Sparcells 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?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This was a comprehensive inspection of Sparcells Surgery and was carried out on the 22 October 2014.

Overall, we found the practice was providing a good service. We found good practice in the way the practice responded to the needs of older patients and patients with long term conditions, providing them with effective care and treatment. The practice had responded well to the needs of working patients and those patients who had barriers to accessing GP services.

Our key findings were as follows:

- The practice was nurse led with a highly qualified nursing team with one GP providing care and treatment each day
- Appointments were easily accessible on the same day but not as accessible to see the GP of choice, however, arrangements were in place to ensure consistency for those patients who had complex needs
- Patients were highly satisfied and had confidence in the nursing team, who treated them with kindness and respect

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

The provider should put the following actions in place:

- Capture patient views regularly to ensure the practice acted on patient views and where needed improved the quality of service it provided.
- Establish an effective way to inform patients of why significant organisational changes in the practice have been made and how the changes may affect them, such as recruiting the nurse practitioner and what care and treatment they could carry out.
- Provide accurate information about how to complain externally on its website and themes of complaints should be shared as learning with the whole team.
- Ensure its policies and procedures are kept up to date and reviewed annually to ensure information is accurate and reflective of current guidelines.
- Ensure clinical audits follow a cycle to ensure improvements have been followed through.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. NICE guidance was referenced and used routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of patients' capacity to make decisions and the promotion of good health lifestyle. Staff had received training appropriate to their roles and further training needs have been identified and planned. Multidisciplinary working was evidenced.

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 saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported a mixed view about continuity of care but we found there were always urgent appointments available on the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system and evidence seen demonstrated the practice responded quickly to issues raised. The practice should share learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver a well led service. Staff we spoke with

Summary of findings

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 tried to implement an active patient participation group. 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

Good

The practice is rated as good for the care of older patients. The practice had 1% of registered patients over 75 years old. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older patients. The practice offered proactive, personalised care to meet the needs of older patients in its population and had a range of enhanced services, for example all patients were allocated a specific GP and had a care plan tailored to their care needs. The practice was responsive to the needs of older patients, including organising urgent home visits through a service organised by Swindon CCG and provided rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the population group of patients with long term conditions. Patients with a long-term condition were well supported to manage their health, care and treatment. Approximately 16% of the patients in the practice were diagnosed with a long term condition, which excluded mental health needs. The practice offered a range of specific clinics each week, such as diabetes and respiratory conditions, run by specially trained nurses. Nurse practitioners would carry out home visits, when necessary including visiting those patients with long term conditions.

The practice monitored annual checks to ensure patients were seen at the right time or reminded to book an appointment. Reminders were sent to the patient by telephone or text reminders. Nurses provided support and signposting to local support groups to increase health and wellbeing in patients.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young patients. Systems were in place to identify and following-up children living in disadvantaged circumstances and who were at potential risk of harm. For example, children and young people who were on the child protection register were to prompt professionals to their particular needs. Immunisation rates were high for all standard childhood immunisations. Patients told us and we saw evidence to demonstrate that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours. We were provided with good examples of joint working with midwives, health visitors and school nurses.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age patients (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 was proactive in offering online services for repeat prescriptions as well as a full range of health promotion and screening opportunities which reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients 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 for patients with a learning disability and 100% of these patients had received a follow-up.

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.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of patients experiencing poor mental health (including patients with a form of dementia). Since April 2014, 89% of the 26 patients identified as experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health including those with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations including MIND and SANE. The practice had weekly dedicated counselling clinics supplied by Swindon Primary Care Psychology Service. 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 identified.

Summary of findings

What people who use the service say

We received 47 comment cards completed by patients prior to our inspection and spoke with six patients during our inspection. We found patients had a high regard for the GPs and nursing staff and felt confident in diagnosis made and treatment provided. The comment cards showed 68% of patients were very satisfied with the service received compared to 15% who said they had to wait an unreasonable amount of time to see the GP of their choice. For example, timescales quoted were from seven days to three weeks wait to see their GP. The practice did allocate same day appointment slots every day. However due to the practice size and three GPs covering the full time workload of one GP, it meant patients would have to wait longer periods to see a specific GP.

