

Merchiston Surgery

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?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	7
What people who use the service say	10
Areas for improvement	10

Detailed findings from this inspection

Our inspection team	11
Background to Merchiston Surgery	11
Why we carried out this inspection	11
How we carried out this inspection	11
Detailed findings	13
Action we have told the provider to take	25

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection visit to Merchiston Surgery on 21 October 2014.

During the inspection we gathered information from a variety of sources. For example, we spoke with patients, members of the patient participation group, interviewed staff of all levels and checked the systems and processes in place.

Overall the practice is one which is rated as good. This is because we found Merchiston Surgery provided the care and treatment patients required in order to meet their needs. We found patients using this service experienced good effective, responsive and caring outcomes. However, we found that services provided were not safe in respect of medicines management.

Our key findings were as follows:

- On the whole patients' safety and welfare was protected.

- Patients in the population groups of older people and those with long term health needs were supported well and there were systems in place to ensure their needs would be met.
- Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions
- Patients were able to have appointments with a GP of their choice and continuity of care, with urgent appointments available the same day.
- Merchiston Surgery participated in pilot schemes which promoted self-care and good health.
- There was a clear leadership structure and staff felt supported by management to deliver care

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

- Review the medicines management policy and procedure and ensure that there are safe systems in

Summary of findings

place. There were risks as medicines were not being stored securely as access to where these were stored was available to all staff working in the building. Medicine fridges were left unlocked.

- Ensure there is a written policy and procedure for the system of receiving and checking vaccines

when they were delivered and therefore ensuring the cold chain was maintained.

In addition the provider should:

- There should be a system for monitoring blood and other pathology results at the practice so that any patients' abnormal results were responded to quickly.
- Emergency equipment and medicines are required to be stored in a central area and easily accessible.
- The practice should have a written protocol for receiving, handling and storing specimens. Checks should be made on temperatures of the specimen fridge to ensure the correct temperature was maintained.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Staff had been trained at the appropriate level to be able to recognise and respond to concerns of possible abuse or harm for children and vulnerable adults. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were not always identified or acted upon. For example we found there were gaps in the system for monitoring blood and other pathology results at the practice. There were delays in some results being checked when they were returned to the practice if they had not been assigned to a specific GP, if the results related to a new patient or if results had been assigned to the visiting midwife.

There were risks to medicines being stored securely. This was because access to areas where they were stored was available to all staff working in the building. Medicine fridges were left unlocked. There was no written policy or procedure for the system of receiving and checking vaccines when they were delivered ensuring the cold chain was maintained. The room temperature for where the small stocks of medicines were kept was not routinely checked to ensure correct storage in accordance to the manufacturer's instructions. The room was hot from the vaccine fridges and not ventilated.

Cleaning audits did not identify the extractor fans around the building were clogged with dust and required attention. The practice did not have a written protocol for receiving, handling and storing specimens. Checks were not made on temperatures of the specimen fridge to ensure the correct temperature was maintained. We found the integrity of the fridge temperature was compromised by the cooling element being heavily iced.

The emergency equipment and medicines were not stored in a central area and was in a room with a keypad entry. This meant there may have been delays in responding to an emergency whilst staff retrieve equipment. There were enough staff to keep people safe.

Requires improvement



Are services effective?

The practice is rated as good for effective. 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. Care plans were developed

Good



Summary of findings

for patients with long term physical and mental health needs and included an assessment of capacity and the promotion of good health. Specific patient groups were offered well women and well man checks. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice had provided staff with appraisals and opportunities for personal development. Multidisciplinary working was evidenced.

Are services caring?

The practice is rated as good for caring. Information from patients showed they thought the practice staffs were caring. 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. Patients were positive about the emotional support provided by the practice and rated it highly. Carers were identified on the record system and prioritised for flexible appointment times and offered regular screening and health checks. Carers could attend a monthly drop in carers group with was facilitated by a named member of staff.

Good



Are services responsive to people's needs?

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported accessibility to appointments with a GP of their choice and continuity of care, with urgent appointments available the same day. Merchiston Surgery participated in pilot schemes which promoted self-care and good health such as the telehealth system 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 and other stakeholders.

Good



Are services well-led?

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. 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 had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients

Good



Summary of findings

and this had been acted upon. The practice had completed reviews of significant events, complaints and other incidents and shared with staff via meetings to ensure the practice improved outcomes for patients. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended 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

The practice is rated as good for the population group of Older People. An example of good practice was how the practice employed a full time nurse and a full time administrator whose role was to specifically monitor and address the needs of the patients over 75 years. (11.6% of the practices patient population). They also offered health checks for those over 75 years not seen in over three years.

The practice had good outcomes for conditions commonly associated with this age group and had a system to highlight vulnerable patients. Falls risk management was in place for patients at risk of frequent falls. A register was kept of patients who were identified as being at high risk or receiving end of life care. Patients received annual medication reviews. Opportunistic testing for memory and dementia screening took place when patients were seen by health practitioners. Multidisciplinary case management meetings were supported by staff. Home visits were available as well as longer appointments when needed for patients with multiple care needs. The practice were working with the Swindon's Clinical Commissioning Group in regard to a new responsive home visiting service. This service was called SUCCESS and had been set up in order to respond to patients' urgent medical needs such as deteriorating respiratory problems.

