The Whalebridge Practice

Quality Report

Health Centre
Carfax Street
Swindon
Wiltshire
SN1 1ED
Tel: 01793 692933
Website: www.**whalebridge**.nhs.uk

Date of inspection visit: 10 October 2014
Date of publication: 05/02/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

The Whalebridge Practice is a GP practice situated in Swindon and has approximately 9,700 registered patients. The practice team consisted of four GP partners, a salaried GP, three practice nurses, reception and administration staff, a healthcare assistant, and the practice manager.

We carried out an announced, comprehensive visit on 10 October 2014. During our visit we spoke with a range of staff. These included three of the GPs, two practice nurses, the practice manager, and the reception and administration staff on duty. 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 The Whalebridge Practice is requires improvement. Our key findings were as follows:

- Patients told us they found the practice to be caring and supportive.
- Patients with long term medical conditions were monitored regularly and were provided with the treatment and support they needed.
- Staff were trained and competent to undertake their roles although a structured training plan was not in place.
- Checks were not made regularly to ensure vaccines were stored at the correct temperature and suitable for use.
- Vaccines and liquid nitrogen were not kept secure and were accessible to unauthorised people.
- Clinical audits and systems for assessing the quality of the service were carried out.
- There were gaps in the management of infection control by the use of an adjoining sluice room between the practice's two treatment rooms. Nursing

Summary of findings

staff moved between these rooms to access equipment and facilities. There were open areas where equipment was stored in the sluice room and was at risk of contamination.
- The building in which the practice was located was not well adapted to meet the needs of people with disabilities.
- The shared use and storage of the emergency equipment should be reviewed as to ensure that patients and staff welfare were not put at risk.

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

The provider must:

- Ensure vaccines and liquid nitrogen are stored securely
- Monitor and record the temperatures of all refrigerators containing medicines and / or vaccines.
- Checks should be made to ensure audits, such as medicines safety and infection control are carried out and are effectual.
- Risk assess current arrangements for accessing resuscitation equipment. .

The provider should:

- Have a planned approach to clinical audits.
- The training needs of staff should be identified and planned for.
- Risk assess access arrangements for patients to the practice building and facilities.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for safe. Concerns about safety, incidents, and near misses were reported. Patient safety alerts were reviewed and changes were made when required. Checks were not made regularly to ensure vaccines were stored at the correct temperature and suitable for use. Vaccines and liquid nitrogen were not kept secure and were accessible by unauthorised people. There were areas of improvement needed in regard to some aspects of infection control management in the sluice room between the nurse's treatment rooms. Staff told us that in order for them to access resuscitation equipment, they were required to go downstairs and carry the equipment up to the practice. There was no policy, procedure and no risk assessments for this.

Are services effective?

Requires improvement

The practice is rated as requires improvement for effective. Care and treatment was delivered in line with recognised best practice standards and guidelines. There was a system for monitoring Medicines and Healthcare Products Regulatory Agency (MHRA) alerts and the dissemination of information from these to other staff. This included regular opportunities for discussion and the implementation of actions to amend patient's medication and treatment to reflect current guidance.

The practice assessed patients' needs and planned care and treatment accordingly. The practice's performance against the Quality and Outcomes Framework (QOF) showed achievement in meeting patients' clinical needs. The GP and nursing team had a particular interest in patients with diabetes. Staff had identified patients from a particular ethnic group registered at the practice who were at greater risk for developing diabetes. Patients from this ethnic group were systematically screened when they registered or when they attended the practice.

Staff at the practice, however could not provide evidence that there was a planned approach to clinical audits and how they collated the findings to show and overall picture of the changes made to improve the care for patients.

Patients were consulted about their wishes and offered appropriate options where they needed further medical treatment outside of the GP practice. The practice had an in house counselling service which took self-referrals which made the service more accessible to

Summary of findings

patients. The practice worked effectively with other health professionals. We heard from other health care professionals who either used the practice facilities or came in contact with the practice about their experiences.

The learning needs of staff were identified and recorded in their personnel records. A central record of training needs or requests for professional development had not been implemented. There was no recorded training plan in place.

Are services caring?

Good

The practice is rated as good for 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. The practice had made improvements as a result of complaints to improve patients' privacy and dignity. There had been raised concerns about difficulties of how confidentiality was maintained in the reception area. The practice had looked at how it could reduce conversations being overheard and had implemented a radio in the waiting area to mask conversations at the reception desk.

Information from patients showed that staff usually took the time to explain and support them with understanding their medical needs and the treatments provided. Patients had access to an in house counselling service and were signposted to external organisations when appropriate.