Prior to our inspection we reviewed other sources about patient experience of the service provided. This included NHS choices (a forum for patients to publicly provide their views about the practice and where the practice can respond to these views). We saw five comments about the practice had been posted in the last year. Four out of the five comments were not happy with the service provided by the practice. The main themes were around the changes made in the practice and long waits for appointments. The practice had not responded to any of these comments.

We also reviewed the national GP patient survey taken from patients for the periods of January to March and July to September 2013. This is a national survey sent to patients by an independent company on behalf of NHS England. Sixty patients had completed the surveys from 194 sent. We found areas for improvement were around how long patients had to wait to get an appointment and waiting longer than 15 minutes after their appointment time to be seen. The period when the surveys were taken was just after Carfax Health Enterprise had taken over the practice. One of the challenges they had faced when they took over the practice was to ensure patient records were accurate and up to date. This had impacted on patient appointment times over running. The practice told us this had improved over time because all records had been reviewed.

The practice had been through a number of major changes since Carfax health Enterprise had taken over, such as refurbishing the practice building, reviewing and updating all patient records to ensure they were accurate, changing the electronic patient record system and developing the practice into a nurse led service. The practice had tried to implement a patient participation group and we saw posters in the waiting area advertising this, however there had not been enough interest from patients. The practice planned to develop a virtual patient feedback group to encourage mothers of young children and younger members of the working population to participate in developing the practice. In the meantime, the practice had developed newsletter to inform patients of the changes it had implemented.

Areas for improvement

Action the service SHOULD take to improve

- The provider should capture patient views regularly to ensure the practice acts on patient views and improves the quality of service provided.
- The provider should establish an effective way to inform patients of why significant changes in the practice have been made and how the changes may affect them.
- The provider should provide accurate information about how to complain externally on its website and themes of complaints should be shared as learning with the whole team.
- The provider should ensure its policies and procedures are kept up to date and reviewed annually to ensure information is accurate and reflective of current guidelines.
- The provider should ensure clinical audits follow a cycle to ensure improvements have been followed through.

Sparcells Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP and a practice manager. The GP had a range of experience in general practice including over 40 years clinical experience with 38 years as a GP. This included several roles in NHS management, where they provided the NHS with the GP perspective of practices and informed GPs of new NHS directives. They are currently a GP appraiser. The practice manager had recently retired from practice management with over 17 years' experience of managing two rural dispensing practices, one of which was a training practice. Also, they were a quality and outcomes framework (QOF) management assessor for four years. Their experience included working in primary and secondary care as well as private medicine, with skills in strategy and planning, project management, human resources including training and development, finance, IT and communications, management of change and governance.

Background to Sparcells Surgery

We inspected the location of Sparcells Surgery, Midwinter Close, Peatmoor, Swindon, SN5 5AN, where all registered regulated activities were carried out.

Sparcells Surgery serves approximately 3180 patients and is situated in the Peatmoor area of Swindon. There is currently a large housing development being built in the area and the practice is anticipating an increase in patient numbers from this development. The practice has a large demographic of working population and families. Only 1% of the patient base was over 75 years and 71% of the patient population age group from 18 to 75 years old. There was no information available to determine the number of patients from ethnic minorities.

Sparcells Surgery is run by a non-profit social enterprise organisation called Carfax Health Enterprise CIC, which has an Alternative Provider Medical Services contract. Sparcells Surgery is contracted through Carfax Health Enterprise CIC with a General Medical Services contract. Sparcells Surgery had opted out of the out of hours service. Carfax Health Enterprise CIC consists of a walk in centre in central Swindon and another practice called Carfax NHS medical centre which is based at the same site as the walk in centre and meets the needs of over 11,000 patients. Carfax NHS medical centre is a registered training practice for GP registrars.

Sparcells Surgery was taken over by Carfax Health Enterprise CIC in January 2013. Previously it had been run a single handed GP and was taken over by the Primary Care Trust (now Clinical Commissioning Group) for two years to support the practice, when the GP left. Since Carfax Health Enterprise CIC took over they have completed extensive refurbishment work and upgrades to clinical records and systems to manage the quality of care provided.

The practice has a full time nurse practitioner, an advanced practice registered nurse, who has completed an additional three years training to enable them to have an increased knowledge base, clinical expertise and decision making skills. They are also trained to prescribe medicines for a number of additional treatments, such as for a urinary tract infection. This enables the GP to see more patients with more complex needs.

