Dr Pasquali & Partners

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

We carried out an announced inspection of Dr Pasquali & Partners on 8 October 2014. This was a comprehensive inspection. The practice achieved an overall rating of Good. This was based on our rating of all of the five domains. Each of the six population groups we looked at achieved the same good rating.

Our key findings were as follows:

- Patients were satisfied with the service and felt they were treated with dignity, care and respect and involved in their care.
- There was a good understanding of the needs of the practice population and services were offered to meet these.
- Systems were in place to identify and respond to concerns about the safeguarding of adults and children. All staff demonstrated a good awareness of the processes.
- Systems were in place to maintain the appropriate standards of cleanliness and protect people from the risks of infection. The practice was clean.

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

The provider should:

- Ensure that all staff receive training in the Mental Capacity Act (2005)
- Improve the telephone system so access to appointments can be made easier
- Improve their record keeping so results of complaint investigations and outcomes from it are readily evident.
- Take action to provide management arrangements and strengthen systems for governance and monitoring

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 people 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. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. People's needs were assessed and care is planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs were identified and planned. It was evident that the practice staff worked with other agencies to meet patients' needs.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also 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 good access to the practice and a named GP and continuity of care, with urgent appointments available 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 with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. Staff described a vision and a strategy to deliver a quality safe service, however this was not documented. At the time of this report the practice did not have a registered manager but the GP partner told us that they were in the process of appointing one. Staff described a leadership structure and felt they were well supported by management. The practice had a number of policies and procedures to govern activity. Governance meetings were held but these were not documented. The practice proactively sought feedback from patients and had an active patient participation group. Staff had not received regular performance reviews in 2014 but had 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 people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia care and in end of life care. 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.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of 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 was proactive in offering a full range of health promotion and screening which reflects 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 people whose circumstances may make them vulnerable. The practice offered primary care services to patients living in vulnerable circumstances including homeless people, travellers and those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities and the majority of these patients had received a follow-up. The practice offered longer appointments for people with learning disabilities.

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

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. 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. 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. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with six patients who used the service and received 13 comment cards. Ten comment cards we received expressed satisfaction with the service and clinical care received and noted a caring and dedicated service from helpful staff. In three comments cards patients noted that requests for an appointment to see a doctor of their choice was not always available on the day they requested this appointment.

Overall people we spoke with were satisfied with the service, although one of them told us that they had experienced delays in being referred to other services after test results indicated this need. Relatives and carers of patients we spoke with told us that they felt safe, well cared for and very happy with the treatment provided. Patients said that staff at the practice treated them with dignity, respect and understanding. All the patients told us that their privacy was maintained.

Areas for improvement

Action the service SHOULD take to improve
Action the provider should take to improve

The provider should:

- Ensure that all staff receive training in the Mental Capacity Act (2005)
- Improve the telephone system so access to appointments can be made easier
- Improve their record keeping so results of complaint investigations and outcomes from it are readily evident.
- Take action to provide management arrangements and strengthen systems for governance and monitoring

Dr Pasquali & Partners

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 second CQC inspector, and a GP and practice manager acting as specialist advisers.

Background to Dr Pasquali & Partners

Dr Pasquali & Partners provide a range of primary medical services for people of Little Irchester in Northamptonshire. The practice serves a population of 4300. This is a rural practice and the population is predominantly white British.

Clinical staff at this practice include one GP partner and three other GPs, two nurses and one health care assistant. The team is supported by a practice manager, and three reception staff. A health visitor midwife and district nurses also work with the practice.

The practice service for out of hours care is through the NHS 111 service.

Why we carried out this inspection

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

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

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We spoke with the local Clinical

Detailed findings

Commissioning Group (CCG), the Local Medical Committee (LMC) and NHS England. We carried out an announced visit on 8 October 2014. During our visit we spoke with a range of staff, including GPs, reception staff, nurses and the practice manager. We spoke with patients who used the service. We observed how patients and family members were responded to and collected comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe Track Record

The practice used a range of information such as reported incidents, national patient safety alerts as well as comments and complaints received from patients, to identify risks and improve quality in relation to patient safety. For example the practice had made changes to the way it gave test results to patients as a result of analysis of complaints received. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses

Safety and related issues were regularly reviewed during practice meetings and we saw evidence of this. This showed the practice had managed safety consistently over time and so could evidence a safe track record over the past and current year.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw a log of significant events which showed that action was taken when required. The events were discussed at practice meetings and shared with staff as appropriate. Staff told us that there was a no blame culture and they were encouraged to report incidents.

