commitments. A team of four nurses, a health care assistant nurse and a phlebotomist provide a range of nursing services and clinics over the five days of the week which the practice is open. In addition there are 14 administrative and reception staff including a practice manager who support the day to day running of the practice.

The practice has approximately 12,000 patients registered from an area immediately surrounding the practice and nearby villages. The practice age distribution is very different to the national average with most patients being under the age of 60 years. Information from our data sources shows the population falls within the least deprived in the country. The Quality and Outcomes Framework (QOF) value for the practice is in the middle range and is indicated as being average.

The practice has opted out of providing out of hours services to its own patients, the service was provided by Carfax Healthcare.

Why we carried out this inspection

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

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

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?

Detailed findings

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We asked the provider to send us information about their practice and to tell us about the things they did well. We carried out an announced visit on 21 October 2014.

We talked with the majority of staff employed in the practice. This included four GPs, two practice nurses, two health care assistant, the practice manager and six administrative/reception staff.

We spoke with 14 patients and received comment cards from a further 17 patients.

Inadequate

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 and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, GPs and nurses reported incidents to the practice manager and these were logged. There had been seven significant events reported and logged by the practice since the beginning of 2014. However non-clinical staff were less clear about the practices formal processes to report incidents and near misses so that significant events, complaints and accidents could be audited and learnt from.

We reviewed minutes of the last review meeting held in March 2014 where significant events were discussed. The notes showed the GP's had considered the significant events, taken action where required but had not stated, clear learning outcomes, timeframes for which the learning should be completed by and who was responsible for any actions. Significant events were not recorded in the practice's monthly clinical meeting minutes.

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 18 months and we were able to review these. Significant events were not a standing item on the practice meeting agenda however a dedicated meeting was last held in March 2014 to review actions from past significant events. Complaints were discussed in a separate meeting. There was evidence that the GPs had taken some learning from these events however findings were not shared with other practice staff. Staff, including receptionists and administrators told us they were not routinely given information about the outcomes of significant events.

We saw incidents were reported by email, these were sent to the practice manager who showed us the system they used to oversee, manage and monitor them. We tracked four incidents and saw records were completed however, there was no evidence to support how promptly they had been responded to. We saw evidence of action taken as a result. Where patients had been affected by something that had gone wrong, they were written to and informed of the actions taken.

National patient safety alerts were disseminated to GPs at clinical meetings. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at clinical meetings to ensure GPs were aware of any that were relevant to the practice and where they needed to take action. There was no evidence of this information having been shared with other staff in the practice.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that not all staff had received relevant role specific training about safeguarding vulnerable patients. We asked GPs, Nurses and administrative staff about their most recent training. They told us they had completed safeguarding vulnerable children training however, they had not undertaken recent update training. Training had not been completed for vulnerable adults. Staff we spoke with were able to describe how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities in regard of information sharing and documentation of safeguarding concerns within the practice but were less clear about who to contact outside the practice both in and out of hours.

The practice had a dedicated level three skilled GP appointed as lead in safeguarding vulnerable children and a similar level for vulnerable adults. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. Most staff we spoke with were aware who the lead GP was and who to speak to in the practice if they had a safeguarding concern. However, the lead person only worked in the practice one day each week which could result in delays in advice being gained and opportunities for midwives or other staff to discuss vulnerable patients being missed due to their absence.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to

make staff aware of any relevant issues when patients attended appointments for example, children subject to safeguarding concerns had alerts placed on their patient record to inform staff of the concerns.

The practice had a chaperoning policy which made clear the roles of staff involved. There was a sign which informed patients about the availability of chaperones in the waiting room and in consulting rooms. We saw from training records and heard from staff that chaperone training had not been undertaken by all staff fulfilling this role. However, staff told us they understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination. We found evidence to show two staff who provided chaperone support had not had a criminal records check through the Disclosure and Barring Service (DBS) and a risk assessment of this had not been carried out.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about each patient including scanned copies of communications from hospitals. We saw limited evidence audits had been carried out to assess the completeness of these records. There was no systematic plan which ensured all records were audited over a period of time.

The practice had clear systems in place for identifying children and young people with a high number of A&E attendances. A daily report was provided which showed all hospital admissions and discharges for all patients known to the practice as well as contacts with the out of hour's GP service. A GP from the practice attended child protection case conferences and reviews. There were systems in place to follow up children who persistently failed to attend appointments, for example, for childhood immunisations.