The practice has the equivalent of three full-time nurses and health care assistants including the nurse practitioner. There is also the equivalent of one full-time GP, which is

Detailed findings

made up of three GPs (two female and one male) who cover patient care throughout the week. Two out of the three GPs are employed as long term locums and the other is a salaried GP. The practice has advertised for permanent GPs however interest for the role has been limited, this has been a challenge for the practice. There is a team of directors that oversee Sparcells Surgery and all have a role in maintaining the quality of service provided at the practice.

Why we carried out this inspection

We carried out a comprehensive inspection of this practice 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 practice, and to provide a rating for the practice under the Care Act 2014.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We spoke with the Swindon Clinical Commissioning Group, NHS England local area team and Swindon Healthwatch. We carried out an announced visit on the 22 October 2014. During our visit we spoke with a range of staff including clinical, operations and nursing directors, two GPs, three members of the nursing team, office manager, receptionist, a visiting midwife and spoke with six patients. We reviewed 47 comment cards where patients shared their views and experiences of the service prior to our inspection.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, following completion of an audit, concerns had been highlighted and the incident had been reported to the relevant authorities.

We reviewed safety records, incident reports and minutes of meetings where these were discussed in the last year. This showed the practice had managed these consistently over time and so could evidence a safe track record over the longer term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last year and these were made available to us. A slot for significant events was on the weekly GP meeting agenda to review actions from past significant events and complaints. There was evidence appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so, if the need arose.

We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager who showed us the system they used to oversee these were managed and monitored. We saw records of seven incidents which were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us, such as when a home visit was missed, the triage system was reviewed and discussed at a significant event meeting.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable patients. Practice training records made available to us showed all staff had received relevant role specific training about safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in 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 easily accessible and displayed within treatment rooms.

The practice had dedicated GP's appointed as leads in safeguarding vulnerable adults and children who had been trained to enable them to fulfil this role. For example, the GP we spoke with had completed level 3 training in safeguarding children. All staff we spoke with were aware who these lead staff were and who to speak to in the practice if they had a safeguarding concern.

There was a system on the practice's electronic records to highlight vulnerable patients. This included key information so staff were aware of any relevant issues when patients attended appointments. For example, children subject to child protection plans or high attendance at accident and emergency. A member of staff completed regular medicine reviews audits to ensure patients were receiving the right medicine for their condition.

A chaperone policy was in place and advertisement of chaperone availability was visible in the waiting room and in consulting/treatment rooms. Four receptionists had undertaken training and understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals. Part of the provider induction covered good record keeping and its importance due to a number of GPs providing care and treatment within the practice.

Medicines management

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

Good

Are services safe?

Processes were in place to check medicines were within their expiry date and suitable for use. One emergency medicine was a month out of date when we checked it. We were informed by the managing director that the practice had replaced this medicine within 24 hours after the inspection and reviewed its monitoring system. Expired and unwanted medicines were disposed of in line with waste regulations.

Vaccines were administered by nursing staff using directions that had been produced in line with legal requirements and national guidance. For example, the nurse told us the differences between particular vaccines to ensure patients received the right vaccine appropriate to their needs. We saw refrigerators holding vaccines could be accidently switched off or unplugged. The practice told us they would review their arrangements to ensure risks affecting the fridge temperature were reduced.

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

Prescriptions were computer generated and produced by the prescriber. Medicine reviews were completed for patients whose prescriptions were out of date. This helped to ensure patient's repeat prescriptions were still appropriate and necessary.

The practice did not hold any controlled drugs on the practice premises. If necessary controlled drugs were easily accessible from the pharmacy next door to the practice.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place. We had no concerns about cleanliness or infection control.

The practice had a lead person for infection control. All staff had completed online infection control training in the last year. We saw evidence the lead person had carried out an audit last year and improvements identified for action were completed on time.

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. Disposable curtains were used which were changed if visible bodily fluids were on them or would now be changing the curtains every six months. There was bodily fluid spillage kit available for staff to use if an incident occurred.

Staff were taught hand hygiene techniques within their annual training. Hand washing sinks with wall mounted hand soap, hand gel and hand towel dispensers were available in treatment rooms and patient and staff toilets.