Are services responsive to people's needs?

Good

The practice is rated as requires good for responsive. 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.

There was a flexible approach to providing support to patients such as offering influenza vaccinations at lunch time and on a Saturday to meet the needs of working people and families. GPs also offered early morning appointments for patients. Patients reported good access to the practice with urgent appointments available the same day.

Summary of findings

The practice had systems in place to communicate with patients whose first language was not English including information in other languages.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for well-led. The practice had a number of policies and procedures to govern activity. The practice sought feedback from patients and had an active patient participation group (PPG). All staff had received inductions and nearly all staff had received regular performance reviews and attended staff meetings.

The practice had looked at the sustainability of providing a comprehensive service at its current location. There was a clear vision for the practice to move to new purpose built premises in 2015/2016 which was under control of the current building provider. Changes in the GP partnership through retirement had already been discussed and plans were in progress of being put in place as not disrupt the delivery of the service to patients. All of the staff we spoke with had a good understanding of the ethos and vision of the practice this included from the reception and administration staff to the GPs.

There were some systems for audit including those for the health and safety at the practice as well as some of the aspects of the management of the service. We found that there were gaps in some of the audit processes that had the potential to put patients and others at risk. Medicine and infection control audits were not always carried out effectively. There was not a planned approach to the training of staff or clinical audits.

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. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs and home visits.

The practice offered on-going care and support for older people. Information from patients showed they had experienced treatment in a caring way from staff and they were satisfied with the support they had.

The location of the practice presented a challenge to some patients who we observed to walk into the wrong service. The signage for the building did not meet good practice recommendations for those who had sight impairments or dementia. The central patient waiting area was cramped and we observed during morning surgery that there was limited space for patients to get past each other, there and in adjacent corridors.

The passenger lift which was shared with the other services on the first floor of the building was small and the lighting was poor. We observed patients with wheelchairs and mobility scooters had difficulty negotiating the lift.

Patients were referred to the memory clinic and other services at the local hospital which were specifically for patients with dementia.

People with long term conditions

Good

Each patient was seen by a GP as part of the registration process and if further tests and screening were needed, such as joining the on-going monitoring for long-term health conditions like diabetes and high blood pressure, these were arranged.

We found patients' long-term conditions were monitored effectively using the information from the Quality and Outcomes Framework (QOF) data for 2012/2013. The long-term conditions included asthma, coronary heart disease and diabetes. The GP and nursing team had a particular interest in patient with diabetes. Staff had identified patients from a particular ethnic group who were at greater risk for developing diabetes. Patients from this ethnic group were systematically screened when they registered or when they attended the practice.

Summary of findings

Patients were directed to other providers and external support groups for additional help and support for long terms conditions such as stroke and dementia.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people.

There was multidisciplinary working for mothers and babies for post natal checks and first immunisation. The midwives worked with the GPs and practice nurses to ensure that post natal checks including mental health occurred at eight weeks so that new mothers could attend and their babies could receive their immunisations at the same time. We were told midwives had experienced their opinions on patients care needs were listened to and acted upon by the GPs.

Staff ensured that they had a flexible approach to providing support to patients such as offering influenza vaccinations on a Saturday to meet the needs of families.

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 offer continuity of care. The practice offered a range of health promotion and screening which reflected the needs for this age group.

The practice had a flexible approach to providing appointments and access to services for patients who were not able to attend during usual working hours. There were opportunities for early morning booked appointments so that patients who worked could attend.

The practice offered well person checks for the working age population which looked at patients' cardiovascular health. There were targeted health concerns that patients were alerted to and encouraged to attend screening for such as testicular cancer. Staff offered influenza vaccinations at lunch time and on a Saturday to meet the needs of working people.

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 sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in

Summary of findings

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.

The practice partners told us they worked in collaboration with the drug and alcohol service for the medical care of people who were drug or alcohol dependent.

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). 82% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

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 patients who had attended accident and emergency where there may have been mental health needs.

The practice provided support to patients with a variety of mental health needs, including depression, dementia and poor mental health. Patients were assessed and had on-going reviews, with additional support from other professionals. The practice offered counselling services to patients which they could refer themselves without seeing a GP.

Patients with dementia and their carers were directed for more specific access to external support from other organisations.

Summary of findings

What people who use the service say

We spoke with three patients and received 18 comment cards. The verbal and written feedback we received from patients had common themes about their experiences. Patients found staff to be professional, friendly, helpful and caring. Examples patients shared with us demonstrated they experienced staff listening to them and being responsive to their changed needs or concerns.

