Dr Anna Ungaro

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 comprehensive inspection at Dr Anna Ungaro's practice. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, safe, effective, caring and responsive services. It was also good for providing services for the six population groups.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Most patients said they found it easy to make an appointment with a named GP and that there was 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 a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider should:

- Introduce a system so blank prescription forms are tracked through the practice and kept securely

Summary of findings

- Assess the risk of liquid spillage to the carpeted area around the hand washing sink in GP consultation rooms and take appropriate action
- Take action to ensure the water temperature of the hot tap in GP consultation rooms is such that hand washing under running water can be done without the risk of a scald
- Identify areas where liquid nitrogen and oxygen are stored and mark them with 'hazardous substance' notices
- Review the above the CCG average referral rates to hospital and other community care services
- Identify repeat audit dates so at least two cycles of a clinical audit can be demonstrated
- Consider options in the reception area so a patient whose circumstances may make them vulnerable can discuss their needs in private with the receptionist or other appropriate clinicians
- Consider options so patients in wheelchairs could communicate with the receptionist without being overheard

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 providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to 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 providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that 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 decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was 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

Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. 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 people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in 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 and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that 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 care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care 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 offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary 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 normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We spoke with seven patients and received 44 comments cards completed by patients. We received feedback from both male and female patients. A number of patients we spoke with and a significant number of patients that completed a comments card had been registered at the practice for many years. A few patients commented that they lived on the outskirts of Bedford resulting in considerable travel time to get to the practice. But they also noted that it was worth the journey as they thought the GP offered a considerate and personal service.

Patients spoke positively about the practice, and the care and treatment they had received. They described a helpful, kind and friendly attitude to care provision and noted that they were treated with compassion, dignity and respect. Staff had listened to them and given them time to discuss their care issues and had involved them when they explained treatment options. In a large number of the comment cards patients noted the service they had received was excellent and could not be faulted in any way.

The extended opening time and appointments on a Thursday was very useful, and had allowed patients to see their GP without having to take time off work.

Several patients commented that the environment welcoming, comfortable, clean, tidy and warm.

Patients who had to be referred to other services noted that communication between hospital consultants and the practice was good and GPs were prompt in recalling them if a follow-up was needed.

Comment left on six cards told us about the difficulties these patients had experienced when making an appointment to see a GP. They told us that they found it difficult to get appointments at peak periods which are early mornings and early afternoons when the practice appointment systems were opened for booking. Two comment cards noted that there was a long wait of up to four weeks for routine appointments.

Areas for improvement

Action the service SHOULD take to improve

- Introduce a system so blank prescription forms are tracked through the practice and kept securely
- Assess the risk of liquid spillage to the carpeted area around the hand washing sink in GP consultation rooms and take appropriate action
- Take action to ensure the water temperature of the hot tap in GP consultation rooms is such that hand washing under running water can be done without the risk of a scald
- Identify areas where liquid nitrogen and oxygen are stored and mark them with 'hazardous substance' notices
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- Consider options so patients in wheelchairs could communicate with the receptionist without being overheard

Dr Anna Ungaro

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and included a GP acting as a specialist adviser.

Background to Dr Anna Ungaro

Dr Anna Ungaro provides a range of personal medical services for people of Bedford in Bedfordshire and serves a registered population of approximately 3000 patients. The practice population is a mix of white British and patients from ethnic minority groups mostly of Italian, Bengali and eastern European backgrounds.

Clinical staff at this practice include a sole GP Partner, one salaried GP, a locum GP, two practice nurses, and one healthcare assistant. Management, administration and reception staff support the practice. Community nurses, health visitors and a midwife from the local NHS trust also provide a service to this practice. A mix of male and female clinical staff is available.

Out of hours care when the surgery is closed was through BEDOC (a GP co-operative service). Patients were diverted to this service by telephoning the normal surgery contact number.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out 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. These 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

Detailed findings

People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 22 January 2015.

During our visit we spoke with a range of staff including GPs, reception staff, nurses, the practice manager and other practice staff and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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. We noted the practice had a system in place to ensure all significant events were recorded, analysed and reviewed.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. The practice was able to demonstrate learning from significant events had taken place with appropriate actions to maximise the learning for practice staff. We saw evidence that significant events were discussed at practice meetings to ensure all staff had an awareness of the issues following such events. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

The practice completed a review of significant events annually. The last review concerned an incident which resulted in a delay in issuing a medical certificate. The practice consequently had amended their protocol so these certificates were issued in a timely way. We saw records that confirmed this discussion and agreements.

