Hawthorn Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Hawthorn Medical Centre is a GP practice situated in Swindon and has approximately 12,000 registered patients. Our inspection team was led by a CQC Lead Inspector**.** The team included a GP, a practice manager and two practice nurses. All team members had been involved in previous CQC inspections across a range of service types including, GP practices and hospitals. All team members had many years' experience in their fields of employment

We carried out an announced, comprehensive visit on 1 October 2014. During our visit we spoke with a range of staff. These included GP partners, salaried GPs, nurses, a health care assistant, a phlebotomist (someone who is trained to take blood samples) and administration staff. We also spoke with patients who used the practice and we reviewed comment cards where patients shared their views and experiences of treatment and care provided by staff.

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

The overall rating for Hawthorn Medical Practice is good. Our key findings were as follows:

- Patients felt they were treated with kindness and professionalism.
- Mechanisms were in place to report and record safety incidents, including concerns and near misses, and to learn from them.
- The practice was clean and tidy, and infection prevention and control protocols were implemented.
- There were six weekly gold standard framework meetings with the multi-disciplinary team which consisted of community district nurses, mental health nurses, health visitors to discuss and meet the needs of patients with palliative care needs.
- As a result of a high rate of referrals to hospital to the ENT (ear, nose and throat), general surgery and

rheumatology. Consequently the practice put in place a system of GP peer review to look at the consistency of its referrals and to identify reasons why the referral rate was high.

We saw several areas of outstanding practice including:

- In response to a prevalence of obesity and diabetes in the local population, the practice had developed an innovative service for patients with diabetes which included a specialist diabetes clinic where patients with complex needs were started on insulin/injectable treatment without the need to be referred to a hospital. Two of the GP partners were trained to run these clinics, which were linked with a hospital consultant who specialised in diabetes.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, reviewed and addressed. Risks to patients were assessed and generally well managed. Recruitment checks were undertaken. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. Guidance from the National Institute for Health and Care Excellence (NICE) was referenced and used routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included the assessment of capacity and the promotion of good health. Staff received training appropriate to their roles and further training needs were identified and planned. Staff had appraisals and had personal development plans. There was evidence of multidisciplinary working.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of its local population and responded quickly to improvements suggested by its patient participation group. Patients reported about recent improvements in accessing the practice. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy for delivering services and meeting patients' needs. Staff were clear about the vision and their responsibilities in

relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings took place. There were systems to monitor quality and identify risk. The practice sought feedback from staff and patients and this had been acted on. The practice had an active patient participation group. Staff received inductions, regular performance reviews, and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. It offered personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in supporting carers and in end of life care. The practice was responsive to the needs of older people, including offering home visits and same day telephone access to a GP for those over 75 years of age. There were strategies in place for reducing unplanned hospital admissions amongst the over 75 year olds. GPs visited local nursing homes where they completed weekly ward rounds to check on patients' health and welfare.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. There were specific clinics for a range of long term conditions including diabetes, dementia, chronic obstructive pulmonary disease (COPD) and asthma. GPs and nurses had taken specific training in the management of these conditions. GPs followed guidance from the National Institute for Health and Care Excellence (NICE) in treating COPD and asthma. In response to a prevalence of obesity and diabetes in the local population, the practice had developed an innovative service for patients with diabetes which included a specialist diabetes clinic where patients with complex needs were started on insulin/injectable treatment without the need to be referred to a hospital. Two of the GP partners were trained to run these clinics which were linked with a hospital consultant who specialised in diabetes. 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. Care was tailored to individual needs and circumstances, including the patients' expectations, values and choices.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, the practice referred children experiencing poor mental health to local mental health services or liaised with members from a local group of practitioners and care workers who come together to offer co-ordinated support to children and young people, and their families. We were provided with good examples of joint working with midwives, health visitors

Summary of findings

and school nurses. Antenatal clinics were available for pregnant women. Young people were offered opportunistic health screening including screening for sexually transmitted diseases. Emergency arrangements 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)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of the working age population, those recently retired, and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible, and offered continuity of care. For example, the flu clinic was by appointment or via a walk-in service on Saturdays.