Patients told us the practice nurses were kind, caring and knowledgeable and felt the treatment they received was good. Some patients found the waiting area cramped and were concerned that people with walking sticks, walking frames, wheelchairs or prams would find the area difficult to negotiate. Some patients told us the seating did not always suit patients' needs because it was too low or narrow to their needs.

Some patients told us they had concerns about accessing appointments with the GP of their choice and the telephone manner of reception staff was abrupt. However, this was not the experience had by others who praised the prompt access to appointments and the friendliness of staff.

Areas for improvement

Action the service MUST take to improve

Ensure vaccines and liquid nitrogen are stored securely and monitor and record the temperatures of all refrigerators containing medicines and / or vaccines. Infection control was compromised by the use of an adjoining sluice room between the practice's two treatment rooms where nursing staff moved between these rooms to access equipment and facilities and equipment stored in this area was at risk of contamination.

Checks must be made to ensure audits, such as medicines safety and infection control are carried out and are effectual. The current arrangements for accessing resuscitation equipment must be risk assessed to ensure the safety and welfare of patients and staff.

Action the service SHOULD take to improve

There should be a planned approach to clinical audits. The training needs of staff should be identified and planned for. Risk assess access arrangements for patients to the practice building and facilities.

The Whalebridge Practice

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 second CQC inspector and a practice manager specialist advisor.

Background to The Whalebridge Practice

The Whalebridge Practice is situated in the town centre area of Swindon, Wiltshire. The practice has approximately 9,700 registered patients across a large area of Swindon. The practice is located in premises which are shared with another GP practice and a GP walk in service. Other community healthcare services are also based in the same building. The practice has four consulting rooms and two treatment rooms. The practice is on a primary medical service contract with the Swindon Clinical Commissioning Group.

The Whalebridge Practice is only provided from one location:

Health Centre

Carfax Street

Swindon

Wiltshire

SN1 1ED

The practice supported patients from all the population groups: 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 44% of patients registered with the practice were working aged from 15 to 44 years, 25% were aged from 45 to 64 years old. Just above 7% were over 65 years old and 16% 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 11% and 7.9% of the working population were unemployed.

There were four GP partners and one salaried GP. Three practice nurses and one healthcare assistant provided health screening and treatment five days a week. Additional clinics were available occasionally to meet specific needs such as influenza vaccinations. The GPs were available for routine surgeries between the hours of 8am and 6.30pm Monday to Friday. Early morning appointments were available on request from 7am to 8am.

The practice referred patients to another provider for an Out of Hours service to deal with any urgent 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.

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 other healthcare practitioners associated with Whalebridge Practice. These included a palliative nurse specialist, midwife and counsellor.

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 three of the GPs, two practice nurses, the practice manager, and the reception and administration staff on duty. We spoke with three patients in person during the day. We used information from the 18 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.

Inadequate

Are services safe?

Our findings

Safe track record

The records we looked at showed that 19 incidents had occurred during the last 12 months. These incidents included clinical events and drug errors. The practice monitored and responded to safety alerts such as those from MRHA (Medicines and Healthcare products Regulatory Agency).

The practice had a system in place for reporting, recording and monitoring significant events. There was a policy document regarding significant and incident reporting for clinical and other incidents. The records we reviewed showed that each clinical event or incident that impacted upon the practice was analysed and discussed by the GPs, senior practice nurse and practice manager.

Where events needed to be raised externally, such as with other providers or other relevant bodies, this was done. We found that any events that impacted on the safety and safe delivery of the service at the practice were dealt with in a similar manner.

Learning and improvement from safety incidents

When we spoke with other nursing staff we were told that some of the findings from the investigation of significant events were disseminated verbally to them when it was relevant to their role. For example changes to how they staff responded and put checks in place for mental health patients discharged to the community following a long term stay in hospital. This was to ensure that systems of support, plans of care and stable medication regimes were in place.

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 in safeguarding. The practice had a dedicated GP who had been trained in child protection (Level 3) and as practice lead in safeguarding vulnerable adults.

The training records showed that of the other 17 staff employed, all except six of them had safeguarding training updates during the last two years. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. All staff we spoke with could name the practice's safeguarding lead and who to speak to in the practice if they had a safeguarding concern. Information and contact numbers were available so staff could escalate concerns when they arose.

The GPs ensured relevant information was available to staff about children, young people and families at risk. The practice used a system of alerts on the computer patient record system to do this. Patients at risk from abuse and domestic abuse were also identified.