National patient safety and medicines alerts were received by the practice manager and prioritised by the GP for relevance and shared with clinical and other staff as appropriate to ensure they were noted and acted upon. Relevant alerts were also discussed during practice meeting if specific discussions were needed or discussed directly with relevant clinical staff. A nurse told us how they had acted on a safety alert that concerned blood glucose meters used at home by patients that had the potential to give false readings. As a result the practice had checked that patients that used such devices did not have the affected type.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children and adults.

There were procedures for escalating concerns to the relevant protection agencies. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Where training updates were due we saw that these had been booked. There was a system on the practice's electronic records that alerted the GPs and practice nurses when a safeguarding issue or safeguarding plan had been identified and developed for individual patients.

There was a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary safeguarding training to enable them to fulfil this role.

Staff demonstrated a clear understanding of how to recognise possible signs of abuse in children and vulnerable adults. They were aware who the safeguarding lead was and who to speak to in the practice if they had a safeguarding concern.

There was a system to identify children and young people who were recurrent hospital attenders or those at risk of abuse, and to communicate with the health visitor and school nurse for any follow up actions as needed.

The practice followed up children who failed to attend childhood immunisations and current data showed that the practice had performed better than similar practices in the local area for childhood immunisation. The practice looked after patients in a local refuge for women and children escaping domestic violence and operated an alert system to ensure their needs were safety and appropriately met.

A chaperone policy was in place. Notices were displayed in the waiting area advising patients that they could request a chaperone during their consultation if they wished. Non clinical practice staff who performed this duty were trained on being a chaperone.

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 policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure.

Good

Are services safe?

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice regularly compared its prescribing data with similar practices in the local CCG area. For example, patterns of antibiotic prescriptions were at or better than the target set by the CCG.

The practice nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these directions and evidence that the practice nurse had received appropriate training to administer vaccines.

The practice operated Electronic Prescription Service (EPS) whereby prescriptions and repeat prescriptions were sent electronically to a pharmacy nominated by the patient. The practice manager told us that 81% of the prescriptions issued were transmitted in this way. The remaining paper prescriptions were reviewed and signed by a GP before they were given to the patient. The practice did not have a system for recording/tracking serial numbers of blank prescription forms in accordance with national guidance so these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. The practice employed a cleaner for their cleaning requirements. The management of this cleaner was undertaken by the practice manager. We saw there were cleaning schedules in place and cleaning records were kept. The cleaning equipment was appropriately stored with clear systems in place to ensure equipment used for cleaning clinical and non-clinical areas were kept separate. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice nurse held the lead position for infection control management. All staff received induction training about infection control specific to their role and received annual updates and we saw records that confirmed this training. There was evidence of a recent audit on infection control and prevention. Following this audit the practice had introduced a number of improvements for example introduction of disposable privacy curtains, and targeted replacement of bins with the pedestal type.

An infection control policy was available for staff to refer to, which enabled them to plan and implement measures to control infection. 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 to comply with the practice's infection control policy. There was also a policy for needle stick injury, The practice had access to spillage kits to enable staff to appropriately and effectively deal with any spillage of body fluids. We saw sharps containers that were labelled correctly and not overfilled.

The practice with the exception of the treatment room used by the practice nurse was carpeted throughout. In patient consultation rooms we noticed that the hand wash sink area could be occasionally used to test urine. However we did not see a risk assessment to ensure these areas were protected from spillage.

We saw that there were separate taps for hot and cold water in GP consultation rooms. In the absence of a mixer tap, we were unsure how the water temperature of the hot tap was adjusted so hand washing under running water could be done without the risk of a scald. There were appropriate hand washing materials available throughout the practice and a plentiful supply of personal protective equipment available for Staff. All privacy curtains were of the disposable type and were under six month old.

The practice had undertaken a Legionella risk assessment of their water supply for the presence of Legionella. (Legionella is a bacterium found in the water storage systems which can cause illness in people). This assessment had recommended that the practice undertake periodic measurements of hot and cold water temperatures to make sure that these remained within safe limits to prevent the presence of Legionella. We however did not see evidence that these checks had been done. After our inspection the practice manager confirmed in writing us that they had commenced these temperature measurements.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments

and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, blood pressure monitors and electro cardiograph (ECG) machine.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS).

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We noted that while proof of identification was obtained prior to the DBS check and for the issue of a NHS smart card, the practice did not retain a copy of this proof, as required by schedule 3 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.