Health promotion and screening reflected the needs of this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice had a system in place to identify patients with a learning disability and to ensure GPs arranged annual health checks for these patients. Patients with learning disabilities were offered additional time when speaking with GPs and were encouraged to involve their carers in supporting them with communication. Translation services were available for patients whose first language was not English. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns, and how to contact relevant agencies.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). There were strong links with local substance misuse services to which patients were referred when required. Guidelines from the National Institute for Health and Care Excellence (NICE) were used, for example, cognitive behavioural therapy. There was a system for ensuring patients experiencing poor mental health were reviewed. The practice assisted children and young people with mental health concerns. They directly referred patients to the local mental health services or liaised with members from a local group of practitioners/ workers who offer co-ordinated support to the child/young person

and their family. A GP partner cared for patients in a local nursing home specialising in dementia. The practice maintained close links with the local old age psychiatry team to optimise the management of nursing home patients.

Summary of findings

What people who use the service say

The 16 patients we spoke with and all 15 patients who left us comment cards spoke positively about practice staff. They described staff as nice, polite, efficient and friendly.

Patients had a mixed view about the appointment booking system. Six of the 16 patients we spoke with on the day of our visit expressed dissatisfaction with the system. They said appointments were not always available when they needed them. Three of the comment cards we received showed concerns about the appointment system. However the results of the most recent national patient survey in 2013 identified positive feedback from patients about the appointment system. There were 296 surveys sent to patients and 117 were returned with feedback. Of these 67% of respondents described their experience of making an appointment as good and 83% were able to get an appointment to see or speak to someone the last time they tried

The practice recently undertook an audit of the needs of 2% of their patients presenting with complex needs and were identified as being a highest risk. The audit identified 290 patients who required updated care plans. A senior GP partner told us the audit impacted negatively on appointments in the practice as it took GPs time away from face to face contact with patients for around two months. This resulted in patients waiting longer to get appointments and was reflected in the feedback from patients at the time.

Outstanding practice

- In response to a prevalence of obesity and diabetes in the local population, the practice had developed an innovative service for patients with diabetes which included a specialist diabetes clinic where patients with complex needs were started on insulin/injectable treatment without the need to be referred to a hospital. Two of the GP partners were trained to run these clinics, which were linked with a hospital consultant who specialised in diabetes.

Hawthorn Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP specialist advisor. The team included a practice manager specialist advisor and a second CQC inspector.

Background to Hawthorn Medical Centre

The practice provides a range of primary medical services to approximately 12,000 patients. Staffing consists of the practice manager, four GP partners, five salaried GPs, three nurses, three nurse practitioners, a health care assistant, two phlebotomist (someone who is trained to take blood samples) and administration staff. In addition there are administrative and reception staff who support the day to day running of the practice. The practice is a member of the Swindon Clinical Commissioning Group.

The latest demographic population data available for the practice from Public Health England, published in 2013 indicated the majority of the practice's population was older patients of working age. The practice manager told us the patient group was predominately middle aged with complex problems in a relatively deprived area of Swindon. Obesity, weight management, smoking, diabetes and mental health were the practice's main areas of concerns. There was a higher prevalence of asthma, chronic pulmonary disease, dementia, atrial fibrillation (a type of heart condition), and stroke than the national average. Over 10% of the patient population had received some treatment for depression or had presented with low mood.

The practice was a teaching practice. The practice opted out of providing Out of Hours services to its own patients. Outside standard opening hours patients were able to access emergency care from an alternative provider.

Why we carried out this inspection

We inspected this GP practice 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?

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Detailed findings

We carried out an announced, comprehensive visit on 1 October 2014. During our visit we spoke with a range of staff. These included GP partners, salaried GPs, nurses, a health care assistant, a phlebotomist (someone who is trained to take blood samples) and administration staff. We also spoke with patients who used the practice and we reviewed comment cards where patients shared their views and experiences of treatment and care provided by staff.