The practice had a policy and procedure for supporting patients who wished to be accompanied by a chaperone or who were risk assessed as needing a chaperone. The written chaperone policy provided guidelines to staff but did not make reference to recognised practice or professional guidance on chaperoning. Nursing staff told us they supported GPs when a chaperone was required. Staff told us in addition alternative appointments were made if the appropriate gender of GP was not on duty should it be required by the patient. There was no evidence from the training record that any staff had training for providing a chaperone role.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found that the medicine refrigerator where the central stocks of vaccines were stored was not locked and was kept in an unsecure area. In addition we found that there were gaps in records which indicated that the refrigerator temperatures had not been monitored regularly. When temperatures had risen above the required level, action had not been taken by staff. Appropriate checks had been made for the medicines stored in all other refrigerators. We found the staff had not followed the practices protocols for safe monitoring of the storage and cold chain of medicines held at the practice.

There were protocols for the administration of vaccines. Nursing staff had received regular training updates for the administration of vaccines.

A cylinder of liquid nitrogen, which was used for treatment for skin disorders, was kept in an unsecured area. There was no safety lock on the handle of the cylinder to prevent the liquid nitrogen being discharged accidentally. There were two sets of guidelines for the use of the liquid nitrogen and there were risk assessments with differing

information for storing, handling and using liquid nitrogen. Gloves and a safety mask were kept with the cylinder as protective equipment to be worn when liquid nitrogen was decanted for use.

There were systems in place to audit other medicines held in the practice. There was a log and checks for expiry dates of medicines kept in GPs bags used for home visits. Emergency medicines were not kept in the practice but held centrally downstairs with other resuscitation equipment by another service and shared between providers. We found these medicines were checked monthly. There was no risk assessment carried out to check that this was a safe system for patients' and staff that did not compromise their well-being.

A member of the nursing staff was qualified as an independent prescriber and they received regular supervision and support in their role. They told us they received updates in the specific clinical areas of expertise for which they prescribed.

Patients were informed of the processes for obtaining prescription medications on the practices website and in leaflets and information on display. Patients were guided to make appointments to see the senior practice nurse who could issue prescriptions for common ailments.

There was a computerised repeat prescription service and patients were required to attend regular checks to monitor their health and the effectiveness of the medications.

The practice does not have a designated prescribing lead for medicines management at the practice. From information made available to us during the inspection the practice was below budget and there were no concerns about the medicines prescribing at the practice.

Cleanliness & Infection Control

We observed the premises to be clean although not all areas were tidy. Equipment, files and documents on shelves and surfaces in the clinical treatment rooms did not aid quick cleaning between patient consultations. The use of an adjoining sluice room between the practice's two treatment rooms posed a risk of spreading infection. Nursing staff moved between these rooms to access equipment and facilities. There were open areas where equipment was stored in the sluice room and was at risk of contamination. Sample bottles, bags and other equipment were stored near the sluice sink which was used to dispose of unwanted specimens of bodily fluids.

There was shared responsibility with the building owner for cleaning and the disposal of clinical waste, sharps and household waste. There were policies and procedures in place for this. However, lines of accountability were not clear for the waste movement/ handover to the cleaning staff who were the responsibility of the building provider. The cleaning and maintenance staff were part of the practice's contractual agreement with the provider of the building.

The practice had a nurse lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and to carry out staff training. All staff received induction training about infection control specific to their role and thereafter received annual updates. We saw evidence the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Practice meeting minutes showed the findings of the audits were discussed. However, these infection control audits had not picked up issues with the sluice room being used as a link to access the other clinical room or the equipment stored there.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement infection control measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use.

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 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. There was a system in place for monitoring the medical equipment used at the practice. Equipment such as spirometers and nebulisers machine were regularly serviced.

Inadequate

Are services safe?

The equipment for the general operation of the practice, such as computers, screens and photocopiers, was in place. There was evidence that these and other electrical equipment were subject to regular portable electrical appliance testing.

Staffing & Recruitment

The practice had four GP partners and employed one salaried GP, three practice nurses, and a health care assistant. There was also a practice manager and a team of administration and reception staff.

The practice had a low turnover of staff. Three new administration and reception staff had been employed in the last few months. We reviewed the records for the recruitment of the new staff and found the required information was obtained including proof of identity and references. All members of staff had a criminal record check via the Disclosure and Barring Service (DBS) before they commenced working in the practice.

The practice had recruitment and employment policies and when we spoke to new staff they confirmed that the processes had been followed. New staff were also provided with induction training and they told us they had been supported by other staff to learn their new roles.