GPs used the required indicators on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. However, multidisciplinary meetings to discuss vulnerable patients or patients with complex medical needs were not recorded when they took place. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

Medicines management

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

Processes were in place to check medicines such as vaccines but they were not always followed. We found expired medicines on the practice's emergency medicines trolley and which were unsuitable for use. For example, five ampules of one medicine used to make the heart beat faster and reverse the effects of some medicines or poisons reached its expiry date in May 2013. Two other items in the medicines trolley were similarly out of date. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of a practice audit that noted the actions taken in response to review of prescribing data. For example, patterns of contraception prescribing for patients with epilepsy within the practice. The audit identified prescribing was in line with National Institute for Health and Care Excellence (NICE) and the Faculty of Sexual and Reproductive Health's latest guidelines. Where improvements were required as a result of these audits, steps were taken in response. For example, for two patients identified as not using any contraception, where contraception advice had not been recorded for over nine months, an action plan was in place.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance.

All prescriptions were reviewed and signed by a GP before they were given to the patient. New blank prescription forms were held in the practice's safe in accordance with national guidance. However, once the pads were provided to GPs they were not tracked through the practice and were not kept securely at all times. For example, if a GP stepped out of their consulting room leaving the patient in the room, the pads were not kept in locked drawers. Additionally there was no system in place for the formal management of prescribing nurses' prescription pads or an audit of these.

Inadequate

Are services safe?

The practice had established a service for people to pick up their dispensed prescriptions at a choice of pharmacy locations and had systems in place to monitor how these medicines were collected.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Clinical areas of the surgeries had designated clinical spaces with surfaces which could be wiped clean or washed. We saw there were cleaning schedules in place with a recognised external contractor. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. Administration and reception staff had not received induction training about infection control specific to their role or had not received annual updates. We saw the cleaning company and the practice manager carried out hygiene audits that improvements identified for action were completed.

However, the audits had failed to identify that hand hygiene gels were not provided in the reception areas where patients could bring in urine samples or where patients booked in for their appointments electronically. Signage indicated that hand cleaning equipment was located in nearby toilets however this did not encourage patients to follow good hygiene practices. Two foot operated waste bins in public area toilets were broken and required manual opening that could result in cross contamination through contact with waste items.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. For example, during intimate examinations or providing vaccinations. Hand washing sinks with hand soap, hand gel and hand towel dispensers and appropriate clinical waste bins were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). Staff told us they carried out regular checks in line with this policy but there were no records to confirm these checks had taken place.

Equipment

The design, maintenance and use of facilities and premises kept patients safe. The building was constructed approximately 10 years ago and is accessible. 'Staff only' areas such as offices, medicines stores, cleaning stores and equipment areas were fully secured and only accessible with electronic access cards.

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

All cleaning materials and chemicals were securely stored in line with Control of Substances Hazardous to Health (CoSHH) guidance. We were told surgeries were deep cleaned as required and at least annually. All portable electrical equipment was routinely portable appliance tested (PAT) and displayed stickers indicating testing dates.

Staffing and recruitment

The practice had considered how staffing levels and skill mix were planned and reviewed. A rota was in place which allocated sessions for each GP. A similar rota arrangement was in place for the nursing team which focused on sessions and clinics they were involved in. We were told by the staff we spoke with that these staffing levels were the normal day to day levels.

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

Inadequate

Are services safe?

Most staff had been employed by the practice for many years with few staff having been recruited recently. Recently appointed staff we spoke with told us about their on the job induction to the practice and about how colleagues supported them in the early days of their employment. We saw that information was available for new staff about the practice, the systems in daily use and the roles of all the staff.

A recruitment policy was in place which covered aspects of staff recruitment but which missed out key points in regard to how shortlisting should be carried out. What interviews should include, who should carry out interviews and timescales for informing successful or unsuccessful candidates was not made clear. The need for criminal records checks through the Disclosure and Barring Service (DBS) and that references should be gained before the post was offered were also missing to ensure the safety of vulnerable patients. We spoke with a nurse and a receptionist who had been recently employed. Both told us they had not had a criminal records check and they were working unsupervised. This was contrary to the practice's policy.

Reception staff told us they carried out chaperoning support if nursing staff were unavailable. A risk assessment had not been completed for reception staff to carry out this role. This was a particular issue because reception staff did not have criminal records checks through the DBS.