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 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 calibration of relevant equipment; for example weighing scales and ECG machine.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

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 actual staffing levels and skill mix were in line with planned staffing requirements.

Good

Are services safe?

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all administration staff had received training in basic life support. GPs and nurses had received intermediate life support training. Emergency equipment was available including access to oxygen, pulse oximeters for adults and children and an automated external defibrillator (used to attempt to restart a patients heart in an emergency). All staff asked knew the location of this equipment and records seen by us confirmed these were checked regularly. We noted not all equipment was in the same place for ease of access, for example the pulse oximeters and one of the emergency medicines was in the home visit bag. The practice reviewed their protocols for medical emergencies and changed their system within 24 hours after the inspection.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The practice did not routinely hold stocks of medicines for the treatment for severe pain. The reason for this was because they had a very low number of palliative care patients and there was quick access from the pharmacy if any were needed. We were assured a full risk assessment had been undertaken and a protocol was in place to manage this. Processes were also in place to check that emergency medicines were within their expiry date and suitable for use. One of the emergency medicines we checked was one month out of date. All others were in date. The practice took immediate action to rectify this and changed their protocols to ensure their systems for checking these medicines was more robust.

A business continuity plan was in place to deal with a range of emergencies which may impact 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 which staff could refer. For example, the contact details of a heating company to contact in the event of failure of the heating system.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance and accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. There was a shared internet system where updates were kept and GPs and nursing staff could review current guidance. The staff we spoke with and evidence we reviewed confirmed these actions were aimed to ensure 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 completed a review of all case notes for all registered patients over the last 18 months. This ensured all patient notes were up to date and patients received appropriate treatment and regular reviews. The practice used computerised tools to identify patients with complex health needs and they had multidisciplinary care plans documented in their case notes. Patients who had recently attended accident and emergency were reviewed on a weekly basis and highlighted for follow up consultations, if required.

All referrals made by a locum GP were reviewed by a senior GP prior to being sent to hospital unless they were urgent referrals. This was another step to ensure patient consistency and referrals were relevant.

Interviews with GPs showed there was no evidence of discrimination when making care and treatment decisions.

Management, monitoring and improving outcomes for patients

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the operations and clinical directors and lead GPs to support the practice to carry out clinical audits.

The practice showed us 17 clinical audits that had been undertaken in the last seven months. Our GP specialist advisor discussed audits with a GP at the practice and they agreed they needed to improve how they demonstrated improvements to patient care through clinical audit cycles. Other examples of clinical audit included audits to confirm the GPs who prescribed contraception were doing so in line with their registration and NICE guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. We saw 11 audits had been carried out for reviewing medicines to ensure they were appropriate for the patient. Following the audit the GPs carried out medicines reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, 83.8% of patients with a diagnosis of diabetes had an annual medicine review. The practice met all the minimum standards for QOF in asthma and chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved.

Staff ensured all routine health checks were completed for patients with long-term conditions such as diabetes and evidenced that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP prescribed medicines.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all administration staff were up to date with attendance at mandatory courses such as annual basic life support. GPs and nurses had completed intermediate life support training. All GPs were up to date with their annual continuing professional development requirements and all

Good

Are services effective?

(for example, treatment is effective)

had either 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 received annual appraisal which identified learning needs from which a personal development plan was documented. Staff interviews confirmed the practice was proactive in providing training and funding for relevant courses, for example nursing staff were encouraged to complete additional training and qualifications such as independent prescribing, diabetes and respiratory conditions management.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, in the administration of vaccines and provision of smoking cessation advice. Those with extended roles, for example seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease and diabetes told us they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients needs and manage complex care needs. Blood results, X ray results, letters from the local hospital including discharge summaries and out of hours attendance reports were received both electronically and by post. The practice had a policy which outlined the responsibilities of all relevant staff to ensure all information was passed on, read and any issues arising were addressed on the day they were received. The GP who received these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice had a low number of vulnerable and at risk patients. The practice found holding regular telephone conservations was better than holding multidisciplinary meetings. This had worked well for the midwife we spoke with who regularly visited the practice. They told us communication was good with the practice. If they needed to relay any urgent messages, one would be left and the GP would get back to them quickly with a response. They said what was good about the practice was they could use a treatment room to see their patients once a week and this day could be varied if required. They also told us since the company had taken over the practice care had improved dramatically. A regular meeting with the multidisciplinary team if the patient's at risk increased.