However, we did identify there were potential risks to patients safety in all population groups. This was in regard the safe administration and management of medicines at the practice.

Good



People with long term conditions

The practice is rated as good for the population group of people with long term conditions. 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 a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice was working with the Swindon's Clinical Commissioning Group in regard to a new responsive service provided by them called SUCCESS. A home visiting service had been set up by GPs in order for them to see patients during practice opening hours. This was in

Good



Summary of findings

order to respond to patients urgent needs such as worsening respiratory problems. The practice was involved with a pilot project which is a Telehealth system to monitor patients' vital health signs remotely.

However, we did identify there were potential risks to patients safety in all population groups. This was in regard the safe administration and management of medicines at the practice.

Families, children and young people

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. An example of this circumstance was ensuring that patients at local sheltered accommodation were fully registered at the practice instead of temporary registration so that their full medical history was obtained and they were provided with appropriate on-going healthcare. 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 was suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses.

There was a planned schedule of immunisation for children and young people and the practice signposted young people towards sexual health clinics for advice and support and also by offering confidential testing packs for sexually transmitted infections.

However, we did identify there were potential risks to patients safety in all population groups. This was in regard the safe administration and management of medicines at the practice.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of these groups of people had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care. The practice was proactive in offering online services such as the ability to book appointments. A range of health promotion and screening was on offer such as 'well women' and 'well man' health checks. Staff carried out health promotion for smoking cessation.

However, we did identify there were potential risks to patients safety in all population groups. This was in regard the safe administration and management of medicines at the practice.

Good



Summary of findings

People whose circumstances may make them vulnerable

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice had carried out annual health checks and the practice offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

However, we did identify there were potential risks to patients safety in all population groups. This was in regard the safe administration and management of medicines at the practice.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of this population group. The practice had in place advance care planning for patients with a diagnosis of dementia. Patients with learning difficulties or experiencing poor mental health were identified and were monitored. Each patient with specialist identified needs had a plan of on-going care. These patients were offered longer patient appointments or visited at home if they needed this.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. The practice had a system in place to follow up on the wellbeing of patients who had attended accident and emergency and may also have mental health needs.

However, we did identify there were potential risks to patients safety in all population groups. This was in regard the safe administration and management of medicines at the practice.

Good



Summary of findings

What people who use the service say

Patients who completed CQC comment cards provided us with feedback on the practice. We received 27 completed cards and all were positive about the care and treatment they had received. Patients said they felt the practice offered an excellent, caring and a much appreciated service. Patients said that staff had treated them with dignity and respect. Patients had found clinical staff efficient and told us they not felt rushed through their appointments.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. However, we were told by some patients that they felt confidentiality was compromised in the waiting area and reception desk. Information from the practices own survey showed patients were positive about the emotional support provided by the practice and rated it well in this area. One person i told us how much they had

appreciated staff support, including the care the family received when ill-health had occurred. Other patients echoed this and told us that staff had responded compassionately when they needed help and had provided support when required.

Some patients had fed back on our comment cards that there were times when the appointment system was not satisfactory. However, this was not the opinion of all the patients we spoke with or had comments from. Patients told us they could see a doctor on the same day in if they had an urgent need for treatment and they could see another doctor if they could not see the doctor of their choice.

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Areas for improvement

Action the service **MUST** take to improve

- Review the medicines management policy and procedure and ensure that there are safe systems in place. There were risks as medicines were not being stored securely as access to where these were stored was available to all staff working in the building. Medicine fridges were left unlocked.
- Ensure there is a written policy and procedure for the system of receiving and checking vaccines when they were delivered and therefore ensuring the cold chain was maintained.
- Ensure that recruitment checks are carried out for those staff who require them, ensuring that a risk assessment is completed to evidence that all factors have been considered for those who do not require a check by the disclosure and barring scheme.

Action the service **SHOULD** take to improve

- There should be a system for monitoring blood and other pathology results at the practice so that any patients' abnormal results were responded to quickly.
- Emergency equipment and medicines are required to be stored in a central area and easily accessible.
- The practice should have a written protocol for receiving, handling and storing specimens. Checks should be made on temperatures of the specimen fridge to ensure the correct temperature was maintained.

Merchiston Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team also included a GP, a Care Quality Commission inspector, practice manager specialist adviser and an Expert by Experience.

Background to Merchiston Surgery

Merchiston Surgery is situated in a residential area of Stratton St Margaret, Swindon, Wiltshire. The practice had approximately 14,100 registered patients. This included patients from the outlying villages of Blunsdon, Highworth, Shrivenham, South Marston, Bishopstone, Hinton Parva, Wanborough and Liddington. The practice provides care and support to patients living in two nursing homes in the area. Based on information from NHS England this shows us that the practice has a larger than average population of older people.