Safety alerts were reviewed by and distributed to the relevant staff by the practice manager. We saw recent examples of how the alerts were distributed to staff by email. The staff we spoke with displayed an awareness of how safety alerts were communicated and told us they were receiving those relevant to their roles regularly. They were able to give examples of recent alerts relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice adopted an approach to safeguarding children and vulnerable adults that was in line with established guidance and the local authority procedures. One of the GPs had the designated lead role for safeguarding. That GP was also the designated Caldicott Guardian, a person who is responsible for ensuring that patients' personal information is kept safe.

We saw the practice policy and procedures on safeguarding children and young people and related records management which were relevant and up to date. We also saw training certificates for all staff members which showed they had received role specific training on safeguarding children and vulnerable adults in the month before our inspection.

Staff told us that they received this training annually as well as training in protecting people's personal information. Furthermore, they could describe, with some confidence, what the procedures were for escalating any concerns they might have about patients through the GPs. During our discussions we learned of a recent incident where these procedures had been effective. We also noted that staff were aware of and understood the practice whistleblowing policy but there were no instances where this had been used.

The practice held quarterly safeguarding meetings chaired by the designated safeguarding lead and attended by another GP, the practice manager and a health visitor. At these meetings we noted that individual patients who were being looked after by the local authority or subject of a protection plan were discussed and their progress monitored. This ensured that the practice was able to contribute up to date information to local authority safeguarding systems.

Staff were proactive in monitoring if children or vulnerable adults attended Accident and Emergency or missed appointments frequently. These were brought to the attention of the GP who worked with other health professionals such as health visitors, midwives and district nurses.

In conjunction with the Children Services of the local NHS community trust, the practice monitored immunisation uptake. Failed attendees were followed up by the health visitor.

Patients were also cared for by staff whose suitability was assured through effective recruitment processes. All staff had their identity verified and references taken up before commencing employment. All the GPs had undertaken criminal records checks. This process which is now called the Disclosure and Barring Service (DBS) check gathers information about an applicant's possible criminal activity and helps determine their suitability to work with vulnerable people. The practice manager explained that

they had not yet undertaken such checks for their nursing staff. However most were long standing staff and they assured us that these checks were being carried out as part of a range of activities the practice had recently begun to ensure they could meet their regulatory requirements and those of the commissioners.

The practice manager also explained that none of the non clinical staff that worked in an administrative capacity had been subject of DBS checks although there were no risk assessments or other records in place to show how this decision had been reached. The practice should ensure that this is carried out before staff commence employment.

A chaperone policy was available and staff we spoke with confirmed that chaperoning was carried out by the practice nurses. They told us that the reception staff would only be called upon in extreme circumstances to chaperone. Discussions with the reception staff confirmed that they had not received chaperone training. The practice was advised during the inspection that non clinical staff must be trained to carry out this procedure.

Medicines Management

The GPs reviewed medication for patients on an annual basis or more frequently if necessary.

Prescription pads and repeat prescriptions were stored securely. Repeat prescriptions were authorised by a GP before being issued to the patient. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients when they collected them. They were also able to describe the additional checks required when giving out prescriptions for controlled drugs.

The practice had arrangements that made sure temperature sensitive vaccines were transported and stored at the correct temperature. We saw records of temperature checks to ensure the vaccine storage fridge remained within acceptable limits for vaccine safety and potency.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

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. There was also a policy for needle stick injury.

We looked at the cleaning schedules and saw that the practice had a daily, weekly and six-monthly cleaning routine. The cleaning was carried out by an independent contractor and the quality of this was monitored by the local NHS property services who sent the practice manager a report every three months. Cleaning equipment and materials were stored in a separate cupboard and we noted that they conformed to the guidance on cleaning primary medical care settings issued by the Department of Health.

There were also arrangements for the disposal of used sharp instruments for the weekly collection of clinical waste. 'Sharps' containers were properly marked and dated in each clinical room.

All surfaces in clinical areas were cleaned by the nursing team either after each use or in accordance with a start-up and close-down procedure for each area set out in the infection control policy. This ensured that the risk of patients acquiring a healthcare associated infection through contaminated treatment areas was significantly reduced.

Staff were trained annually in infection prevention and control and also in workplace health and safety. We noted that there was posted information about hand-cleanliness in each clinical area. This was supported by the use of appropriate hand-wash dispensers by each sink.

The testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings) was carried out by local NHS property services who advised the practice manager of any related issues.