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 that enough staff were 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 keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. Patients told us they felt the practice was adequately staffed. They told us that they sometimes waited they a short while for their appointments but that was not always the case as they were seen quickly even at busy times.

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. The practice had a health and safety policy potential risks were assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks were also identified through the incident reporting, complaints analysis and significant events monitoring and discussed at practice meetings. For example, the practice nurse had shared the recent findings from an infection control audit with the team.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being. For example the practice held six weekly multi-disciplinary meetings to discuss the care needs of all patients suffering with cancer and reviewed their changing needs including of those involved in their care.

The practice had a process for summoning help from other practice staff in the event of a medical emergency by activating an emergency icon on their computer.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. Liquid nitrogen that was used for cryotherapy (freezing of warts) was also stored in this room. Hazardous substance warning notices were not displayed on the door of the room where the liquid nitrogen and oxygen were stored.

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 and anaphylaxis. We did not see emergency medicines for the treatment of hypoglycaemia (an emergency suffered by diabetics). Following our inspection the practice manager wrote to us and told us that appropriate medicines were now available for the treatment of hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Good

Are services safe?

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff was up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We spoke with the main GP and the practice nurse. They were able to describe how they accessed guidelines from both the National Institute for Health and Care Excellence (NICE) and from the local Clinical Commissioning Group (CCG). The GP also told us that they attended internal and external educational meetings as well as hospital education sessions once a month which helped them keep up to date with clinical issues. Practice implications of applicable new guidelines were discussed by the GP with the practice nurses.

We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. For example we saw evidence of mental health reviews in line with best practice guidelines. Patients with long term conditions were regularly assessed and their medicine needs checked to ensure continued usefulness.

The GP told us that they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work. The practice nurses took responsibility for monitoring patients and health promotion activities such as smoking cessation, hypertension, diabetes, chronic obstructive airways disease (COPD), and asthma. We saw each nurse held appropriate training for their chosen specialised area. The practice nurse worked jointly with the community specialist nurse in some areas, for example the diabetes clinic which offered the practice nurse learning opportunities as well as a forum to discuss practice issues.

The practice appeared to refer patients appropriately to hospital and other community care services, although referral rates were above the CCG average. We saw examples of the practice working collaboratively with others such as the palliative care team and the local community mental health team. The practice had systems to identify patients with complex needs and ensured they had had appropriate care plans so any unplanned hospital admissions for these patients were minimised.

The main GP showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The main GP talked us through the process used to review patients recently discharged from hospital. Discharge letters were read by the GP, who subsequently reviewed their care according to need. This could involve a telephone call, the patient attending the surgery or a home visit by the GP.

Interviews with the GPs, nurse and practice staff indicated that the culture in the practice was that patients were referred on need and that age, sex and race were not taken into account in this decision making.

Management, monitoring and improving outcomes for people

Patients we spoke with and comments made in comments cards left for us showed that patients were very satisfied with the care and treatment received from GPs and nurses at the practice. The GP practice nurse and other practice staff told us that they frequently raise and share concerns about clinical performance and ways of making improvements.

Staff 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 collated and used to support the practice to carry out clinical audits.

The practice showed us four clinical audits that had been undertaken in the last two years. One of these was a completed audit where the practice was able to demonstrate the changes made to the way they prescribed antipsychotics since the initial audit. Other examples included audits to confirm that the GPs were prescribing high dose of inhaled corticosteroids for asthma patients in line with good practice guidance. However we did not see formal repeat audit dates identified for some of the audits shown to us to check the effectiveness of any improvements made.

The main GP told us that they used the information from the quality and outcomes framework (QOF) monitoring to check the effectiveness of changes made as a result of some clinical audits (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example to monitor outcomes for patients that were prescribed inhaled corticosteroids.

Good

Are services effective?

(for example, treatment is effective)

The practice also used the information collected for the QOF to check performance against national screening programmes to monitor outcomes for patients. For example, the practice had introduced measures to improve the targeted prescription of antibacterial medicines as monitoring data showed that this could be improved. The practice collectively compared their results with other practices in the local area so they could learn from better performing practices and improve their own performance.

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

There was a protocol for repeat prescribing which was in line with national guidance. Patients could request repeat prescriptions in person, by post or on line through the practice website. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Practice staffing included medical, nursing, reception and administrative staff. We reviewed a training matrix which recorded staff training needs and training attended and saw that all staff were up to date with attending mandatory courses such as annual basic life support. Where training updates were due we saw that these had been scheduled. Staff told us that they felt supported by the GPs and the practice manager.