The practice is located in purpose built premises with the main patient areas situated on the ground floor. The practice has six consulting rooms and two treatment rooms. The practice has a primary medical service contract with Swindon Clinical Commissioning Group.

The services provided at Merchiston Surgery are delivered from one location:

Merchiston Surgery

Highworth Road

Stratton St Margaret

Swindon

Wiltshire

SN3 4BF

The practice supported patients from all of the population groups such as older people; people with long-term conditions; mothers, babies, children and young people; working-age population and those recently retired; people in vulnerable circumstances who may have poor access to primary care and people experiencing poor mental health.

Over 33% of patients registered with the practice were working aged from 15 to 44 years, 29% were aged from 45 to 64 years old. Just above 11% were over 65 years old. Around 8% of the practice's patients were 75-84 years old and just under 3% of patients were over 85%. 15% patients were less than 14 years of age. Information from the Swindon Clinical Commissioning Group (CCG) showed that 52% of the patients had long standing health conditions, which was similar to the national average of 53%. The percentage of patients who had caring responsibilities was just over 23% which is above the national average of 18.5%. 2.5% of the working population were unemployed which is below the national average of 6.3%.

The practice has seven partners who employed three salaried GPs. At the time of the inspection there was one registrar GP. Of these 11 GPs there were four male and seven female GPs. The practice was a training practice with up to two GP trainees at any one time. Four practice nurses and two health care assistants provided health screening and treatment five days a week; additional clinics were implemented occasionally to meet patient's needs such as the undertaking of influenza vaccinations. The practice was open between the hours of 8am and 6.30pm Monday to Friday. Early morning appointments were available from 7am to 8am Monday and Friday each week. Evening

Detailed findings

surgeries were available between 6pm to 7.30pm Mondays and Tuesdays. The practice referred patients to another provider for an out of hours service to deal with any urgent patient needs when the practice was closed.

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.

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

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

The practice provided us with information to review before we carried out an inspection visit. We used this, in addition to information from their public website. We obtained information from other organisations, such as the local Healthwatch, the Swindon Clinical Commissioning Group (CCG), and the local NHS England team. We looked at recent information left by patients on the NHS Choices

website. We spoke with the Community Matron and the community midwife associated with the practice. We received feedback from other healthcare practitioners associated with Merchiston Surgery. These included a prescribing advisor engaged with the Swindon Clinical Commissioning Group and a community diabetes specialist nurse. We also had comments from the manager of a care home who supported patients who received treatment from the practice.

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

During our visit we spoke with five of the GPs, two practice nurses, the practice manager and the reception and administration staff on duty. We spoke with eight patients in person during the day. We received information from the 27 comment cards left at the practice premises.

We observed how the practice was run, the interactions between patients and staff and the overall patient experience.

Are services safe?

Our findings

Safe track record

We spoke with five GPs and reviewed information about both clinical and other incidents that had occurred at the practice. We were given information about seven incidents which had occurred during the last 12 months. These had been reviewed under the practice's significant events analysis process. These incidents included a complex unexpected diagnosis and issues regarding on-going monitoring and medicines management. Events linked to the administration of the practice and the delivery of the service were also reviewed.

Where events needed to be raised externally, such as with other providers or other relevant bodies, this was done and appropriate steps were taken, such as providing information to other care providers who were supporting the patients concerned.

GPs told us national patient safety alerts as well as comments and complaints received from patients were responded to. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents or events. For example reception staff alerted a GP when the incorrect patient had attended a consultation.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. The records we reviewed showed that each clinical event or incident was analysed and discussed by the GPs, nursing staff and practice manager. When we spoke with other nursing staff we were told that the findings from these Significant Events Analysis (SEA) processes were disseminated to other practice staff if relevant to their role.

We saw from the detail of the analysis of these events and complaints which had been received that the practice put actions in place in order to minimise or prevent reoccurrence of events. For example, a review of the systems in place to check patient details before commencing a consultation or treatment.

Safety alerts were monitored by a member of staff who disseminated the information to practice staff through practice meetings and by contacting individual staff where necessary. Staff we spoke with were able to give examples of how this worked and gave examples of how this improved patient care.

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 GPs had received relevant role specific training on safeguarding children and adults (Level 3). We heard from the GP who was the safeguarding lead that they had been involved with the development of a new on line training system at the practice. The practice's training record showed most staff were required to complete the new online training for safeguarding appropriate to their role. New members of staff had automatically been provided training through this method as part of their induction process. Staff told us about their previous training which was provided by the local safeguarding team in early 2014, and discussed issues about vulnerable adults and consent.

We asked members of medical, nursing and administrative staff about their knowledge. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were accessible electronically and on display in various areas around the building. Details were included in the packs of information provided to locum GPs when working at the practice.

There was a system to highlight vulnerable patients and those at risk on the practice's electronic record system. Such as 'Child at risk' or 'Risk of domestic violence' and older people at risk of abuse or harm. Records included information so staff were aware of any relevant issues when patients attended appointments.