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. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety & responding to risk

The practice was located in a purpose built environment which it shared with other tenants and NHS services. The health and safety of the building and external grounds was managed by a property management provider. There were audits and maintenance plans for the practice and grounds. There was a process to ensure that defects were reported and action taken in a timely way. The practice retained responsibility for the safety of their patients and employees, and had procedures in place that promoted safe working practices. Health and safety notices and information were on display in patient and staff areas.

We observed patients enter the building and walk into the wrong service. The signage for the building did not meet good practice recommendations for those who had sight impairments or dementia. For example, the information on the doors of the consulting and treatment rooms was very small. The practice manager told us they had put up additional signage but that the layout of the premises did not flow well and was not easy to navigate. The central patient waiting area was cramped and we observed during morning surgery that there was limited space for patients to get past each other there and in adjacent corridors. Seating did not meet different patients' health or physical needs as it was too low and narrow.

The passenger lift was shared with the other services on the first floor of the building. It was small and patients with wheelchairs, prams and mobility scooters had difficulty negotiating the lift. Lighting in the lift was also poor.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing 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 asked knew the location of this equipment and records we saw confirmed these were checked regularly.

We found this emergency resuscitation equipment was stored in separate areas within the building. The practice's own equipment, including an adult ambu-bag (hand-held device used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately) and mask, was kept in a central administration room of the practice. The rest of the emergency resuscitation equipment was shared by the three main services and was located downstairs in a consultation room in the walk in centre. Staff told us that in order for them to access resuscitation equipment, they were required to go downstairs and carry the equipment up to the practice. There was no policy or procedure and there were no risk assessments for this.

We inspected the defibrillator, the emergency drugs and two full portable cylinders of oxygen which were all in date and included the drugs required. Emergency equipment and medicines were checked weekly.

There were panic buttons in consulting rooms which staff could use in an emergency. However, there were at least three systems in place as a result of how the premises had

Inadequate

Are services safe?

used in the past for different purposes. Staff could use the computer system to call for help or either press a call button. One room had neither facility and staff had the use of an 'attack' alarm.

The practice had systems in place for fire safety and there were regular fire drills and safety checks including the alarm system. The practice had a business contingency plan should there be a disruption in delivering the practice.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

Care and treatment was delivered in line with recognised best practice standards and guidelines. There was a system for monitoring Medicines and Healthcare Products Regulatory Agency (MHRA) alerts and the dissemination of information from these to other staff. This included regular opportunities for discussion and the implementation of actions to amend patient's medication and treatment to reflect current guidance.

Staff explained to us how prospective patients were told about services at the practice and the processes carried out when new patients registered with the practice. Patients had access to information from the practice's website, which told them about the services on offer and the opening times. This information was also provided in leaflets and brochures at the reception.

Each patient was seen by a GP as part of the registration process and if further tests and screening were needed, such as joining the on-going monitoring for long-term health conditions like diabetes and high blood pressure, these were arranged.

The practice assessed patients' needs and planned care and treatment accordingly. The practice's performance against the Quality and Outcomes Framework (QOF) showed achievement in meeting patients' clinical needs. The Quality and Outcomes Framework **(**QOF**)** is the annual reward and incentive programme detailing GP practice achievement results with the aim to improve care provided to patients.

The figures showed the targets for providing treatment for patients with atrial fibrillation were level with the national average. 82% of people experiencing poor mental health had received an annual physical health check. The figures also showed that 75% (national average of 83%) of patients with a diagnosis of dementia had a review of their care in the previous 15 months.

Patients were consulted about their wishes and offered appropriate options where they needed further medical treatment outside of the GP practice, for example, the local palliative care nurse and the drug and alcohol service.

The practice had an in house counselling service which took self-referrals which made the service more accessible to patients.

Management, monitoring and improving outcomes for people

We looked at information provided by the practice and from the Swindon Clinical Commissioning Group. QOF data for 2012/2013 showed patients' long-term conditions were similar to the national average of 52%. The long-term conditions which were specifically monitored included asthma, coronary heart disease and diabetes. The GP and nursing team had a particular interest in patients with diabetes. Staff had identified patients from a particular ethnic group registered at the practice who were at greater risk for developing diabetes. Patients from this ethnic group were systematically screened when they registered or when they attended the practice.

Clinical audits took place. One GP described three audits in detail that the practice had found helpful in improving patient monitoring. These had been carried out in regard to patients with long term conditions and included audits of patients with atrial fibrillation (irregular heart rhythm) and the care of patients with mental health needs. These audits resulted in changes in the long term monitoring of their conditions. Staff at the practice, however could not provide evidence that there was a planned approach to clinical audits and how they collated the findings to show and overall picture of the changes made to improve the care for patients.