Criminal records checks which were carried out did not include locum GPs employed in the practice. We were told criminal records checks were not done as the locum GPs were on the performers list and would have had a criminal records check when they were put on the list. Staff told us the practice had not considered re-looking at this approach for long standing staff. The practice did not have a risk assessment in place to assess the risks of not carrying out relevant checks to establish whether a GP had been the subject of complaints or disciplinary investigations. The lack of criminal records checks for nurses was contrary to guidance from The Royal College of Nursing. We heard from staff that the nurse had been employed in the practice for many years before retiring and returning; however the risk to patients through lack of checks had not been fully assessed.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. However they did not cover all aspects of the practice for example, recruitment and emergency medical equipment management.

Checks in place included annual and monthly checks of the building, the environment and the safety of other equipment such as fire alarms and extinguishers. The practice also had a health and safety policy. Health and safety information was displayed for staff to see.

Where risks had been identified and were included on a risk log. Each risk was assessed and mitigating actions recorded to reduce and manage the risk. The practice had a detailed business continuity plan, some of these arrangements had been successfully applied during a recent fire alarm incident. We saw evidence that learning had taken place from this occurrence.

Arrangements were in place for staff to call for help in emergency situations. Panic alarms were fitted to reception desks and staff told us they knew how to use them. However they also informed us they had not received any training on managing challenging behaviour or managing conflict, which they had requested.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, for patients with long term conditions there were emergency processes in place to ensure they saw GPs or nurses promptly. Staff gave us examples of referrals made for patients that had a sudden deterioration in health.

Arrangements to deal with emergencies and major incidents

The practice did not have adequate arrangements in place to manage emergencies. In the staff files we looked at we did not see certificates showing staff had received training in basic life support. Reception and admin staff we spoke with told us they had not completed this type of training and that it was the responsibility of the GPs and nurses. An emergency equipment trolley was available in a central location, this included access to oxygen and an automated external defibrillator (AED) (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment. However, the emergency equipment trolley was badly organised and finding

Inadequate

Are services safe?

equipment promptly was difficult. Emergency medicines in the top drawer of the trolley were accounted for however, medicines elsewhere in the trolley were not routinely checked.

Emergency medicines were available in the equipment trolley and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were not in place to check emergency medicines were within their expiry date and suitable for use. We found medicines were out of date and the contact pads for the AED device were significantly past their safe to use by date. This placed patients at risk of significant harm. New replacement pads were ordered during our visit. A plan was put in place to ensure patient safety until replacement pads arrived

First aid equipment was located in first aid boxes in the practice. When we checked the content of these boxes we found many items had exceeded their use by date and could result in them not being sterile or safe to use on patients.

A business continuity plan was in place to deal with a range of emergencies that could impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire alarm tests were undertaken.

Requires improvement

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 treatment approaches. Staff telephoned patients with test results. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. However, we observed that there were no formal mechanisms for this information to be disseminated to all staff. For example, practice meetings had not taken place for over six months, nurses met informally over lunch and no meetings we held for administrative staff. We found from our discussions with the GPs and nurses that staff completed, in line with National Institute for Health and Care Excellence (NICE) guidelines assessments of the most vulnerable patients' needs. However, these were not routinely reviewed and could result in treatment being less effective.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. The GPs and nurses told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and how other nurses supported this work which allowed the practice to focus on specific conditions. Our intelligence monitoring data showed us the practice's performance for effective patient care in these areas was comparable to similar practices in the area. In other areas the practice population demographic and the weighting of the data provided resulted in some indicators being highlighted as concerns. We spoke with the registered manager about this. They told us weighting had not been applied and therefore produced higher levels of concern than were actually the case.

Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers were referred and seen within two weeks.

Management, monitoring and improving outcomes for people

All the patients we spoke with during our inspection were complimentary about the care and treatment provided by the GPs and nurses in the practice. These comments were corroborated by the comment cards we received and the thank you cards we saw in the practice.

Information about the outcomes of patient care and treatment was not routinely collected and monitored. Where information was collected it included an assessment of patient needs, diagnosis of their condition and referrals to other services. The management of patients' long-term or chronic conditions, including those in the last 12 months of life was undertaken by practice staff. Patients with diabetes, asthma and chronic obstructive pulmonary disease (COPD), received outcome monitoring during routine appointments with the nursing team. However, there was no system in place for routine recall appointments for patients with this diagnosis.

The practice showed us examples of three clinical audits that had been undertaken in the last year. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, inviting two patients diagnosed with epilepsy for consultations as they had not received contraception advice for up to six years. Other examples included antibiotic prescribing and a retrospective audit and reflection on a clinical session.