The practice ensured that patients at local sheltered accommodation were fully registered at the practice instead of temporary registration so that their full medical history was obtained and they were provided with appropriate on-going healthcare.

A chaperone policy was in place and visible on the waiting room noticeboard and in some of the treatment and consulting rooms. The training records showed that one GP had undertaken chaperone training recently using the new training programme.

Are services safe?

Medicines Management

We checked how medicines were stored and found there were risks as medicines were not being stored securely. This was because access to these areas was available to all staff working in the building. Facilities for medicines storage was not limited to authorised staff and we found that medicine fridges were left unlocked. We were informed that door access codes to these areas were changed immediately during our inspection in light of the risks being identified. This meant action was taken and access to medicines was restricted to the appropriate authorised staff.

We saw appropriate checks on fridge temperatures were carried out routinely and records showed there were no gaps or risks to the safe temperature storage for the vaccines held. Staff told us about the system of receiving and checking vaccines when they were delivered and the handover to practice nurses for safe storage. There was no written policy or procedure for this.

GPs at the practice carried out a small number of minor surgical treatments. This included the use of liquid nitrogen. We noted the liquid nitrogen was correctly stored with personal protective equipment available to handle it safely.

Processes were in place to check medicines were within their expiry date and suitable for use. A small amount of medicines were purchased and kept by the practice for patients with regular treatment such as depot injections. The stock levels of these medicines were managed jointly by the practice nurses and the administrators responsible for the prescriptions management. The practice nurses were able to show evidence that these medicines were monitored. Expired and unwanted medicines were disposed of in line with waste regulations.

No controlled medicines were kept at the practice or included in the GPs bags taken for home visits. The medicines in GPs bags were monitored and checked for use and expiry dates. GPs monitored the Medicines and Healthcare Regulatory Agency (MHRA) information for the most recent guidance and information. Information was cascaded to colleagues and either emailed or discussed at weekly partner's meetings.

We heard how specific medicines audits had led to changes in management of patients' long term treatment. For example where a GP had been alerted to possible

contra-indications for a patients medicines which had been identified by a local pharmacist following a patients discharge from hospital. This had generated a review of all patients receiving a similar plan of care. Changes were made to ensure that safe prescribing occurred.

Patients with long term health needs had their medicines regularly reviewed and treatment was changed in accordance to best practice and to meet their needs. Patients with insulin dependent diabetes and mental health needs were provided with support with treatment 'passports' to ensure an accurate accessible record was available of the current was available.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary. There were systems in place for urgent repeat prescriptions to be processed both morning and afternoon each day. Treatment 'passports' for people with diabetes or mental health needs were provided to ensure they obtained their medication when they needed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness & Infection Control

We saw there were cleaning schedules in place and cleaning records were kept. 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 lead nurse provided training and guidance for correct hand washing techniques. They recorded a yearly observation of each member of staff washing their hands and provided additional training when needed.

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We saw that the last audit for cleaning the practice was undertaken on 16 September 2014 and had not highlighted any concerns.

The practice had a lead nurse for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out

Are services safe?

staff training. All staff received induction training about infection control specific to their role and there after annual updates. We saw evidence the lead had carried out regular audits and that any improvements identified for action were completed on time. Practice meeting minutes showed the findings of the audits were discussed. 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. There was also a policy for needle stick injury.

We looked at the systems for safe handling and storage of specimens at the practice. The practice did not have a written protocol for receiving, handling and storing specimens for all staff to follow. For example, when patients dropped off specimens at reception, these were then transferred to the sluice area where they were checked by the nursing staff. Checks were not made on temperatures of the specimen fridge to ensure the correct temperature was maintained. We found the integrity of the fridge temperature was compromised by the cooling element being heavily iced.

The practice had a policy for the management, testing and investigation of legionella (bacteria found in the environment which can contaminate water systems in buildings). We saw records that 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 diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place.

We saw evidence of fire safety equipment was checked and regularly monitored. This included emergency lighting. Fire extinguishers had been checked by an external company in August 2014.

Staffing & Recruitment

Records we looked at contained evidence that some recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body. We saw that some but not all staff had criminal records checks via the Disclosure and Barring Service (DBS). The practice manager informed us that the four practice nurse staff and two healthcare assistants employed were currently in the process of obtaining a DBS check as it had been identified they had not undertaken any check when they had been originally employed. These staff had been employed prior to GPs were required to be registered with the Care Quality Commission. There was no risk assessment carried out to ensure patients were protected until these were returned satisfactorily.

The practice had a recruitment policy that had been reviewed recently that set out the standards it followed when recruiting clinical and non-clinical staff. The policy identified that Criminal Record Checks (now replaced by Disclosure and Barring Checks), would be obtained for certain levels of staff. However, the policy was not clear and did not include which staff this applied to. We also did not see information about any timescale or circumstances when DBS checks would be repeated.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. One member of staff took the responsibility to ensure that staffing needs were met in conjunction with peak times of activity. We heard how they had a stand-by rota to cover any sickness. Staff were trained and encouraged to be multi skilled and cover colleagues. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

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

Are services safe?