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

Good

Are services safe?

Our findings

Safe Track Record

The practice had an incident reporting process which was known to all the staff we spoke with. There were documented examples of safety related incidents which had occurred in the practice and been responded to by the staff team. For example, staff found children could trap their fingers in the heavy door to the practice so they made changes to the door. There was a management structure which supported staff to report concerns and staff told us they felt confident in raising concerns.

The practice reviewed and acted on relevant safety alerts. Safety alerts inform healthcare providers of problems with equipment or medicines or give guidance on clinical practice. Staff we spoke with were aware of the incident reporting process and understood how to respond to and report safety related incidents.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring safety incidents and all staff were responsible for reporting them. We looked at the practice's review of significant events in 2013-2014. The review found the practice had a structured approach to significant event reviews and strove to improve its clinical care through reflective practice. There were significant event review meetings to which all GPs were invited and these were chaired by one of the managing partners. Reviews of significant events that related to administrative or reception staff were programmed into their regular weekly and monthly team meetings.

The practice's records showed that since April 2011, there were 68 significant event reviews conducted during 15 case review meetings. Over the past 12 months the practice conducted 21 significant event reviews over 6 meetings. Staff were able to tell us what they had learned from these and the changes the practice had made as a result. For example in 2013 a patient collapsed in reception and received cardiopulmonary resuscitation (CPR). In reviewing the incident, staff found that a more co-ordinated initial response would have made the resuscitation run more smoothly even though it would not have affected the outcome. In response, staff reviewed cardiac arrest procedures and placed copies of the procedure throughout the practice.

Reliable safety systems and processes including safeguarding

Children and adults were protected from the risk of abuse because the practice took steps to identify and prevent abuse from happening. The senior GP partner was the lead for child protection and was able to describe how referrals were made to child protection teams in social services to ensure children's safety.

All staff had received the relevant level of safeguarding training for their role. Training was provided at induction and through an electronic training package which they completed on the computer. The GP partner who was the safeguarding lead had level three training for children and was also trained in protecting vulnerable adults. The other GPs had level two or level three training in child protection. All GPs and nurses we spoke with demonstrated they knew the practice's safeguarding protocols and procedures for both adults and children.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to ensure staff were aware of any relevant issues when patients attended appointments; for example children subject to safeguarding concerns or protection plans had pop up alerts placed on their patient record to inform staff.

The practice had a chaperone policy. There were identified staff members in the practice who acted as chaperones. These included the practice manager, reception manager and one other staff member. Each had undergone a criminal records check and had received chaperone training. A notice was displayed in the patient waiting area to inform patients of their right to request a chaperone.

Medicines Management

There were medicines management policies in place and staff we spoke with were familiar with them. Medicines for use in the practice were stored securely, with access restricted to those that needed it. A designated nurse was responsible for ensuring expiry dates were monitored. This included medicines kept by GPs in their emergency bags. Records were kept whenever medicines were used. Medicines were purchased from approved suppliers. Medicines requiring refrigeration were stored in designated refrigerators for medicines.

Good

Are services safe?

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Processes were in place to check medicines such as vaccines were within their expiry date and were suitable for use.

The practice stored a small amount of controlled drugs on the premises. Controlled medicines were held securely in a specifically designed cabinet. Access to these was limited to authorised staff. Recording systems were in place to ensure the controlled drugs were used and stored in line with legal requirements There were audits of controlled medicines to ensure their safe use.

All prescriptions were reviewed and signed by a GP before they were given to the patient. New blank prescription forms were held securely in accordance with national guidance. A member of the nursing staff was qualified as an independent prescriber and received regular supervision and support in her role. The audit of GP prescribing patterns in 2013 had resulted in improvements in the quality of prescribing within the practice for various medicines groups.