The clinical team was making use of clinical staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. However these discussions were not minuted or collated so that improvements could be measured

There was a protocol for repeat prescribing which was in line with national guidance. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice used the Swindon area Optimise Referral Management system to support consistent evidence based referrals throughout the practice. Over one hundred referral pathways are in the online system. The system uses a series of check boxes to make sure GPs have tried other

reasonable treatments before a referral is made to secondary care. The system helped ensure patients received the most appropriate referral for their required treatment.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes in some areas that were comparable to other services in the area. For example, influenza vaccinations and the reported prevalence of Coronary Heart Disease (CHD). Other areas were less positive for example blood pressure monitoring for patients diagnosed with hypertension.

Effective staffing

The practice manager told us they checked that GPs and nurses were registered at the level stated and the registered manager checked they maintained their continuous professional development. However these checks did not include locum GPs or nurses. We saw there were opportunities for staff to take on new responsibilities, for example phlebotomy (a process to draw blood from a patient for clinical or medical testing) and to enhance their current learning.

We reviewed staff training records and saw not all staff were up to date with attending mandatory courses such as annual basic life support, infection control and moving and handling people. The learning needs of staff for induction training and routine annual updates, for example infection control, health and safety and safeguarding vulnerable adults were not well managed and the record of training undertaken by staff was poorly maintained. GPs and nursing and admin staff we spoke with told us they had not undertaken any information governance training.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology. Those with extended roles for example, seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles. There was no evidence of nurse appraisals in the staff files we looked at.

Opportunities to improve performance were currently limited due to the commitments of the partners in the practice and the challenges faced due to future, planned, staff departures. A cohesive strategy had not been developed which provided leadership through regular staff support for the whole staff group. On-going support sessions, one-to-one meetings and general staff or team meetings had not taken place for over six months. The systems for communicating information tended to be informal and went unrecorded.

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

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and taking action on any issues arising from communications with other care providers. The GP or nurse seeing these documents and results was responsible for the action required.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract). The practice held multidisciplinary team meetings every three months to discuss the needs of complex patients. For example, those with end of life care needs or children on the 'at risk' register.

The practice had been involved in the co-development of the Swindon area dashboard, DASH reports. The DASH reports were provided to the practice by the hospital team and showed patient activity following patient contact through hospital admissions, the accident and emergency

Requires improvement

Are services effective?

(for example, treatment is effective)

department and out of hour's service. This information enabled the practice to arrange follow up appointments with patients when they were discharged or an appointment was needed.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making 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). Staff reported that this system was easy to use.

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

The systems that managed information about patients supported staff to deliver effective care and treatment. The system gathered and shared information between different computer based and paper-based systems keeping patient information in one place. Paper documents were scanned into the system so they could be easily accessed and the information shared. Emergency processes were in place for the 2% most vulnerable patients and referrals were made for patients in this group that had a sudden deterioration in health. There were systems in place which alerted GPs each day to hospital admissions and discharges so that on-going patient monitoring and follow up appointments could take place.

Consent to care and treatment

The patients we spoke with told us that their consent was always gained before intimate examinations were undertaken or treatment was provided. The staff we spoke with were able to demonstrate they understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. All GPs and nursing staff had undertaken training in this subject as part of their safeguarding and children in need training. Where there was doubt about a patients' capacity to make decisions, the GPs and nurses sought advice from an experienced colleague. They also explained to us that they would involve partners and carers in decision making.

Where a patient's mental capacity to consent to care or treatment had been assessed, this was recorded in the patient's record. The nurses we spoke with told us that where they provided care and treatment for children and young people they carried out assessments of their capacity to consent in line with Gillick competency advice (a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge). When patients lacked the mental capacity to make a decision staff made 'best interest' decisions in accordance with legislation.

Health promotion and prevention

The patients we spoke with throughout our inspection told us about how they were encouraged by the GPs and nurses to follow healthy lifestyles. Where they were diagnosed with diabetes or high blood pressure they were given information and advice from their GP or nurse.

The GPs and nurses we spoke with told us they used every opportunity to identify potential risks to a patients' health and provided them with information leaflets and advice. Where patients required specialist advice, they were referred to other services to support them to live healthier lives. For example, to local drug and alcohol services. However, the practice had very little information by way of leaflets and posters in the waiting areas of the practice. Information about current health promotion campaigns for example, flu vaccination, was missing. We saw flu leaflets were stored in their original packaging in a store room. Where information was available it was located in an area not accessed by most patients and did not ensure patients had access to information which might promote their health unless it was provided by their GP or nurse

There were screening programmes for patients who required blood thinning medicines or those diagnosed with diabetes. There were vaccination programmes for babies and young children with higher than average completion when compared to the CCG area. Vaccinations for children

Requires improvement

Are services effective?