Patients' needs were regularly discussed and monitored and information was shared between GPs and nurses.

Effective staffing

All permanent and temporary staff were qualified to carry out their roles. We reviewed the records for recruitment and employment of staff, including those for induction and appraisals. Staff told us about their experiences of the recruitment, induction and appraisal systems as a positive experience.

The learning needs of staff were identified and recorded in their personnel records. A central record of training needs or requests for professional development had not been implemented. There was no recorded training plan in place.

We were told about training attended and completed by staff. Where required, nursing staff updated their

Requires improvement

Are services effective?

(for example, treatment is effective)

competencies, for example, one nurse told us they had updated their competencies and skills for caring and treating patients with diabetes. Other nursing staff informed us of their recent training for cytology and immunisations of children.

The GPs we spoke with confirmed they were up to date with their revalidations. (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.)

Working with other services

The practice worked effectively with other health professionals. We heard from other health care professionals who either used the practice facilities or came in contact with the practice about their experiences.

There was multidisciplinary team working for mothers and babies for post natal checks and first immunisations. The midwives worked with the practice nurses to ensure that post natal checks, including checks of post natal depression, occurred at eight weeks. These were organised so that new mothers could attend their check and their babies could receive their immunisations at the same time. Midwives told us their opinions on patients' care needs were listened to and acted upon by the GPs.

Staff told us the practice had a good working relationship with the local hospital and this worked well for older patients who could be referred to the hospital's memory clinic. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia that was shared with these other services.

The practice was located in an area of high population. The partners told us they worked in collaboration with the drug and alcohol service for the medical care of people who were dependent on alcohol or drugs.

Information sharing

There was appropriate communication and sharing of information between the health care professionals at the practice and other external professionals. We spoke with the palliative care nurse who worked with the practice in providing end of life care. The nurse told us there was a good and easy communication with the practice GPs. We were given an example of a concern about a patient who was being discharged from hospital without discharge medicines. The palliative care nurse discussed this issue with a GP and agreed an action plan where the GP visited the patient out of hours to ensure they received the treatment and support they needed.

Consent to care and treatment

Patients indicated in the information they provided in comment cards and the practices own surveys that staff were professional in their approach to them. Patients told us they participated in very thorough consultations with GPs and nurses and they felt listened to.

There were policies and procedures for consent including obtaining consent under the Mental Capacity Act 2005. Not all of the health professionals we spoke with had received training about the Mental Capacity Act 2005 but they did have an understanding of their responsibilities and what steps they should take if they had concerns. Two of the GPs we spoke with told us they had received appropriate training and showed awareness of vulnerable people including carers.

Health promotion and prevention

We saw patients were informed about health promotion events and the practice ran regular influenza vaccination sessions each year. Patients over 70 years old were given information about vaccination for shingles.

Patients were directed to external networks and local support groups to gain additional assistance, advice and support. Information leaflets and guidance were available to patients, including for those experiencing domestic violence and for carers. Support for lifestyle changes and healthy living was provided at the practice. This included nutritional advice and promoting sexual health care.

Patients' health needs or risks were targeted. We saw that female patients were advised about access to cervical smear testing. Staff had started a campaign to encourage male patients to undertake 'well men' checks including those for testicular cancer.

For adults aged between 40 and 74 years who had not had a health check with a GP in the last five years were offered a cardiovascular check. Staff had also ensured that some of the health promotion information was in Goan so that they could alert and reach the Goan population who used their services.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice had a recall system for new mothers and babies for the eight week post-natal checks. Staff told us this was in case new mothers did not attend for checks. The practice had recently introduced a text messaging service to remind patients of appointments in general.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The verbal and written feedback we received from 18 patients showed patients common themes about their experiences. Patients found staff to be professional, friendly, helpful and caring. Examples patients shared with us demonstrated they were experienced staff listening to them and being responsive to their changed needs or concerns.

The practice had made improvements as a result of complaints to improve patients' privacy and dignity. Comments left on NHS Choices and concerns raised in complaints showed at times patients had felt their concerns or needs not met. We saw from the practice's responses to the complainants that it has tried to address these issues. One example of this was a comment from the patients' survey carried out 2013 raised concerns about difficulties how confidentiality was maintained in the reception area. The practice had looked at how it could reduce conversations being overheard as there was no space in the reception area where patients could speak privately to staff if they wished to. The practice had implemented a radio in the waiting area to mask conversations at the reception desk they had also arranged should a patient ask to speak to a receptionist in a private room in the practice.