Accidents were logged and recorded satisfactorily. Incidents we looked at demonstrated that changes had been made to workplace and/or procedures as necessary. Staff we spoke with were aware of what needed to be reported to other bodies and would do so as required.

Risks assessments were in place including those for oxygen, liquid nitrogen and clinical waste. The majority of these had been updated in October 2014. The fire risk assessment had been completed in August 2014.

We saw that staff were able to identify and respond to changed risks to patients including deteriorating health and well-being or medical emergencies. Such as for older people, the practice employed a full time nurse and a full time administrator whose role was to specifically monitor and address the needs of the patients over 75 years. (11.6% of the practice's patient population). The practice had a falls risk management system in place. For people in vulnerable circumstances who may have poor access to primary care the practice had implemented daily home visits for patients who were unable to attend surgery.

We saw there was a system for monitoring blood and other pathology results at the practice. These were assigned to the GP lead for the individual patient to be reviewed and there was a lead GP who checked others responded in a timely way. However, we identified there were delays in some results being checked when returned if they were not assigned to a specific GP or if the results related to a new patient or if results had been assigned to the visiting midwife. An example of this was that if the practice was not alerted by the pathology lab of abnormal results, these may not be until the GP IT lead carried out a weekly check. The practice told us they were currently developing protocols in order to manage these results more effectively so that any patients' potential problems were responded to quickly.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received

training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff we asked knew the location of this equipment and records we saw confirmed these were checked regularly.

However, the emergency equipment and medicines were not stored in a central area and was in a room with a keypad entry. This meant there may be delays in responding to an emergency whilst staff retrieve equipment.

A business continuity plan was in place to deal with a range of emergencies that may 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. For example, contact details of power suppliers, telephone and water companies. Copies of the business continuity plan were kept at home by the practice manager and partners and an electronic version stored in the internet training portal for easy access. The business continuity plan showed that the practice had made arrangements with two other local GP practices should they be unable to access their own facilities.

A fire risk assessment had been undertaken on 11 August 2014 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 drills were undertaken. The fire alarm system was tested every week. Alarm points and lights were tested monthly by contractor and the practice manager did a monthly visual check on fire extinguishers. Annual inspection of fire systems were last carried out in January 2014. Emergency call alarms in all consulting rooms and panic button were also checked and were included as part of the regular safety checks.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We heard about practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed showed that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The practice had a programme of regular assessments and reviews of treatment for patients with long term conditions such as asthma, diabetes, rheumatoid conditions and heart disease. Patients with learning difficulties, experiencing poor mental health or complex needs were identified and were monitored with a plan of on-going care developed.

The GPs told us there were clinical leads or clinicians that had particular interests in specialist clinical areas. One GP lead on dermatology and provided minor surgery at the practice. Another GP had interests in providing palliative care and promoting women's health.

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

New patients were required to complete a health questionnaire and offered a health check when they registered. Patients with on-going treatment plans were placed on the schedules of regular monitoring.

Management, monitoring and improving outcomes for people

Staff at the practice had different roles in the monitoring and improvement of outcomes for patients. These roles included providing regular assessment and reviews of treatment and health promotion. Other roles included ensuring information that was input into the electronic records was correct and carried out appropriately. For

example clinical review scheduling, child protection alerts management and medicines optimisation management. This information was collated to support the practice to carry out clinical audits.

The practice showed us four clinical audits that had been undertaken in the last year. All four of these were completed audits where the practice was able to demonstrate the changes resulting in improvements in the outcomes for patients. Audit results showed that the practice had improved compliance with blood monitoring of patients by flagging as a scheduled task and running reports on the electronic patient records system. Another audit looked to identify if appropriate prescribing for certain medicines in accordance to current guidance was carried out. This led to changes in prescribing which in turn led to improved results for patients. There were also clinical reviews of ear, nose and throat, gynaecological, urology referrals on an individual case basis.

There was a system of peer review for GPs within the practice where others reviewed a GPs decision making and plans of treatment. These processes included group and individual discussions.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We read an overview of the staff training and saw that all staff were up to date with attendance at mandatory courses such as annual basic life support. We saw that planning was in place for all staff to revisit training through the new training portal (an online resource available to staff). All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and took an interest in them developing their skills and extending their roles. As the practice was a training practice, doctors who were in

Are services effective?

(for example, treatment is effective)

training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. Feedback from the trainee we spoke with about their placement was positive.

Practice nurses had defined duties they were expected to carry out and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and the on-going monitoring of long term needs such as asthma and diabetes.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and provide treatment and support to people with long term and complex health needs. We were told about the work the practice did with other health providers and practitioners.

Virtual clinics with specialists for diabetes were held. Multidisciplinary working was in place for patients with diabetes with practice nurses screening patients, GPs planning care and treatment and the community diabetic team supporting the patient.