Equipment

The practice had some modern adaptations and all of the fixtures and fittings, such as flooring, lighting, electrical connections and surfaces were either relatively new or had been well maintained. All portable appliances we examined had been tested for electrical safety.

We also saw that clinical areas were properly equipped with appropriate, clean and well maintained equipment, such as hand washing sinks, examination couches and

storage cabinets. Despite the small floor area of the practice, all clinical areas were clean, clutter free. We saw records showing that all clinical equipment, such as the spirometer (a lung function testing machine) and the blood pressure monitor, was calibrated and validated by the local NHS property services.

Staffing & Recruitment

The practice had a stable workforce. There had been one new recruit in the last three months and the practice manager told us that they had not done a DBS check on this person as they had previously worked at the practice. However this check had been scheduled as part of a range of activities the practice had recently begun which included a DBS check for all staff to ensure they could meet their regulatory requirements and those of the commissioners. The practice manager told us that future recruitment will involve all the checks as required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS).

Staff told us that the planning and monitoring of the number of staff and mix of staff needed to meet patients' needs usually took place during practice meetings. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty.

Staff told us there was usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Monitoring Safety & Responding to Risk

We saw that the staff had access to medicines for use in a medical emergency, including those medicines used for treating patients who experienced anaphylactic shock, a severe allergic reaction to vaccinations. These were checked every month to ensure they were within their expiry dates and replacements ordered when required. The practice had access to oxygen and an automated electronic defibrillator and these were also checked monthly to ensure they were in working order. We saw that training in basic life support was provided annually to ensure staff could provide cardio pulmonary resuscitation (CPR) if this was required.

Staff told us that they were confident they could identify patients that might need to be seen by a doctor as a priority. We learned that, three times a year, one of the doctors used the monthly protected learning time sessions to refresh the knowledge of staff on how to recognise which incidents constituted a medical emergency. This was supported by posted information behind the reception desk about how to respond to emergencies such as a suspected heart attack.

For patients with long term conditions there were emergency processes in place. For example patients with chronic obstructive airways disease (COPD) were managed in line with recognised clinical guidelines.

There were arrangements in place for identifying acutely ill children and young people. Patients could access a GP immediately for urgent advice or treatment.

Arrangements to deal with emergencies and major incidents

The practice had a business continuity plan to deal with any emergencies that could disrupt the safe and smooth running of the practice. This plan accounted for business continuity, staffing, records and electronic systems, clinical and environmental events. All staff we spoke with were knowledgeable about the business continuity plan.

Staff told us that in addition to training in dealing with medical emergencies, including CPR they had also received training in other emergencies such as fire and other disruptive events.

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 from the National Institute for Health and Care Excellence (NICE) and from local commissioners. New guidelines were disseminated electronically and discussed during practice meetings as appropriate. From our discussions with the GPs and nurses we found that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

Records we saw indicated that the practice was meeting the local Clinical Commissioning Group's (CCG) targets for enhancing the quality of care in clinical areas such as diabetes, heart disease and asthma. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

The local CCG monitoring of performance for antibacterial prescribing was comparable to similar practices. The practice had also completed a review of case notes of patients who were prescribed steroids and bone protection medication with a view to reducing the side effects associated with taking these medicines.

We saw no evidence of discrimination when making care and treatment decisions.

Management, monitoring and improving outcomes for people

The practice had a system in place for carrying out clinical audits. Clinical audits are a way of identifying if healthcare is provided in line with recommended standards, whether it is effective and where improvements could be made. Examples of clinical audits included those on the use of steroids, bone protection medication and referrals to other services. However, the audits mainly took place over one audit cycle and the effectiveness of any improvements was not measured by re-auditing. The practice had already identified this as an area of improvement and had plans for re-audits to occur.

The practice also used the information they collected from the quality outcomes framework (QOF) about their performance against national screening programmes to monitor outcomes for patients. QOF is a national funding tool linked to performance measurement for services provided by GPs. For example QOF performance information showed that the practice met all the standards for diabetes, asthma and chronic obstructive airways disease (COPD) care. This practice was not outside the accepted reference range for any QOF clinical targets.

Effective staffing

The practice employed staff that were appropriately qualified and competent, with the right skills and experience. Staff told us they received a structured induction programme that provided them with appropriate skills when newly employed. This introduced them to key policies and information about their role. We saw that newly employed staff were also introduced to tasks associated with their role over a short period of time and under the supervision of an experienced staff member acting as mentor.