We observed that staff spoke politely and respectfully to patients, both on the phone and face to face. However, patients told us that at times they had found the reception staffs manner could be a little friendlier on the phone. GPs and the practice nurse collected patients from the waiting room and ensured the consulting and treatment room doors remained shut during patient appointments.

Care planning and involvement in decisions about care and treatment

The information we reviewed from the national patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice satisfactory in these areas.

Comments in the survey cards received from the inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

People with long term conditions, such as diabetes, told us that they were involved in the consultation and the plan of care they required.

Patients' supporters and carers were involved in decisions about care and treatment where patients had given consent and agreement.

Patient/carer support to cope emotionally with care and treatment

Information from patients showed that staff usually took the time to explain and support them with understanding their medical needs and the treatments provided. Patients had access to counselling at the practice if they wished to use it. Patients were signposted to external organisations such as support for people with learning difficulties and carer forums.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. For example, patients with long term health conditions such as diabetes.

Patients and staff told us that all patients who requested urgent attention were always seen on the day of their request. We saw comments from patients who had appreciated their needs being attended to so quickly.

Staff told us, however, that there was high demand for urgent appointments and that limited the availability of the GPs to provide planned appointments for patients. They told us that they intended to commence a triage service so that urgent requests were assessed and requests were prioritised according to need.

Staff had a flexible approach to providing support to patients, for example, offering influenza vaccinations at lunch time and on a Saturday to meet the needs of working people and families.

There was a computerised system for obtaining repeat prescriptions and patients were gradually using the email request service. The email request service allowed patients to ask for repeat prescriptions electronically. Other patients either posted or placed their request in a drop box in reception. Patients told us these systems worked well for them. .

The practice had a Patient Participation Group (PPG) and patients were able to provide feedback about the quality of services at the practice through the PPG. The PPG carried out regular patient surveys and there was evidence that information from these was used to develop services provided by the practice. A spokesperson from the PPG said the practice listened to them about the positive and negative points patients made about the service. This included trying to improve arrangements for maintaining confidentiality in the reception area and the flexibility and availability of appointments.

Tackling inequity and promoting equality

The practice had not recognised the needs of different groups in the planning of its services.

The building in which the practice was located was not well adapted to meet the needs of people with disabilities or accessibility for other population groups. For example, there was a lift which could take patients up to the first floor where the practice was located but it was small and dimly lit. Patients using prams, wheelchairs, or mobility scooters had limited access to the lift. We observed patients having to push through large queues of patients attending the walk-in centre and the pharmacy on the ground floor. The main waiting area was not appropriate to meet the needs of those with poor mobility.

Staff had taken steps to reach patients whose first language was not English. This included providing information in other languages. Staff had a good understanding of the needs of the local Goan population who used the practice. Although they did not have interpreter on site they ensured that access to an interpreting service was available to use.

The practice had recognised that the facilities and environment does not meet patient's needs and had plans to relocate to new shared facilities. The building provider has raised plans to demolish the current building and rebuild a new shared facility. The intention was this to be completed by the end of 2015 but this had now been extended to 2016.

Access to the service

GPs and staff told us how the practice aimed to work flexibly and responsively to patients' needs. The practice had an appointment system between the hours of 8am and 6.30pm Monday to Friday that worked well for some patients but staff and patients told us made it difficult at times for patients to get a timely appointment for non-urgent needs with the GP of their choice. GPs offered early morning appointments from 07:00 to 08:00 for patients before normal working hours so that they could access treatment and support when needed.

Three practice nurses and one healthcare assistant provided health screening and treatment five days a week. Additional clinics were available occasionally to meet specific needs such as influenza vaccinations.

Out of hours was provided by an external provider and information about this service was on display in the practice, their website and in the practice leaflet.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns & complaints

None of the patients who gave us written comments had made a complaint. They commented that they felt staff listened to them and responded appropriately to any concerns they had.

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 and there was a designated responsible person who handled all complaints in the practice. The complaints policy and procedure was on display in patient areas and in the leaflets about the practice left in the waiting area.

According to records given to us by the practice, there had been 16 recorded complaints made during the period of April 2013 to March 2014. We saw that all but one of the complaints had been resolved. One complaint had been referred to the Parliamentary and Health Service Ombudsman and not upheld.