We were told by visiting professionals such as the community matron and community nursing team that they worked together and that communication was good. We found that there was joint working with the palliative care team for supporting those patients in need of end of life care.

The prescribing advisor who regularly visited the practice told us the practice always had a focus on improving patient outcomes and responded well to advice. They also told us they were included and their opinion listened to during discussions about medicines prescribed for patients with complex health needs.

Some vulnerable patients at the practice were included in the community virtual ward overseen by the community matron. We were told that the practice made joint visits to patients with the community matron and that care and treatments were discussed as part of a monthly multidisciplinary team meeting.

The practice used an out of hours service. They ensured that this service had special notes or information about patients with specific care and treatment needs. Patients

who did not attend planned health checks for on-going long term conditions were also identified. Information about patients who were attended or required out of hours support was responded to by the practice the next day.

Information Sharing

The practice used several 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, and the practice made 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). Patient referral letters were monitored for response within a 48 hour window.

The practice had systems in place to provide staff with the information they needed. An electronic patient record system was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. Documents such as hospital treatment plans were scanned and then saved in the system for reference.

Consent to care and treatment

Staff we spoke with were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke to understood the legislation and were able to describe how they implemented it in their practice. The practice guidelines had good information that was an aide memoir to ensure that staff followed the appropriate steps.

Patients with learning disabilities and those with a diagnosis of dementia were supported to make decisions through the use of care plans which they were involved in the development during consultations. GPs were aware of processes and systems for best interest decision making and involved others in assessments of capacity. This often involved other health care practitioners, the patients' carers and social workers involved in patients support. Information was recorded in patients care plans and these care plans were reviewed regularly. Clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Are services effective?

(for example, treatment is effective)

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, written consent was obtained and scanned into electronic patients records. A patient's verbal consent for examination and tests was documented in the electronic patient notes.

Health Promotion & Prevention

The practice offered all new patients registering with the practice a health check with the health care assistant or practice nurse. If health concerns were detected a GP was informed and these were followed-up. Patients on repeat medications were automatically requested to make an appointment with a GP.

The practice also offered 'well women' and 'well men' health checks. Opportunistic health advice and support was given when patients attended appointments for areas such as smoking cessation and dementia screening. Carers were monitored and given a greater flexibility for appointments.

The practice had ways of identifying patients who needed additional support, and were pro-active in offering additional help. The practice kept a register of all patients with learning disabilities and with mental health needs and

provided them with an annual health check. There was a method of identifying at risk groups such as those receiving end of life care and those over 75 years of age. Staff undertook opportunistic testing for memory and dementia screening with older patients and there was a dedicated practice nurse for patients over 75 years. The practice had a system of offering health checks for those over 75 years who had not been seen by a GP for over three years.

There was routine monitoring for patients with long term health conditions and there was evidence of multidisciplinary working to maintain people's health. Patients with a recognised mental health problems received annual physical health checks.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Staff signposted young people towards sexual health clinics and offered confidential testing packs for sexually transmitted infections.

There was information available to patients available to patients about external support groups. Patient health advice leaflets were made available. Patients had access to psychological therapy at the practice.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent information available for the practice on patient satisfaction. This included information from the national patient survey 2013/ 2013, the Patient Participation Group survey 2014 and comment cards we left in the surgery reception. We also looked at information on NHS Choices website and information from Healthwatch. We spent time talking with patients visiting the practice.

Patients who completed the 27 CQC comment cards provided us with feedback on the practice. All patients were positive about the care and treatment they had. Patients said they felt the practice offered an excellent, caring and a much appreciated service. They said staff treated them with dignity and respect. Patients had found clinical staff efficient and had not felt rushed through their appointments.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. 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. However, we were told by some patients that they felt confidentiality was compromised in the waiting area and reception desk. We observed that this was because of the long patient queue at the desk to be checked in, bringing in specimens for testing or patients' with a query. We saw this queue extended outside the practice doors at one point. We observed one patient appeared embarrassed about dropping off a specimen in front of other patients in the queue. Patient conversations could be heard even though staff tried to speak quietly and discreetly.

There was an automatic check in service which was positioned by the desk which was being used well but this was positioned at the desk next to where patients were speaking to reception staff.

Staff told us they were aware of concerns about confidentiality in the waiting and reception desk area. The practice manager had instigated that the practice switchboard was located away from the reception desk which helped keep patient information private. Because of the position of the reception desk close by to the entrance doors the practice had been unable to introduce a system to allow only one patient at a time to approach the reception desk.

Care planning and involvement in decisions about care and treatment

The completed patient comment cards we reviewed showed patients had felt involved in planning and making decisions about their care and treatment. This was confirmed when we spoke with patients. GPs and nursing staff had a good understanding of assessing patients' capacity to be involved in decisions about their care and treatment and they involved others such as carers and advocates when required.

Staff told us that translation services were available for patients who did not have English as a first language. However, there were no notices in the reception areas informing patients this service was available.