Cleanliness & Infection Control

We noted all areas of the practice were visibly clean and tidy. The treatment and consulting rooms had clutter free work surfaces, which were easy to clean. The treatment room curtains were clean. Labels with dates for their replacement were seen on all curtains and all were within the use by dates. Cleaning schedules were in place and cleaning records were kept. We spoke with patients about the cleanliness of the practice. All of them told us they were happy with the environment and cleanliness.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training in infection control relevant to their role. We saw evidence the infection control lead had carried out infection control audits and areas which fell short of required standards were identified and addressed.

There was a clinical waste contract in place for the collection and disposal of clinical waste. Clinical waste bins were secured shut to prevent the waste from being opened or accessed.

An infection control policy and supporting procedures were available for staff to refer to. For example, personal protective equipment including disposable gloves, aprons and coverings were available to staff to use. We observed staff using personal protective equipment.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers 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). We saw records which confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out examinations and to provide care and treatment. They told us that all equipment was tested and maintained regularly. We saw records to confirm practice equipment was maintained in line with manufacturers' guidelines. Portable electronic equipment was tested as part of routine maintenance plans. We saw evidence of calibration of relevant equipment like the sphygmomanometer (blood pressure gauge) and weighing scales.

Staffing & Recruitment

We looked at eight staff files, which contained information on pre-employment checks and met recruitment guidelines. There was a documented recruitment policy to support recruitment procedures. All the nurses and administrative staff and, the practice manager had undergone criminal record checks via the Disclosure and Barring Service (DBS) before they started work. The practice manager told us the GPs had undergone criminal record checks through the performers list. There was also documentary evidence the practice checked every GP was on this list before they started work at the practice. GPs and GP trainees need to be registered on the NHS England Medical Performers Register because if they are not on the register, they are not authorised to work.

Locum GPs were booked by the finance manager on instruction from the GP partners. Practice staff told us they generally used locum GPs that they knew. They said they

Good

Are services safe?

always asked for a copy of the GP's curriculum vitae (CV) and checked their General Medical Council (GMC) number. A locum GP's entry on the performers register was also checked before they started work at the practice.

Staff told us there were us usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. We were told, for example, that when a GP was on leave or unable to attend work, another GP from the practice provided cover.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

Identified risks were included in a risk register. Each risk was assessed and mitigating actions recorded to reduce and manage the risk. We saw, for example, risks were discussed at significant event meetings. Arrangements were in place for staff to call for help in emergency situations. Surveillance cameras and panic alarms were fitted to reception desks and were monitored by the reception manager to ensure the safety of staff from any patient challenging behaviour.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Equipment for dealing with medical emergencies was available within the practice, including emergency medicines. Staff had access to a defibrillator and oxygen within the shared medical centre premises for use in a medical emergency. All of the staff we spoke with knew how to react in urgent or emergency situations. We saw 'panic buttons' in situ in all of the consulting rooms and staff told us they could use these to alert other staff in the event of an emergency.

There was a disaster recovery plan in place to deal with a range of emergencies that could impact on the daily operation of the practice. This included planning for significant events that could affect the service. For example, staff sickness, fire and flood.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records to show staff were up to date in fire training and that regular fire drills were undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. GPs and nurses followed the relevant National Institute for Health and Care Excellence (NICE) guidelines for long term conditions management. For example they showed us how they followed the NICE guidance for the diagnosis and management of essential hypertension. A GP told us they kept up to date with new guidance, legislation and regulations and regularly discussed these at their own meetings and at their meetings with other GP practices.

Patients' needs and any risks associated with their treatment were discussed at their initial consultation with a GP. Treatment plans were agreed with patients and then recorded. Patients we spoke with confirmed this was the case.

Management, monitoring and improving outcomes for people

There were systems for managing, monitoring and improving outcomes for patients. In response to a prevalence of obesity and diabetes in the local population, the practice had developed an innovative service for patients with diabetes which ran three clinics each week. There was a specialist diabetes clinic where patients with complex needs were started on insulin/injectable treatment without the need to be referred to a hospital. Two of the GP partners were trained to run these clinics, which were linked with a hospital consultant who specialised in diabetes.