(for example, treatment is effective)

in all age groups were above the national average for this practice. For example, 98% of 24 month old children had received meningitis C vaccinations compared to the CCG average of 96%.

Patients who may be in need of extra support were identified, for example patients who were caring for a partner or those who were recently bereaved. We heard from patients how they were provided with counselling or put in touch with carer groups. The nurses we spoke with told us about follow-up appointments following the outcome of health assessments and checks.

The practice only had 121 patients over the age of 75 years registered with them, all had a named GP and a written care plan. All elderly patients discharged from hospital received a follow-up consultation. Annual medication reviews for polypharmacy (the use of multiple medicines by patients) were carried out opportunistically at routine or follow up appointments.

Patients with long term conditions had access to clinics for conditions such as, diabetes, cardiovascular disease, musculoskeletal conditions, chronic obstructive pulmonary disorder (COPD) and long term neurological disorders. The practice had adopted the use of summary care records to assist in sharing information with other services such as A&E departments.

Families, children and young patients had access to vaccination clinics. The immunisation rates for all standard Immunisations including diphtheria, pertussis (whooping cough), and tetanus (DPPT) and measles, mumps, and rubella (MMR) and Rotavirus were amongst the highest in the clinical commissioning group (CCG). We saw evidence of signposting young people towards sexual health clinics or offering extra services which included contraception advice.

Patients from the working age population had access to appointments between 8am and 8pm in partnership with the local 'Success' extended hours service. These appointments were available seven days a week. The practice offered health checks opportunistically to patients who worked. About 75% of female patients from the practice took up opportunities for cervical smear tests.

Patients whose circumstances may make them vulnerable for example, patients with learning disabilities received annual follow-up appointments. We saw information was available via GPs and nurses about various support groups and voluntary sector organisations for example, Mencap.

Patients who experienced poor mental health received an annual physical health check. We saw information was available via GPs and nurses about various support groups and voluntary sector organisations for example, MIND and the local primary care psychology services.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The patients we spoke with made positive comments about the caring and supportive nature of all the staff within the practice. The nursing team was highlighted as being professional, knowledgeable and caring and in providing care and treatment which preserved the dignity of patients.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, a survey of patients undertaken by the practice's previous patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'In the middle range' for patients who rated the practice as good or very good. The practice was also In the middle range for its satisfaction scores on consultations with doctors and nurses with 82% of practice respondents saying the GP was good at listening to them and 80% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 17 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with 14 patients on the day of our inspection. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff understood and respected patients' personal, cultural, social and religious needs, and took these into account when supporting patients. All the patients we spoke with told us the GPs and nurses took time get to know them and allowed time for problems to be discussed. We were told how patients were offered appointments with GPs of their own gender and a chaperone if required.

Staff took the time to interact with patients and those close to them in a respectful and considerate manner. We heard from patients how staff showed an encouraging, sensitive and supportive attitude to people and those close to them during appointments and if contacting them by telephone or letter. Where carers accompanied patients to appointments we saw they were involved in consultations and how they were encouraged to complete carer forms so that support networks could be recorded on patient records.

Staff such as GPs and nurses made sure that patients' privacy and dignity was always respected during physical or intimate examinations by making sure consulting room doors were closed, windows were frosted or covered and screens were used in clinical areas. A chaperone service was promoted around the practice and in the consultation rooms. The waiting area was away from reception desks which helped support patient privacy. Separate rooms were available for private discussions.

We observed staff were careful to follow confidentiality processes when discussing patients' treatments. The practice switchboard was located away from the reception desk and was in a separate room which helped keep patient information private. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 62% of practice respondents (In the middle range) said the GP involved them in care decisions and 68% felt the GP was good at explaining treatment and results. Both these results were in the middle range compared to national data.

The patients we spoke with told us staff communicated with them in a way that they understood and which ensured their care, treatment or condition was clearly explained. Staff recognised when patients and those close to them needed additional support to help them understand or be involved in their care and treatment. The practice had access to the NHS language line service for interpreters and a hearing loop was available for patients who were deaf or were experiencing hearing difficulties.

Good

Are services caring?