Patient/carers 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. One person informed us how much they had appreciated what staff had provided including the whole care their family received when ill-health occurred, physical and emotional support. Others told us staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Carers were put on a list and prioritised for flexible appointment times and offered regular screening and health checks. Carers could attend a monthly drop in carers group which was facilitated by a named member of staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responsive to patients needs

The practice was responsive to people's needs and had systems and flexibility to act when patients needs changed. There had been a small turnover of staff during which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to two large local care homes on a specific day each week, by a named GP. We spoke with one of the care home managers who told us that the GP who attended the home was efficient and very supportive who was responsive to calls for assistance sometimes several times a week. They also told us the surgery staff responded very quickly to an emergency situation when called.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). The outcomes had resulted in changes to the methods of prescription repeat requests and booking of appointments. Patients could now do this on line. Patients had also expressed concerns about the delays in obtaining prescriptions from the local pharmacy. The practice manager was regularly meeting with the pharmacy manager to improve the systems to reduce delays in obtaining medicines.

The practice had implemented the gold standards framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

The practice worked collaboratively with other agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment. For example with the Out of Hours service.

Some patients were able to take advantage of the Telehealth system. Telehealth was where electronic sensors or equipment that monitors vital health signs remotely, are placed in patients homes, or they are given equipment that can be used while they are on the move. These readings are automatically transmitted to appropriately trained person who can monitor the health vital signs and make

decisions about potential interventions when required. Patients who required a 24 hour blood pressure monitoring could have this arranged from the practice. This meant patients did not need to travel to a local hospital to have the equipment attached or removed and there were reduced delays in receiving treatment.

The GPs and practice were working with the community matron to use the Telehealth system and were involved in a pilot at a local care scheme. They were using Telehealth systems to monitor and instigate interventions rapidly. For older people and people with long term conditions home visits were available and longer appointments were provided when needed.

The practice were working with the Swindon's Clinical Commissioning Group in regard to a new responsive service provided by them called SUCCESS. This incorporated a home visiting service by GPs who visited patients during practice opening hours in order to respond to urgent needs such as worsening respiratory problems.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. It was able to offer alternative appointments early morning and after surgery usual opening hours for those who were unable to attend during the usual working day.

The practice had access to online and telephone translation services. From information we were provided with there were a low number of patients who attended the practice who did not have English as their first language.

The practice was able to provide equality and diversity training via e-learning and their new training portal. We saw that some but not all staff had undertaken training in equality and diversity. New staff had this included in their induction programme.

The premises and services had facilities to meet the needs of people with disabilities. Patient consultation and treatment rooms were all located on the ground floor. There were accessible toilets and wide corridors. We observed that patients had to open a heavy fire door in order to access the consulting room area.

There was a register of people who may be living in vulnerable circumstances, and there was a system in place for flagging vulnerable patients, this was recorded within individual records.

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Appointments were available from 7am to 7 pm on at least two weekdays. Normal working hours were from 8.am to 6.30pm on the other days.

Information was available to patients about appointments on the practice website and in patient leaflets. This included how to arrange urgent appointments and home visits and how to book appointments through the website. For working age people they told us they appreciated the online booking system that was available to them and told us the system was easy to use and found the a text message reminder for appointments useful. There were early morning or early evening appointments available so that patients could attend out of normal working hours.

There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients in leaflets, on display in the practice and on the practices website.

Feedback from some patients' as provided on our comment cards showed us that there were times when they felt the appointment system was not satisfactory for them. However, this was not the opinion of all the patients we spoke with or had received comment cards from. Patients told us they could see a doctor on the same day in if they had an urgent need for treatment and they could see another doctor if they were unable to see the doctor of their choice.

The practice had arranged special clinics to accommodate patients who required an influenza vaccine and we observed these clinics were publicised throughout the waiting area and on notice boards in the entrance to the building.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. New staff we spoke with had an awareness of the complaints policy and procedure and could advise patients how to use the complaints process.

We saw that information was available to help patients understand the complaints system and was included in information leaflets provided to them and on display in prominent areas of the premises. The practice included detail of the complaints policy and procedure on their website. Patients we spoke with told us they had no reason to raise a complaint.

We looked at eight complaints received in the last twelve months and found these were satisfactorily handled and dealt with in a timely way.

The practice did not have an annual review process to look at complaints or significant events for trends or themes. We looked at the summary report for the last 12 months and we saw lessons learnt from individual complaints had been acted upon. We saw that complainants were always offered a face to face opportunity to discuss their concerns with practice staff. Where complaints have been complicated and difficult to resolve the complainant has been invited to engage with developing the service to resolve issues arising again. We saw that complaints were discussed with the individuals involved. Where there was whole service learning complaints were discussed in staff or partners meetings. Where there was an issue with prescribing medicines, local prescribing guidelines for GPs were reviewed and updated.

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 clear vision to deliver a high standard of care for all their patients. They had identified in their aims and objectives they wanted to provide a service that understood and met the needs of their patients. The practice included patients in the decision making process about their treatment and encouraged them to maintain their health and wellbeing.