GPs in the practice provided minor surgical treatments in line with their registration and NICE guidance. Staff were trained and kept up to date with clinical developments in this area. Staff regularly audited the results of surgical procedures and used their findings to improve their clinical practice.

Clinical audits were completed and staff were able to provide examples of changes that had been made as a result. For example, the practice conducted an audit where it identified patients with a specific skin condition were taking a medicine that was no longer recommended for the condition. Following the audit, GPs contacted patients with the condition to agree an alternative treatment.

The practice used information collected from the quality and outcomes framework (QOF) to monitor outcomes for patients. QOF is a national performance measurement tool. The practice used information from the most recent QOF, to identify areas for improvement and scored highly across all areas. The practice manager told us the Swindon Clinical Governance Group had identified they had high rate of referrals to hospital for ENT (ear, nose and throat), general surgery and rheumatology. Consequently the practice put in place a system of GP peer review to look at the consistency of its referrals and to identify reasons why the referral rate was high.

Effective staffing

There was induction training for recently recruited staff and staff spoke positively about their induction. The practice had developed an induction programme for new staff that included shadowing an established member of the team. Staff spoke positively about their induction.

There was a system in place to ensure staff received yearly appraisals. We saw a training matrix that confirmed all staff, including GPs, had received yearly appraisals. We saw records which confirmed GPs and nurses were up to date with their professional revalidations. Appraisals contained objectives for the following year and were linked to the practice's service delivery plans.

Continuing professional development and training was available for GPs and nurses. The training schedule for all staff at the practice confirmed mandatory training had taken place in areas such as cardiopulmonary resuscitation (CPR), health and safety and safeguarding children. The reception manager and three receptionists we spoke with confirmed they had taken additional training in customer care. They were able to describe how they used the training to improve their communication with patients.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. For example, the practice manager was involved with the clinical commissioning group, in collaboration with seven other GP practices, to implement and manage additional diabetes services in the community.

Two GPs and a nurse from the practice were also involved in workshops which were organised by the CCG to look at care pathways involving the management of diabetes The workshops included representatives from other GP

Good

Are services effective?

(for example, treatment is effective)

practices, hospitals, the voluntary sector, patients and commissioners. The practice's participation enabled staff to share learning. The practice also worked closely with the local hospital and had close links with the GP liaison manager there to share information.

The GPs undertook home visits and visited the local nursing homes where a named GP completed a weekly ward round to check on residents' welfare. The practice also offered visits to patients in care homes for annual checks such as diabetes. All patients who commented on home visits in the comment cards were complimentary about the services they received.

The practice had close links with the primary care liaison service for patients with mental health concerns who completed mid-week visits to the practice to assist patients. Patients were also signposted to appropriate services in Swindon to receive specialist mental health support.

The practice worked closely with local health visitors, midwives and mental health professionals specialising in paediatric care. The practice ensured it had close contact with other members of the health care team including social workers, health visitors and school nurses through daily, dedicated health professional telephone call slots to facilitate communication.

Information Sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local 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. Patients could use the Choose and Book system. This is a system which enables patients to choose which hospital they will be seen in and to book their outpatient appointments.

The practice had a process in place to follow up patients discharged from hospital, information sharing and continuity of care

The practice had close links with the local hospital to ensure information sharing and continuity of care. Following hospital attendances, GPs contacted patients to assess their condition and offer an appointment for follow up treatment if necessary.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was use by all staff to coordinate, document and manage patients' care. All staff were fully trained in using the system. There were daily and weekly meetings of the practice's GPs and nurses to discuss the treatment and care of patients with complex needs.

Consent to care and treatment

The GPs had undertaken training in the Mental Capacity Act 2005 (MCA) and had invested in training packages to assist them to support patients with diminished mental capacity. They demonstrated knowledge of the issues involved in making mental capacity assessments to ensure patients' safety. GPs and nurses we spoke with understood the principles of decision making with regards to patients who lacked capacity to make decisions for themselves.