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. For emergency patients, the practice had signed up to the electronic Summary Care Record. Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained to use the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the GPs we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to understand information and make decisions. All GPs we spoke with demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children under 16 years old who have the legal capacity to consent to medical examination and treatment).

The practice had not had an instance where restraint had been required in the last 3 years but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant or practice nurse. We noted the GPs and nurses used their contact with patients to help maintain or

Good

Are services effective?

(for example, treatment is effective)

improve mental, physical health and wellbeing. We heard this was an established practice. For example, by offering opportunistic chlamydia screening to patients aged 18-25. The practice had also actively offered nurse led smoking cessation clinics to these patients. The practice also offered NHS Health Checks to all its patients aged 40-75.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and all six were offered an annual physical health check. Practice records showed 100% had received a check up in the last 12 months.

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

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national GP patient survey completed from January to March and July to September 2013. A survey of 194 patients' was undertaken and 60 patients returned their questionnaires. This survey had been completed shortly after the provider had taken over the practice. The evidence from this survey showed the patients were satisfied with how they were treated and they experienced compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients rating the practice as good or very good. The practice was also well above average, when measured against the local Clinical Commissioning Group area average, for its satisfaction scores in relation to consultations with nurses. We saw 94% of patients said the nurses were good at listening to them and 94% said the nurses gave them enough time.

Patients completed CQC comment cards to provide us with feedback about the practice. We received 47 completed cards and the majority were positive about the service experienced. The comment cards showed 68% of patients were offered an excellent service and staff were efficient, helpful and caring. Other patients made some negative comments alongside the positive comments. For example, 15% said they had to wait an unreasonable amount of time to see the GP of their choice, such as timescales quoted were from seven days to three weeks wait to see their GP. However, the practice did allocate same day appointment slots every day and due to the practice size and three GPs covering the full time workload of one GP, it meant patients would have to wait longer periods to see a specific GP. We also spoke with six patients on the day of our inspection. Five out of six patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Receptionists received telephone calls from patients at the reception desk and were shielded by glass partitions which helped keep patient information private. In response to patient and staff suggestions, the reception screen had been moved further away from the waiting area to provide more privacy. This helped to reduce patients overhearing potentially private conversations between patients and reception staff. If patients wanted to talk confidentially without other patients overhearing then there were areas in the practice that could be used without other patients overhearing.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the office manager.

Receptionists told us they were aware of what they needed to do if there was a patient who was anxious or behaving inappropriately. They told us they had received training to help them manage challenging behaviour and defuse difficult situations. However, they said rarely experienced any challenging situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national GP patient survey showed 76% of patients said the GP involved them in care decisions, which was below the local CCG area average. We read 83% felt the GP was good at explaining treatment and results, which was above the local CCG area average.

Patients we spoke with on the day of our inspection told us 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

Good

Are services caring?

consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us translation services were available for patients who did not have English as a first language. In cases where this was necessary the GPs and nurses tried to use the translation service rather than a member of the patient's family or friends to ensure patient confidentiality. Also the practice website had the ability for patients to change the page to the language that was most appropriate to them. This showed the practice actively encouraged all their patients to be aware of the services provided through their website.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room and patient website also signposted people to a number of support groups and organisations. The practice's computer system alerted GPs and nurses if a patient was also a carer. The office manager took the lead for supporting and coordinating carers needs and signposted them to ensure they understood the various avenues of support available to them. Local meetings were organised approximately every two months with other practices to support carers and the office manager attended these.

GPs told our GP specialist advisor patients who had suffered bereavement were signposted to local support groups and offered counselling with the practice counsellor.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The practice used the risk stratification tool, which helped GPs detect and prevent unwanted outcomes for patients.