We spoke with partners and some of the staff and they all knew and understood the vision and values of the practice. One partner told us about the ethos of the practice including an open relationship with colleagues where staff have access to training, development and support. Members of the Patient Participation Group also had a good understanding of the aims of the practice.

We were told the practice had a leadership board to monitor progress and strategic development of the service.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We saw policies and procedures taken from a commercial provider and had been adapted to meet the needs of the practice and the specific services it provided. We looked in detail at the practices policies and procedures in relation to clinical care such as infection control, medicines management and emergency procedures. We also reviewed a number of protocols relating to clinical procedures including handling specimens and care of vaccines. There were policies and procedures for safe working practices such as fire safety and COSHH (Control of Substances Hazardous to Health). There were policies relating to the recruitment, employment and training of staff. All policies and procedures we looked at had been reviewed annually.

The practice held two weekly governance meetings. Practice partners with the practice manager and human resources lead looked at different aspects of the practice delivery. There were weekly meetings of the GPs including salaried GPs to look at the clinical governance at the practice.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this

practice showed it was performing in line with national standards. We were told QOF data was regularly discussed at practice meetings and action plans were produced to maintain or improve outcomes.

The practice had a system in place to liaise with specialists when looking at patient management for specific conditions such as dermatology or physiotherapy. There was a system in place and clear lines of accountability for the supervision and appraisal of staff.

The practice had completed a number of clinical audits, for example the most recent were relating to medicines prescribing. The practice had looked at prescribing practices for one particular medicine in order to see if it was in accordance to meeting current guidance, which it was.

The practice had some arrangements in place for identifying, recording and managing risks. We saw risk assessments relating to infection control, fire and water temperature safety. Where risks were identified, action plans had been produced and implemented.

Leadership, openness and transparency

There was a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and a partner was the lead for safeguarding. The staff we spoke with were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We were told that team meetings were held regularly. Meetings were relevant to the roles staff were employed for. Information was cascaded to the different teams. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the recruitment policy. There was information to show that staff were provided with copies of policies and procedures relating to their employment, such as their responsibilities for maintaining confidentiality. Key information regarding working at the practice was available on line for staff. Staff we spoke with knew where to find these policies if required.

Are services well-led?

Good 

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

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

The practice had gathered feedback from patients through patient surveys, complaints and compliments received. We also saw they responded to comments about the practice that were left on NHS Choices. We looked at the results of the annual patient survey that was carried out in early 2014. The practice had 400 respondents and from this exercise identified areas of improvement. They had found that patient's dissatisfaction with access to appointments and difficulties in communication with the practice the main areas of concern.

We saw from this survey the practice developed an action plan to improve appointment access by introducing an on line booking system for routine appointments. They offered from June 2014 onwards an extra session of GP appointments per week. They employed an additional nurse in October 2014 to provide greater access to patients for treatment. The system of a staged release of routine appointments was reviewed and converted to GP slots to allow more same day appointments. Urgent appointments were triaged and further reviews of the changes made to the appointment system were carried out to monitor the changes were effective.

The other area of feedback that was identified from the survey in early 2014 was improvements in patient communication. We were told there was a focus on updating patient records including any email address and telephone numbers. A new patient pack was under review and the intended date for this to be introduced was at the end of December 2014. The practice leaflet and information provided on the website and TV in the waiting room was under review and development.

The practice had an active patient participation group (PPG) which has steadily increased in size. The PPG has 12 patient representatives from 45 years to 80 years, including nine females and four males. The practice with the PPG has recognised a need to broaden the profile of the patient groups and has been actively seeking patients to participate. The PPG had carried out annual surveys and met every quarter. The practice manager shared with us the analysis of the last patient survey which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us they felt supported by all staff including line manager, practice manager and GPs. Training was readily available and they felt that this shows that the GPs are interested in developing staff.

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

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us they had received annual appraisals. When we looked at a sample of staff files records we found they were incomplete and there was no documentary evidence to support what we had been told. The practice recognised the appraisal system required improvement and was in the process of introducing a personal development plan for staff. Staff told us that the practice was very supportive of training and that they had undertaken staff away days where guest speakers and trainers had attended to share their knowledge.

The practice was a GP training practice where they usually supported one or two doctors at one time with their training and development. We spoke with the current trainee at the practice who informed us they were well supported, encouraged to give own viewpoint and become involved with how the practice was provided. GPs were enabled to have a one week's study leave per year. There were in-house study sessions and shared learning. External professionals visited for joint learning with all staff such as safeguarding.

The practice had completed reviews of significant events, complaints and other incidents and shared with staff via meetings to ensure the practice improved outcomes for patients. For example, discussing and sharing improvements in communication skills.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The medicines management policy and procedure did not ensure that there were safe systems in place. There were risks to medicines being stored securely and handled in accordance to manufacturer's instructions. Emergency equipment and medicines are required to be stored in a central area and easily accessible.
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 Recruitment checks were not carried out for those staff who required them. The provider did not ensure that a risk assessment had been completed to evidence that all factors had been considered for those who do not require a check by the disclosure and barring scheme.