The practice also took steps to ensure that staff maintained their skills by holding monthly sessions known as protected learning time (PLT). During PLT sessions staff received updates and refresher training in topics that the practice designated as being key to their role. Such topics included basic life support, safeguarding, information governance and infection prevention and control. One of the practice administrators had been designated as lead for some aspects of training which enabled the practice to run some 'in-house' sessions on topics such as fire safety and health and safety.

We saw that the GPs were revalidated according to the standards set down by their professional body. In the case of nursing staff, the practice also ensured that they had access to knowledge, material and training, known as continuing professional development (CPD), to enable them to maintain their professional registration. For example, one of the nursing team told us that they received regular clinical supervision from one of the GPs. The GP would block out an occasional afternoon to provide mentorship support to ensure the nurse was competent at various skills such as gynaecological examinations or childhood immunisations.

The practice had a programme for annual appraisals of staff that examined their performance in the preceding year and identified any training needs or career development opportunities. We found that all staff except the practice manager had received an appraisal in the preceding 12

months. The practice manager explained that their appraisal should recommence shortly when a new registered manager is appointed. Staff told us they felt supported by both the appraisal system and by the management team's 'open door' approach. In this way the management team were available at any time and whenever such support might be sought.

Both the practice manager and the staff we spoke with said they benefitted from a 'blame-free' culture that emphasised the opportunities for learning from any adverse incidents or events as opposed to disciplinary action in most cases. However, we saw evidence that there was also an effective system in place for managing variable or poor performance when this was required.

Working with colleagues and other services

The practice worked with other service providers to manage and meet people's needs. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. Paper communications were scanned by administration staff. The practice had a process for reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing 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.

We spoke with GPs and nursing staff who demonstrated that communication and work with other agencies took place on a regular basis. We saw evidence of a variety of meetings involving other services for example, health visitors and midwives. There was evidence of co-ordinated integrated pathways, for example care of people who needed end of life care.

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. An electronic system was in place for making referrals through the Choose and Book system. The 'Choose and Book' system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

The practice had systems 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 on the system. 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

Our review of the NHS patient survey from July 2014 indicated a disparity in the patients' experience of either doctors or the nurses. For example, patients' experience of whether the nursing staff were good at listening to them was 87%, explaining test results was 85% and for involving patients in decisions about their care was 74%; all higher than the national average. This figure was 69%, 65% and 58% respectively for the GP and this was lower than the national average.

The practice manager showed us the policy for obtaining consent from patients to their care and treatment. We also spoke with the nurse and the health care assistant who explained how this worked in practice. We learned that patients were provided with information about their care and treatment and that this took various forms. Generally information was provided verbally and consent was also sought in the same way and recorded on patients electronic records at the time. Some treatments were explained with the help of leaflets or written information printed off the computer. Some procedures required written consent, such as flu vaccines. The emphasis was on ensuring patients understood what they were going to experience and seeking their consent.

We explored how consent was dealt with in a variety of situations. For example, we learned that patients who received care at the end of their lives and who had made decisions about what was to happen at the time of their death (known as advanced decisions) had had the opportunity to have this recorded on their end of life plan.

The practice manager explained that mental capacity assessments and 'best interests' decisions were made by the GPs in consultation with patients' families and we learned of a particular patient with a learning disability where the decision was recorded in their notes. A 'best interests' decision relates to people whose ability to

Are services effective?

(for example, treatment is effective)

consent is limited due to their diminished capacity. However, the practice manger acknowledged that there was no formal training in the Mental Capacity Act 2005 offered to staff.

In relation to children and young people under 16, particularly in matters related to family planning and sexual health, we found that the staff had a good understanding of the need for the consent of someone with parental responsibility (PR). Further, the staff understood the specific criteria used to assess a young patient's competence to consent if treatment was requested in the absence of someone with PR. In those instances where that competence might be in doubt, patients were referred to one of the GPs.

Health Promotion & Prevention

The practice operated patient registers and nurse led clinics for a range of long term conditions (chronic diseases) and there was a nominated GP lead for each of these. The practice offered practical advice on diet and exercise, smoking cessation and chlamydia screening.

The practice maintained a register of all patients with learning disabilities and all 18 were offered an annual health check in 2014.

We found that the practice offered a number of services designed to promote patients' health and wellbeing and prevent the onset of illness. We saw various health related information was available for patients in the waiting area. This included information on dementia, flu vaccination, mental health, and keeping warm in winter.

The practice had participated in targeted vaccination programmes for older people and those with long term conditions. These included flu vaccination for people with long term conditions and those over 65.