The practice management had undertaken an audit of the formal complaints received. They had identified that six complaints had been in regard to clinical decisions, advice and treatment. Six complaints had been in regard to the administration of the practice and two about patient experience of staff attitude and communication. The two others that had been received by the practice were for issues which were out of their control, such as waiting times for treatment with another provider. We saw from their own audit processes that GPs and other staff routinely discussed concerns and complaints on a daily basis. There was information to show complaints were responded to appropriately and actions taken to improve or prevent events reoccurring.

Are services well-led?

Requires improvement

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

Our findings

Vision and Strategy

The practice had looked at the sustainability of providing a comprehensive service at its current location. There was a clear vision for the practice to move to new purpose built premises in 2015/2016 which was under control of the current building provider. Changes in the GP partnership through planned retirement of GPs had already been discussed and plans were in progress of being put in place as to not disrupt the delivery of the service to patients. All of the staff we spoke with had a good understanding of the ethos and vision of the practice this included from the reception and administration staff to the GPs.

Governance Arrangements

We found that there were gaps in audit processes that put patients and others at significant risk. Medicine and infection control audits were not always carried out effectively. Vaccines and liquid nitrogen were not stored securely and the system to monitor and record the temperatures of all refrigerators containing medicines and/or vaccines was not carried out sufficiently. There was not a planned approach to clinical audits and checks were not made to ensure audits, such as medicines safety and infection control were carried out and were effectual. The training needs of staff were not identified and planned for.

The practice used information and made changes in accordance to national standards to improve the service to patients. This included using information from the National Institute for Health and Care Excellence (NICE). The practice had a system of governance for meeting the Quality and Outcome Framework (QOF) targets and patients' clinical needs. One GP took the lead for monitoring and ensuring targets were maintained and met.

The practice staff shared responsibilities of governance. There were specific leads for QOF, information and technology, infection control and safeguarding.

There was a system for the GP partners for reviewing the clinical delivery and management of the practice. Every Friday morning they met with the practice manager and senior nurse to discuss formally any events or issues that occurred. We were told the GPs also took the opportunity to discuss at coffee and lunchtime breaks any other issues of how the practice was run. The decisions made at these informal meetings were not always recorded.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. GPs took lead roles in areas such as safeguarding and the overall management of the service. The practice nurse and practice manager also had specific roles they carried out. Staff we spoke with were clear about their roles and responsibilities. Staff knew who to go to in the practice if they had concerns.

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

Patients had participated in the practices own patient survey during 2013/2014, where they commented on their experiences of the practice. They had been asked about appointment access, cleanliness, privacy in reception and telephone contact. Of the 9741 patients 392 survey responses were received. Patients' opinion of access to appointments showed they found appointments were obtained to suit their needs. The did note they would like to make routine appointments further in advance. There was information to show that patients' comments were listened to and where changes could be put in place, acted upon. For example the management team reviewed the timeframe of availability to book appointments in advance. They found that because of GPs and nursing staff commitments and responding to the changing needs this could not be offered to ensure that patient saw the GP or member of staff preferred. Staff discussed issues at the regular staff meetings and actions taken to improve the service. Patients' comments showed staff listened to their concerns and had taken steps to resolve them.

The practice had a small Patient Participation Group (PPG). When we spoke with representatives from the PPG told us they felt supported by practice staff. There were regular staff meetings at different levels where staff could raise topics of discussion and plans for developing the service. GPs had daily and weekly meetings to discuss clinical support to patients and the management of the service. There were monthly staff meetings where significant events, concerns and general administration of the practice were discussed and actions taken. There was a system of induction of new staff and on-going supervision and appraisal of staff.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training

Are services well-led?

Requires improvement

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

and mentoring. We looked at three staff files and saw that appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had attended training away from the practice as well as participating in training provided at the practice.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example a review of a significant event looked at how there had been gaps in support provided to patient and staff had put checks in place for mental health patients discharged to the community following a long term stay in hospital. This was to ensure that systems of support, plans of care and stable medication regimes were in place.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
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 or audits in place. Vaccines and liquid nitrogen were not stored securely and there should be a process to monitor and record the temperatures of all refrigerators containing medicines and / or vaccines. The current arrangements for accessing resuscitation equipment must be risk assessed to ensure the safety and welfare of patients and staff. Regulation 13.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The registered person did not ensure as far as possible services users, persons employed for the purpose of the regulated activity and others were protected against identifiable risks from health care associated infections. Infection control was compromised by the use of an adjoining sluice room between the practice's two treatment rooms where nursing staff moved between these rooms to access equipment and facilities and equipment stored in this area was at risk of contamination. Regulation 12.1, 2(a).