There had been very little turnover of nursing staff during the last three years which enabled good continuity of care for nursing support. When the provider took over the practice they had one part-time salaried GP, who had worked in the practice for a number of years. The practice had tried to recruit another salaried GP but was unable to due to a recruitment problem of GPs within the area. In the meantime the provider had recruited long term locums to cover the remaining workload, so there was less accessibility to appointments with a GP of choice which patient's knew well. However, they were now a nurse led practice and had a nurse practitioner who was able to see patients for a number of conditions for which they would normally see a GP, such as minor illnesses or injuries. Two GPs working at the other location worked regular sessions at Sparcells Surgery to aid consistency for patients. One of these GPs had regular involvement with the practice and was a point of contact for the locum GPs.

Swindon Clinical Commissioning Group had started a number of projects in Swindon to assist practices with home visits and urgent appointments for children. We were informed the project for home visits had worked well with the practice and they had often used the service. This service helped to ensure patients who required a home visit were seen within a reasonable time due to their need. The other project for urgent appointments for children was organised with another practice and if they could not be seen in their own practice they could be referred to this practice. The practice told us they would also try and accommodate patient wishes where possible. Where patients needed a home visit for an annual health check, the nurse practitioner would organise home visits with them.

The practice had implemented a number of improvements and made changes to the way it delivered services since they had taken over the practice. This had included practice refurbishment, review of patient records and an upgrade to the computer systems and systems for monitoring the service. During this period they had attempted to inform patients of these changes via a newsletter. The practice had home delivered this newsletter to every patient. The practice had attempted to form a patient participation group and we saw them advertising this in the practice. However, they had little interest from their patients to attend. The practice had now decided they would try setting up a virtual patient group because the majority of their patients were either working or young families.

We also reviewed the national GP patient survey taken from patients for the periods of January to March and July to September 2013. This is a national survey sent to patients by an independent company on behalf of NHS England. Sixty patients had completed the surveys from 194 sent. We found areas for improvement were around how long patients had to wait to get an appointment and waiting longer than 15 minutes after their appointment time to be seen. The period of when the surveys were taken was just after the Carfax Health Enterprise had taken over the practice. One of the challenges they had faced when they took over the practice was to ensure patient records were accurate and up to date. This had impacted on patient appointment times running over. The practice told us this had improved over time because all records had been reviewed.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. There was a high proportion of patients who were working or retired and patients with young families. Also, because the practice had a small number of registered patients' staff told us they knew their patients well and would know when a patient needed additional assistance when they visited the practice and needed assistance. Carers were recognised by the practice and added to a register so the GPs and nurses were aware of their circumstances when they visited. The practice had a care coordinator who signposted carers to a local support group. The care coordinator attended the support group meetings approximately every six weeks.

The practice had access to online and telephone translation services. The practice website had the ability to translate the language into the patient's preferred

Good

Are services responsive to people's needs?

(for example, to feedback?)

language. This could increase access for patients to learn about services provided. We were told no patient would be turned away from the practice including patients with no fixed address.

Access to the service

Appointments were available from 8am to 6:30pm on weekdays. The practice provided extended hours on a Monday evening until 8pm. For patient's that required an urgent appointment there were unallocated appointment slots for each day. There were three GPs who provided treatment and they either worked two days or one day a week at the practice. The nurse practitioner would triage calls received from patients requesting an appointment or home visit. This ensured patients were seen by the appropriate person and prioritised depending on their needs.

Comprehensive information was available to patients on the practice website about appointments. This included how to arrange urgent appointments, cancel appointments and home visits. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Information about the out-of-hours service was provided to patients.

Patients were generally satisfied with the appointments system. They confirmed they could see a GP on the same day if needed. They could see another GP if there was a wait to see the GP of their choice. Patients also commented on the text reminder service provided for their appointments, which they had found useful.

The premises and services had been adapted to meet the needs of people with disabilities. The practice treatment and consulting rooms were situated on the ground floor of the building. There was a hearing loop in reception and adequate reception desk space. There was plenty of space in the waiting area and corridors for wheelchair and prams, which allowed for easy access to the treatment and consultation rooms. There was also an accessible toilet facility which was available for all patients attending the practice. Areas highlighted to the practice to review were an automatic door for wheelchair users and alternative larger or cushioned seating.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. There was a designated responsible person who handled all complaints in the practice. The practice website informed patients what action they needed to take to complain internally. The website did not provide up to date information about how to complain externally.