Patients gave written and verbal consent to treatment and decisions like the use of a chaperone. Written consent to immunisations and invasive examinations were recorded in patients' notes. Ten of the fifteen patients we spoke with, who expressed an opinion, confirmed they were involved in discussions about their treatment and were asked for their consent to treatment before it was provided.

Patients with learning disabilities and dementia were supported to make decisions through the use of care plans which they were involved in agreeing. Staff were able to give examples of how a patient's best interests were taken into account if a patient did not have capacity to consent to care and treatment. GPs and nurses were able to describe when and how Gillick competencies would be used. Gillick competence refers to an assessment framework which identifies whether a child under 16 has the legal capacity to consent to medical and examination and treatment.

Health Promotion & Prevention

The practice offered all new patients a consultation to assess their past medical and social history, care needs and risks to their health and wellbeing. These were completed by GPs and nursing staff.

There were clinics for coronary heart disease, stroke, hypertension, asthma, chronic obstructive pulmonary disease (COPD) and epilepsy. Nurses told us that as part of this service they talked with patients about managing their long term health conditions and worked with them to develop management plans. Patients with long term conditions were recalled at regular intervals, to check on their health and review their medications.

Are services effective?

(for example, treatment is effective)

There were weight management clinics, a smoking cessation service, and flu clinic which were available in the evening and at weekends.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients told us the practice provided a compassionate, friendly and caring service. All 15 patients we spoke to on the day of our visit spoke positively about the staff team. Of the 15 CQC comment cards completed, 12 patients made direct reference to the caring manner of the practice staff. All staff we spoke with told us patients' care was central to their work. We saw staff treating patients with dignity and respect. We observed reception staff making sure patients waiting to check in or make an appointment were assisted promptly.

In the 2013 national patient survey 83% of the 117 patients who responded said the last GP they saw or spoke to was good at treating them with care and concern

Three staff members had been trained to provide a chaperone service during consultations. Staff told us they made patients aware of the chaperone service but patients did not often use it. Two of the 15 patients we spoke with had used the chaperone service and they were positive about their experiences. All the patients we spoke with knew they could request a chaperone if they needed to.

We saw the practice's policy for protecting the confidentiality of teenage patients. Staff understood the policy and explained how they used it in practice. Staff told us the policy was a regular item on the staff meeting agenda and we saw minutes of these meetings which confirmed this. Confidential information was stored securely in a locked room that was only accessible via a key pad security system.

We observed that consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations, and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. There was a small room next to the reception area which patients could use if they wanted to speak to a receptionist in private.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us they were involved in making decisions about their care and treatment. They said they were given sufficient information to enable them to make informed decisions about treatment and they were offered options of care from which to choose. The practice operated the 'Choose and Book' scheme which meant patients were able to choose where they wanted to be referred for specialist care and treatment.

Patients with long term conditions were supported to manage their health, care and treatment and there were detailed care planning records for patients with long term conditions such as diabetes and asthma. Nurses told us they talked with patients about managing their long term health conditions and worked with them to develop management plans. For example, one nurse told us of a patient who had a long term condition and who expressed concerns about pain relief they used. The nurse told us they looked though the patient's notes with the patient to identify whether the patient had a contraindication for the use of the pain medicine to make a decision about its use.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting area signposted patients to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

Support was provided to patients during times of bereavement. GPs and the practice manager told us sympathy cards were sent to the family once the practice had been notified of a patient's death. The practice also offered details of bereavement services upon request, with information displayed on notice boards in the patient waiting area. Staff we spoke with in the practice recognised the importance of being sensitive to patients' wishes. Staff told us support was tailored to the needs of individuals, with consideration given at all times to the individual's preference. A counselling service was available to patients through referral by a GP. Patients who we spoke with about this service told us they found it useful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

As part of our pre-inspection preparation we looked at the latest demographic population data available for the practice from Public Health England, published in 2013. This indicated the majority of the practice's population were older patients of working age. The practice manager told us the patient group was predominately middle aged with complex problems in a relatively deprived area of Swindon. Obesity, weight management, smoking, diabetes and mental health were the practice's main areas of concerns. There was a higher prevalence of asthma, chronic pulmonary disease, dementia, atrial fibrillation (a type of heart condition), and stroke than the national average.