Patients told us that staff made sure that they and those close to them were able to find further information or ask questions about their care and treatment. They told us about being given leaflets, having discussions or being shown where to find information on the internet

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, 72% of respondents to the National patient survey said the last GP they saw or spoke with was good at treating them with care and concern. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Staff such as GPs and nurses understood the impact that a patient's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially. We heard from patients how they were given appropriate and timely support and information to cope emotionally with their care, treatment or condition; such as being diagnosed with cancer. We heard how they were also signposted to other support services such as counselling or to cancer support organisations locally.

Notices in the patient waiting room, on the TV screen and patient website also told people how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the information available for carers to ensure they understood the various avenues of support available to them. Staff told us families who had experienced bereavement or loss were called by their GP. This call was either followed by a patient consultation or was directed to an external support service. Patients we spoke to who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The practice used the audits they carried out as a risk tool, which helped GPs detect and prevent unwanted outcomes for patients with some diagnoses. This helped to profile patients by allocating a risk rating dependent on the complexity of their disease type or multiple co-morbidities. Patients at most risk were placed on the 2% most vulnerable patients list and were regularly monitored.

The NHS England Local Area Team (LAT) and clinical commissioning group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements. We saw minutes of meetings where this had been discussed and actions agreed to improve services and manage the delivery of healthcare to the local patient population. Service priorities included urgent care, cancer identification, self-care and prevention, carer support, children, long term conditions, end of life care, mental health and learning disability services.

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

The patients we spoke with during our inspection told us the services provided reflected the needs of the population served and they provided flexibility, choice and continuity of care. This included longer appointments for those that need them, for example, for patients who were carers. It also included appointments with a named GP or nurse, choice of a male or female GP, or a home visit for patients that would benefit from these. Patient feedback from the National GP survey and the NHS Choices website showed that access to a named GP was not always available, although urgent appointments were usually available the same day.

The practice premises included a range of purpose built facilities including consulting rooms, clinical areas, surgical theatres, offices and meeting rooms. The facilities were provided over two floors and had lift access to all patient areas. There were facilities for mothers and young children, patients with reduced mobility or who used a wheelchair. There was a range of modern equipment available in the clinical areas, most of which was routinely maintained. Some areas of the premises were rented to other complementary services such as physiotherapy.

The practice did not have an active patient participation group although staff told us the practice had been trying to gain patient involvement for several months. The practice had just commenced a "friends and family test" survey. This survey showed 96% of patients were 'extremely likely' or 'likely' to recommend the GP practice. Additional limited patient feedback had been gained from a suggestion box located in the practice however this had not been included in complaints or survey reports. Four of the patients we spoke with said they had been asked to complete patient satisfaction surveys or other forms to gain their feedback about the services provided.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, patient appointments were provided between 8am and 6:30pm. With additional appointment support to 8pm provided by the Success service, this allowed working age patients and school age patients to access their services as well as other population groups. A range of clinics were available to support mothers and babies, older people and vulnerable patients.

The practice maintained a list of its most vulnerable patients and those with complex needs. For example, those living with dementia, or those with a learning disability. Information about these patients was shared with the out of hour's service to ensure care plans were shared and key contact carers were identified. Information about diagnosed illnesses was made available to patients and their carers as well as information about other support services and organisations.

The practice engaged with patients who were in vulnerable circumstances. For example by visiting elderly patients in nearby residential and nursing homes. Patients with learning disabilities living in the community were also

Good

Are services responsive to people's needs?

(for example, to feedback?)

provided with home visits if required as well as being encouraged to attend the practice for appointments. Patients with a mental health diagnosis were seen in the practice and benefitted from prompt referrals to other community based support services. This included services specifically for children.

The practice was situated on the ground and first of the building with most services for patients on the ground floor. There was lift access to the first floor. The practice had provided turning circles in the wide corridors for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Appointments were available from 8am to 6:30pm on weekdays and were extended to 8:00pm through the 'Success' urgent care service. This service was also available from 8:00am to 8:00pm at weekends. Information was available to patients about appointments via a link on the practice website. 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 they should ring depending on the circumstances. Information on the out of hour's service was provided to patients.

The patients we spoke with were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see one of their choice. Home visits are available where needed and longer appointments were provided for patients with complex illnesses and when needed to discuss diagnoses such as cancer.