We saw information was available to help patients understand the complaints system in a patient summary leaflet, which was available at reception. However, there was no information displayed in the waiting area. None of the patients spoken with had ever needed to make a complaint about the practice.

We saw seven complaints had been received in the last twelve months. We read one complaint in detail and found it had been satisfactorily handled and dealt with in a timely way. Complaints were usually dealt with individually with the staff member involved with no shared learning between the team.

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 high quality care and promote good outcomes for patients. These values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included the following aims: to offer a high level service providing care and treatment to patients through appropriate GPs and nurses to meet their needs. We spoke with nine members of staff and they all knew and understood the vision and values of the practice and their responsibilities in relation to these.

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 throughout the company. We reviewed the company's recruitment, and safeguarding policies which did not show a date of review or completion. The criminal record disclosure policy had been dated 2010 and showed out of date information. For example, it still referred to the Criminal Records Bureau which is now the Disclosure and Barring Service. It did however show clearly its risk assessment for all levels of staff for whom a criminal record check needed to be obtained.

The practice held weekly GP meetings for both locations within the company. This gave GPs a chance to discuss performance, quality and risks and whether any learning could be taken forward for both locations. Minutes from the meetings held were always saved onto the shared staff internet for staff learning and review. Two other weekly meetings were held, one with all directors and the other with middle management to develop the initiatives within the company.

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 for 2013 to 2014 at a 95% completion rate. The practice had reviewed all processes when it took over the practice to improve the QOF data because it had a low completion rate. The practice had reviewed and updated patient records to ensure they had been coded correctly. This ensured they could achieve a good score alongside improving patient care and treatment.

The practice had completed a number of clinical audits, for example minor surgery, contraception and medicine reviews audits. The auditing process could be improved overall by measuring improvements to patient care from previous audits completed. The QOF was a good indicator of improvements to patient care and the completion rate for 2012-2013 was 65.4%, the practice had achieved this total in the last three months of the year after they had been taken over by the current provider. The QOF score was now 95% which showed there had been a focus on ensuring patients had received care and treatment which followed the national guidelines.

The practice had robust arrangements for identifying, recording and managing risks. The practice showed us their risk log which addressed a wide range of potential issues, such as a missed home visit or an incorrect referral. We saw the risk log was updated in a timely way and if the incident was classed as a significant event then it was discussed at a team meeting.

Leadership, openness and transparency

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

All staff team meetings were held twice a year for the whole company with the exception of a small number of staff who covered the practice whilst the meeting took place. We were told minutes were shared with all staff after the meeting and feedback given to those who did not attend. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

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

The practice had gathered feedback from patients through the GP national survey and complaints received. The practice had not carried out their own patient survey since they had taken over the practice. They told us they had been focusing on improving patient care and treatment and trying to implement a patient participation group. We received 47 comment cards from patients prior to our inspection and spoke with five patients which showed

Are services well-led?

Good

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

patient satisfaction was high with the service received. The main themes of dissatisfaction were how long patients had to wait to be seen and seeing the same GP. As mentioned previously the practice had taken action to improve patient consultation times and tried to recruit permanent GPs. The practice could improve how it informed patients of changes to ensure it captured its whole patient base. Since the practice had been taken over they had received an additional 200 registered patients.

The practice had gathered feedback from staff through staff away days and generally 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 the organisation, management and standard of care had improved since it had been taken over. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice talked with staff about whistle blowing in their induction and the policy was available to all staff electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. GPs and nurses had a clear leadership structure of who they could refer to for advice and support. One nurse told us they were about to trial 360 degree appraisal, which involved on-going appraisal, gaining feedback from 35 of their patients and 17 staff members including external health care workers and completing a daily reflective diary. If this achieved a good outcome then the company would implement this for all their nursing staff. Staff told us the company was very supportive of training and they had opportunities to progress their own career development. For example a nurse told us they had been encouraged to complete additional training in chronic pulmonary obstructive disease and contraception. Also, a receptionist had been supported with their personal development and subsequently promoted into an office managers position.

The practice had completed reviews of significant events and other incidents and shared with staff via the shared intranet, meetings and away days to ensure the practice improved outcomes for patients. For example, GPs met weekly to discuss incidents that had occurred. However, shared learning could be improved to ensure all staff were involved.