The practice offered a full range of immunisations for children, and flu vaccinations in line with current national guidance Last year's performance for all immunisations was in line with similar practices locally.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Our review of the latest NHS patient survey published in July 2014 showed that patients had a differing experience of whether they were treated well by either the GPs or the nurses. For example, the percentage of patients who experienced nursing staff who were good at treating them with care and concern or good at giving them enough time was 85%; higher than the national average. Conversely, the experience of patients who felt the same way about their experience of the doctors at the practice was around 60% and this was lower than the average.

During our inspection we observed that patients were treated with dignity and respect. All of the patients we spoke with on the day confirmed this experience. We saw and heard respectful, empathetic and dignified conversation from staff throughout our visit, both with patients who were visiting and those who called on the telephone. Staff dealt with patients' questions and concerns and generally were helpful and sympathetic to patients experiencing discomfort.

This was also borne out by the comments we received from patients who had completed comment cards in advance of our visit. Comments were positive and spoke highly of the attitudes and behaviours of staff towards patients.

Consultations took place in private where the doors to the treatment rooms were closed during such consultations. Privacy curtains were also available in all the consultation rooms.

We saw that staff were aware of the possibility for personal information to be overheard from the reception window due to the open-plan nature of the reception. However, we saw that staff were discrete in their discussions with patients. The practice manager and the staff explained that patients who wished to speak privately were taken into another room although there was no posted information for patients to tell them this facility was available.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our 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. Patient feedback on the comment cards we received was also positive and aligned with these views.

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.

Patient/carer support to cope emotionally with care and treatment

We saw that a process was in place at the practice for recently bereaved patients to be highlighted on the electronic patient records system. The practice manager and the nurses told us that patients who were recently bereaved were contacted by the GP or practice nurse to ascertain what support they required. This resulted in a formal referral being made to either the local NHS trust 'Wellbeing' service or to a bereavement support organisation.

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.

There was a named GP to look after the care needs of patients over 75 years old. The GP or a designated nurse made home visits for those patients, including providing the flu immunisation.

For people with long term conditions such as chronic obstructive airways disease (COPD) and Asthma home visits were available where needed. This included people that who lived in care homes.

The practice operated a register of patients that needed support with their learning disabilities which ensured appropriate care for these patients.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

The practice had a patient participation group (PPG). The PPG is a group of patients who work with the practice to discuss and develop the services provided. The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the PPG. For example the practice had replaced the low chairs with high ones in the waiting areas so patients could get out of them more easily. The telephone system remained an issue with patients highlighting difficulty in getting through to get an appointment. The PPG told us that the practice was working to improve it. The practice manager told us that the telephone system had previously been operated and maintained by the local NHS trust but this responsibility had recently passed on to the practice and the practice was working with the PPG to improve the telephone system so access to appointments could be improved.

The surgery was open until 6 30pm Monday to Friday making appointments available outside of school hours for children and young people.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. We saw that the practice offered primary care services to a nearby travellers site. The practice manager told us that most residents of this site were registered with the practice.

The practice had access to telephone translation services.

We saw the premises and services were adapted to meet the needs of people with disabilities. A hearing loop was available at reception for those who may benefit from it. Consultation rooms were provided at ground level allowing access to patients with wheelchairs. There were accessible toilet facilities for all patients who attended the practice.

Access to the service

Appointments were available from 8 am to 6.30 pm on weekdays. In addition to requesting an appointment with a GP, the practice nurse also offered appointments during Monday, Tuesday, Thursday and Friday afternoon from 1.30 pm and morning appointments every Wednesday. There was a daily phlebotomy service (taking of blood for tests) provided by a health care assistant. Patients were allocated any available GP but could request an appointment with a specific GP. The practice manager told us that this would take approximately three weeks. Where appointments were fully booked, patents were offered a telephone consultation with a GP and where necessary patients would be asked to attend the surgery based on the telephone consultation. GPs made home visits to those that needed it and usually these occurred between 1 pm and 3 pm. Comments left by patients showed that patients could obtain urgent appointments on the same day of contacting the practice.

Information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments. At the time of our inspection the practice did not offer on line appointments. The practice manager told us that they were exploring this facility through their computer system.

There were arrangements which ensured patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring. Information on the out-of-hours service was provided to patients both in the surgery and on the practice website.

Are services responsive to people's needs?

(for example, to feedback?)