As a result the practice had developed an innovative service for patients with diabetes which ran three clinics each week. There was a specialist diabetes clinic where patients with complex needs were started on insulin/injectable treatment without the need to be referred to a hospital. Two of the GP partners were trained to run these clinics and the clinics were linked to three monthly joint clinics with the consultant in diabetes. This provided patients with a more accessible service in partnership with the hospital service.

For patients with long term conditions the practice developed a nurse led clinics to support patients in managing their condition. In 2013 the practice started healthy heart clinics so patients with heart or chest conditions had one appointment and all their concerns were dealt with at once.

The practice addressed the mental health needs of its patient population by working closely with a mental health organisation to provide counselling for patients. There were counsellors working on site at the practice four days a week. Patients we spoke with who had used this service commented positively about it.

After the last patient survey the practice's patient participation group (PPG) had identified patients would like text messaging to remind patients to attend appointments. The practice implemented this to assist patients to attend the practice.

The practice assisted children and young people with mental health concerns. They directly referred patients to the local mental health services or liaised with a specialist group of practitioners/workers who offered co-ordinated support to children, young people, and their families.

Tackling inequity and promoting equality

The practice had equality and diversity policy which stated it did not tolerate discrimination. There were also policies called 'dignity and respect' and 'being open' which set out the practice's expectations about how staff should behave and how patients should be treated. The practice had purchased an on-line computer training package which staff told us they used. Staff we spoke with demonstrated they understood issues around equality and applied their knowledge to practical situations.

Access to the service

The practice was a purpose built medical centre, built in 1991. It had been adapted to accommodate a variety of patient needs. For example, there was wheelchair access to the premises and accessible facilities for patients with restricted mobility. We noted the area in front of reception was limited and it would be difficult to use a wheel chair or pushchair in this area when there was a queue of patients waiting to see the receptionist.

The practice had large working population age groups between 19 and 74 years .They accommodated working patient's needs by providing extended hour clinics. They had long opening times between 8.00 am to 6.30pm and extended opening hours twice weekly until 7.30pm on Mondays and Thursdays to suit the needs of working patients. The practice opted out of providing out of hours primary medical services for its patients. Outside normal surgery hours Hawthorn Medical Centre patients were able to access emergency care from an alternative out of hours provider. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

The practice assessed and monitored the use of the phones to improve service delivery as a result of informal and direct feedback from patients and feedback through the PPG about the difficulties patient had in making appointments. This proved successful as the results of the most recent national patient survey identified positive feedback from patients about the appointment system.

Good

Are services responsive to people's needs?

(for example, to feedback?)

There were 296 surveys sent to patients and 117 were returned with feedback. Of these respondents, 67% described their experience of making an appointment as good and 83% said they were able to get an appointment to see or speak to someone the last time they tried.

A senior GP partner told us the recent audit of 2% of their patients presenting with complex needs had impacted negatively on appointments in the practice as it took GPs time away from face to face contact with patients for around two months. He said this resulted in patients waiting longer to get appointments and this was reflected in the feedback from patients.

Patients with long term conditions were offered double appointments when they were experienced more than one health condition so they were only being called once per year.

Staff told us that translation services were available for patients who did not have English as a first language. The practice also employed two reception staff who spoke four languages between them. The languages they spoke reflected the languages spoken in the patient population.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person (the practice manager) who managed and monitored complaints. We saw a log of complaints which showed there were 17 complaints in the last year (2013-2014). Each one was investigated promptly in line with their policy. No themes had been identified and lessons learnt from individual complaints had been acted upon to improve services and outcomes for patients. For example

the practice reviewed the competency framework for all reception staff following two complaints from patients about their waiting times in 2014. There were no further complaints from patients about his issue following the framework review.