The practice was situated on the ground and first floors of the building with the majority of services for patients on the ground floor. Lift access was provided to the first and second floors. There was sufficient space in the corridors for the use of patients with mobility scooters. The lift could also accommodate this type of mobility aid if required. This made movement around the practice easier for patients and helped to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with wheelchairs, mothers with children in pushchairs and allowed for easy access to the treatment and consultation rooms. Accessible facilities were available for all patients who attended the practice and included baby changing facilities.

The practice had a population of predominantly English speaking patients. Those patients who spoke different languages could be supported through a translation service.

For patients of working age an online booking system was available and patients told us it was easy to use. Staff telephoned patients with test results. To respond to demand the practice had provided three duty GPs on each Friday in addition to their normal GP rota. Telephone consultations where appropriate, were available to this and other groups of patients. The practice provided support to enable patients to return to work and provided "fit notes" when patients were fit to return to work.

We observed that appointments generally ran on time. Where we observed that appointments ran late the majority understood the reasons for this and told us they valued the flexibility of GPs in spending the time to listen to their problems. However, one or two patients told us they would have preferred being informed about how long the wait might have been.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. This was supplemented by a policy document, invitations for patients to make comments via the practices NHS Choices website as well as through a suggestion box in the practice. There was a designated responsible person who handled all complaints in the practice. The majority of patients we spoke with knew how to make a complaint or felt able to raise concerns with the practice.

We asked the practice to provide us with a summary of complaints they had received and the actions they had

Good

Are services responsive to people's needs?

(for example, to feedback?)

taken. There were 14 complaints in the summary. Examples of these complaints concerned making appointments, staff attitude, concerns about treatment and referrals to specialists. The action the practice took was in line with their policy, with all complainants having been responded to. However, the complaints log did not accurately reflect who had responded to the complaint; the timescales, learning, when action points had to be completed by or who was responsible for carrying out the actions.

There had been 10 comments made on the NHS Choices website to which the practice had responded. The comments left by patients had not been included on the comments log.

Minutes of clinical meetings showing that complaints were discussed to ensure those staff were able to learn and contribute to determining any improvement action that might be required. However, without meetings for other staff groups there was no formal mechanism that ensured all staff were made aware of the improvements required.

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 deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy. The practice vision and values included, to offer skilled care to enable patients to achieve their optimum state of health and well-being; treat all patients with respect at all times; uphold the human and citizenship rights of all who receive treatment, work and visit the practice; support individual choice and personal decision-making as the right of all patients. Respect and encourage the right of independence of all patients; recognise the individual uniqueness of patients, staff and visitors, and treat them with dignity and respect at all times; respect individual requirement for privacy at all times and treat all information relating to individuals in a confidential manner.

The staff we spoke with were aware of the strategy but told us they had not been involved in its development. They told us that because there were no staff meetings they had not had a chance to discuss how the values were used in day to day practice. They told us they were unaware about whether the values were measured or changed to help improve the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice or in the practice manager's office. We looked at 12 of these policies and procedures. The majority of the policies and procedures we looked at had been reviewed and were up to date. However the practice did not have a system in place which ensured staff had read and understood the policies. The practice did not hold recorded governance meetings to review these policies. There was no record of information governance training and both GPs and nursing and administration and reception staff we spoke with confirmed they had not received such training,

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data available to us at the time of our inspection for this practice showed 14 of the outcome measures were indicating areas of risk. We spoke with the senior partner about this information. They told us they had raised concerns about the ratings as they felt population group weighting (a way of establishing overall scores) had not been applied to their practices scores.

The practice nurse told us about a local peer review system they took part in with neighbouring GP practices. However, formal arrangements for the clinical supervision of nurses and membership of a nurse prescribing forum for the independent nurse prescribers, was not in place. The nurses we spoke with stated they gave each other informal supervision and sourced their own prescribing updates. This was not in line with guidance from the Nursing and Midwifery Council (NMC) (2006) Standards of proficiency for nurse and midwifery prescribers.

The practice had completed a number of clinical audits, for example contraception advice provided to patients diagnosed with epilepsy; antibiotic prescribing and a retrospective reflection audit on a clinical session. Each audit had produced results which indicated no need for changes to the way GPs had practiced.

An initial audit looking at urgent, on the day appointments had also been implemented. This was prior to the 'Success' urgent illness clinic service being established. The intention was to carry out another audit after the 'Success' service was fully implemented. This would allow the practice to see if they had been successful in referring minor illness to the service, resulting in the practice having more appointments available for patients.