Some patients we spoke with and the comments cards patients left for us indicated that they would like improvements to the telephone system so they could make appointments more easily and quickly. Two patients told us that they would rather visit the surgery at 8 am to secure an appointment than hang on the telephone. The practice manager told us that the telephone system had previously been operated and maintained by the local NHS trust but this responsibility had recently passed on to the practice. The practice was working with the PPG to improve the telephone system so access to appointments could be improved.

The practice's extended weekday opening hours till 6.30 pm was particularly useful to patients with work commitments and for children and young people.

Listening and learning from concerns and complaints

There was a system in place for recording, investigating and responding to complaints and comments in line with their contractual obligations for GPs in England. This system gave patients 12 months to complain and stipulated an initial acknowledgement within three days of the complaint being made. The practice manager told us that complaints were discussed at practice meetings to ensure patients concerns were shared with staff and any necessary action taken to alleviate the complaint or prevent similar instances in the future.

This system was communicated to patients by means of an information leaflet that was available in reception or handed to patients who expressed dissatisfaction. The leaflet contained information about where to take the matter if the complainant was dissatisfied with the outcome, including information about complaining to NHS England and involving an advocacy service. The practice web-site had information on how to complain, although there were no details provided. Instead, patients were directed by the web site to the practice manager and to the leaflet in reception.

We reviewed the records of the six complaints made in the year to date preceding our inspection. We noted that there were template forms for use in managing complaints including a form for recording the meetings with the complainant to resolve the issue. However, it was not always clear from these records how the complaints had been resolved. In one instance, we saw that a particular complaint had been made about communicating test results. The records of the practice meeting following the complaint being made showed that the issue had been discussed with staff. The meeting records showed that the complaint had resulted in a new system being implemented for notifying patients of their blood test results. However, there was no record to show whether the complaint was considered 'resolved' or if the complainant had been satisfied with the outcome. In two other cases we saw that there was no obvious resolution recorded and the complaint was seemingly left open-ended. We spoke with the practice manager who told us that the complaints had been concluded but acknowledged that the records were incomplete.

Are services well-led?

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

Our findings

Vision and Strategy

We spoke with five members of staff and they all told us that they worked well as a team and supported each other. They told us about their commitment to good patient care from the moment a patient walked through the door. Administration and reception staff were flexible and supported clinical staff in their work well. However we did not see a clear statement of vision and values which showed staff responsibilities in relation to these. The practice manager told us that there had been some delay in this work, but that this would recommence shortly when new manager is appointed.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at a number of these policies and procedures for example the infection control and prevention policy. Staff were knowledgeable about the requirements of this policy. All 10 policies and procedures we looked at had agreed review dates.

We did not see evidence of formal governance arrangements nor did we see evidence of arrangements for identifying, recording and managing risks. The practice manager told us that due to unforeseen circumstance this work had been delayed, and work should recommence shortly with the appointment of a new registered manager.

The sole partner told us that they held regular Quality and Outcomes Framework (QOF) reviews with the other GPs in the local area with the last review being in May 2014. The QOF data for this practice showed it was performing in line with national standards. We saw minutes that confirmed this review.

The practice had a system in place for completing clinical audits. Clinical audits are a way of identifying if healthcare is provided in line with recommended standards, whether it is effective and where improvements could be made. Examples of clinical audits included those on the use of steroids, bone protection medication and referrals to other services. However, the audits mainly took place over one audit cycle and the effectiveness of any improvements was not measured by re-auditing. The practice had already identified this as an area of improvement and had plans for re-audits to occur.

Leadership, openness and transparency

We did not see a documented leadership structure which had named members of staff in lead roles. There was however a lead nurse for infection control and a GP was the lead for safeguarding and information governance. The main partner took responsibility for significant leadership and was informed, aware and approachable. We spoke with five members of staff and they told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

We looked at meetings notes and saw that practice meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the latest practice commissioned patient survey and found the majority of comments related to the telephone and appointments systems. As a result of this the practice had commenced a review of its telephone and appointment systems and hoped to bring about improvements shortly. The practice had recently implemented a system to match capacity to patient appointment requests which they were monitoring closely. They had also installed a hearing loop in reception which had improved the service for people who were hearing impaired.

There was a patient participation group (PPG) that had about seven active members. The practice was exploring the possibility of a virtual PPG.

The practice had gathered feedback from staff through practice meetings, clinical meetings and reception meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Are services well-led?

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

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

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The practice manager told us that staff mentoring and appraisals had not happened for most of 2014, owing to the disruptions to the practice management structure.

The practice had completed reviews of significant events and other incidents and shared learning with staff via practice meetings to ensure the practice improved outcomes for patients.