There was a complaints information leaflet for patients to explain how they could make a complaint.

The patients we spoke with told us if they had concerns about their care they would not hesitate to raise them with staff. The practice manager told us they always spoke to patients at the time they made a verbal complaint. They said they asked patients how they would like to progress with the complaint and this approach normally allowed the situation to be resolved.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a vision and strategy to deliver high quality care and promote good outcomes for patients. Staff we spoke with were clear about the ethos of the organisation. They described it as having a relaxed environment with staff who were caring and committed to providing a good service to patients. The partnership team included four GPs, a nurse practitioner and the practice manager. Together they provided clear leadership within the practice. The practice manager told us the partnership, whilst new, was developing quickly and felt the partners worked as a team. The partners told as that as part of their professional and business development, they were undertaking leadership management training and had developed a five year business plan.

All the staff we spoke with told us they felt comfortable raising concerns with the GP partners and were confident they would be taken seriously if they did so. Staff we spoke with told us the practice worked well as a team.

Governance Arrangements

The practice had a number of policies and procedures in place to govern its activities and service delivery. These were available to staff. For example the practice had a written policy about how they manage newly registered patients who are 75 years and older, existing patients who turn 75 and what to do when a GP was on long term sick leave or maternity leave.

The practice held monthly governance meetings. We looked at minutes from some of these meetings and found that performance, quality, and risks had been discussed. Information that related to administrative or reception staff were discussed in weekly and monthly team meetings. The practice had daily mid-morning GP meetings where complex clinical cases were discussed with the rest of the primary care team.

The practice had systems in place to monitor and improve quality. We saw evidence of audit activity within the practice during the last 12 months. Full clinical audits had been undertaken in a number of areas, including prescribing. The audit and re-audit of prescribing patterns had resulted in improvements in the quality of prescribing within the practice for various medicines groups.

The practice undertook an audit of the needs of 2% of their patients presenting with complex needs and were identified as being a highest risk. Patients included those with long term conditions, those receiving palliative care, COPD, frail and elderly and those who were frequently admitted to hospital. The audit identified 290 patients who required updated care plans. Each audit showed evidence of the results having been analysed and records of improvements made or actions required.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example, there was a lead for infection control and a senior GP partner was the lead for safeguarding. The deputy practice manager was the Caldicott Guardian (a Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient information and enabling appropriate information-sharing.)

Staff we spoke with were clear about their roles and responsibilities. They said they felt valued, supported, and knew who to go to in the practice with any concerns.

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

The practice had a small patient participation group (PPG) with around six active members and 15 virtual members (virtual members did not attend face to face meetings but did contribute to the group's work). A PPG is a voluntary group of patients registered with the practice who represent patient views. We spoke with the coordinator of the PPG who told us the practice listened to its members and was open to making changes which the group suggested. For example, the PPG had asked for the installation of an information screen in the waiting room and this was done. All of the patients we spoke with told us they knew about the PPG. They told us they could also make comments or suggestions through the practice's website.

The practice carried out an annual patient survey and reviewed its findings in partnership with the PPG. The results were compared with the previous year's results to identify any improvements or areas for improvement. The practice posted the results of the survey on their website. Results from the most recent survey in 2013 were consistent with previous results achieved. Patients reported they were generally very happy with the services provided.

Are services well-led?

Good

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

The practice used the information from the PPG to effect change. For example, as a result of comments from the patient survey, the practice developed an appointments leaflet so that patients were aware of how to access appointments and the days on which the different GPs and nurses worked. The PPG suggested the leaflet should include details of the different types of appointments the practice offered such as counselling, minor operations and family planning and this was taken on board. The leaflet was written and circulated to both PPG and partners for their views before being given to patients.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and development. We looked at staff records and saw that annual appraisals took place. Staff told us the practice was supportive of training.

The practice had completed reviews of significant events and other incidents and shared findings with staff in order to improve outcomes for patients.