The practice had arrangements for identifying, recording and managing risks in regard of the premises and equipment. The practice manager showed us their risk log which addressed a wide range of potential issues, such as health and safety; fire safety, lone working, display screen equipment and the environment. We saw that the risk log was regularly reviewed and updated with each room having a separate risk assessment. The staff we spoke with told us if they identified risks they would pass these on to the practice manager who would ensure action was taken to reduce or remove the risks. However some risks had not been identified or reported. For example, criminal records checks, staff training and medical equipment.

Governance arrangements had not identified issues with other aspects of the way the practice was managed. For

Are services well-led?

Requires improvement

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

example, criminal records checks for staff who worked with vulnerable patients and training for staff who were new to the practice or who required refresher training to maintain their skills and knowledge.

Leadership, openness and transparency

There are two partner GPs, one of which worked in the practice one day a week due to their clinical commissioning group commitments. Additionally there are three salaried GPs and six locum GPs in the practice. The practice is a registered teaching practice with two partners forming the leadership team. The registered manager, who is the main partner, was currently contracted to the NHS clinical commissioning group four days each week and did not provide clinical sessions in the practice. The other partner provided six clinical sessions each week.

We were shown a leadership structure which had named members of staff in lead roles. For example, there was a lead nurse for infection control and one of the partners was the lead GP trainer. We spoke with six members of staff about leadership and they were all clear about their own roles and responsibilities. They all told us that they felt well supported by their immediate peers but lacked a whole practice approach to the way services were delivered and developed.

The practice manager was responsible for human resources as well as other policies and procedures. Staff we spoke with told us they knew where to find these policies if required. Most policies were reviewed and up to date, however the recruitment policy was new and did not include all steps required for safe recruitment. For example, criminal records checks through the Disclosure and Barring Service.

There was a lack of formal processes in place for leaders to encourage cooperative, supportive and appreciative relationships between all staff. There were very few staff meetings or other occasions where the whole team could raise issues and discuss them together. In this regard staff told us they felt unsupported except from their immediate peers.

Seeking and acting on feedback from patients, public and staff

The practice was in the process of establishing a patient participation group. A patient participation group is one of the ways GP practices can demonstrate they are fulfilling their responsibility to consult with patients to help inform and improve the services they offer. Other formal processes were also not in place, for example, patient surveys. There was a suggestion box in the practice, a 'friends and family test' survey had recently been started and one GP showed us a large number of 'thank you' cards from patients. However, these feedback comments were not collated with comments from the NHS Choices website to inform how the practice might improve its services.

Patients who used the practice, those close to them and their representatives told us the GPs and nurses actively engaged and involved them in decision-making. This engagement focused on their individual health needs, the choices of treatment available to them and the impact on their wellbeing rather than practice improvements. All the patients we spoke with told us they had not been asked to complete patient satisfaction surveys or other forms of patient feedback This was confirmed to us by the practice manager. The staff we spoke with told us they felt engaged with at the level they worked at but felt their views were not always reflected in the planning and delivery of services or in shaping the culture of the practice.

The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice.

Management lead through learning and improvement

Staff worked individually towards continuous learning, improvement and innovation through a range of learning opportunities. For example, local professional groups and online learning providers were used. Each GP and nurse took responsibility for their own continuous professional development however; this was not always monitored in line with professional guidelines. The nursing staff we spoke with told us about attending locally based specialist training to enhance their role, for example in diabetes treatment and support. This enabled the practice to support this group of patients more effectively.

The practice was unable to reassure us that all staff regularly had access to meetings which allowed them to work together to resolve problems and to review performance. Opportunities to improve performance were currently limited due to the commitments of the partners in the practice and the challenges faced due to future, planned, staff departures. A cohesive strategy had not been developed which provided leadership through regular staff

Are services well-led?

Requires improvement

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

support for the whole staff group, careful analysis of learning from incidents, complaints and significant events. There was also no system for regularly reviewing learning and development needs for all staff. The practice was engaged with the 'friends and families test' but did not have a system for gaining patients' views about the quality and management of services they received.

The practice was a GP training practice. One of the partners provided GP trainer support to registrars at the practice.

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 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person must ensure that information specified in Schedule 3 is available in respect of a person employed for the purposes of carrying on a regulated activity, and such other information as is appropriate. **Regulation 21 (b)**

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 The registered person must make suitable arrangements to protect service users and others who may be at risk from the use of unsafe equipment by ensuring that equipment provided for the purposes of the carrying on of a regulated activity is properly maintained and suitable for its purpose. **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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity. **Regulation 13**

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. **Regulation 10 (1)(a)(b)**