GPs were supported to obtain the evidence and information required for their professional revalidation. This was when doctors demonstrated to their regulatory body, the GMC, that they were up to date and fit to practice. All GPs had a scheduled programme for revalidation or had been revalidated. The practice nurses were supported to attend updates to training that enabled them to maintain and enhance their professional skills.

We saw that appraisals had taken place and included a process for further review of identified learning needs and targets made during appraisals. These were as a minimum conducted annually but the practice manager told us interim appraisals were offered every three months as currently there were a number of new starters. Appraisals records were kept within staff personal records.

The practice nurses had specific roles in which they specialised. We saw records that showed the nurses had completed the required training in order for them to effectively and safely deliver their role. Examples of specialised roles included diabetes and spirometry (which is a test used to measure a patient's lung capacity).

The practice had a process to manage poor performance both for clinical and non clinical staff.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. Systems were in place to ensure patients were able to access treatment and care from other health and social care providers where necessary. This included where patients had complex needs or suffered from a long term condition. There were clear mechanisms to make such referrals in a timely way and this ensured patients received effective, co-ordinated and integrated care. We saw that referrals were assessed as being urgent or routine.

Clinical staff at the practice followed a multidisciplinary approach in the care and treatment of their patients. This included regular meetings with professionals such MacMillan nurses to plan and co-ordinate the care of patients coming to the end of their life. They also liaised with the out of hours service and provided detailed clinical information about patients with complex healthcare needs. Staff told us that this approach worked well to share important information with colleagues and other services and ensured safe and appropriate patient care.

A system was in place for hospital discharge letters blood test results and X ray results to be reviewed by the responsible GP who would initiate the appropriate action in response. The GP who saw 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.

Information sharing

There was effective communication, information sharing and decision making about a patient's care across all of the services involved both internal and external to the organisation, in particular when a patient had complex

Good

Are services effective?

(for example, treatment is effective)

health needs. Care was delivered in a co-ordinated and integrated manner with appropriate sharing of patient sensitive data. We saw evidence of information sharing, for example with the out of hours service, palliative care team and the Macmillan service. There were arrangements to receive hospital summaries of recently discharged patients.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record called SystmOne to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. Archived paper records were securely stored on the premises and were locked via a key code mechanism. Paper records could be accessed by appropriate staff as required.

The practice supported the electronic NHS summary care record scheme for emergency patients. Under the scheme, with a patient's consent, a summary of their care record is provided to healthcare staff that treat patients in an emergency or out of hour's situation which enabled them to have faster access to essential clinical information about that patient. The practice planned to have this scheme fully operational during 2015.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation. The main GP told us that an external speaker had attended the practice team to provide training and further discussions had taken place at external CCG supported meetings. The two GPs at the practice had received Mental Capacity Act training within the last two years. A GP we spoke with gave us examples where they had been involved in decisions about the granting of power of attorney.

Nurses and GPs we spoke with demonstrated clear understanding of Gillick competence. Gillick competence refers to a child under 16 who is able to demonstrate they are capable of making decisions and give consent to care and treatment without parental consultation. A GP talked us through an example where they used the competency check to prescribe the contraceptive pill to a young person. We noted all staff had attended protection of children and vulnerable adults training which included information regarding the Mental Capacity Act 2005 appropriate to their role.

The practice had policies and procedures concerning gaining consent from patients and staff told us they were aware of the need to accurately record all patient consent when it was given either verbally or in writing. A GP who performed cryotherapy (freezing of warts) obtained written consent from each patient before the procedure. These were scanned to the patient's electronic records.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. Clinical staff we spoke were knowledgeable about how a patient's best interests should be taken into account if a patient did not have capacity to make a decision.

The practice provided care for patients in nearby nursing/care homes that cared for people with dementia and support for people with learning difficulties. Part of this was to provide support and advice as needed to use restraint. Staff we spoke with were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

Patients told us that they felt fully listened to in their consultations and stated the GPs made sure they understood their conditions. People gave us examples of how GPs had clearly explained their treatment to them and made sure they fully understood their diagnosis and treatment. Patients told us they felt involved in the decision making process of their care and treatment.

It was practice policy to offer a health check with the health care assistant or the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs and practice nurses to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice offered NHS Health Checks to all its patients aged 40-75. A GP showed us how patients were followed up immediately if they had risk factors for disease identified at the health check and how they scheduled further investigations.

Good

Are services effective?

(for example, treatment is effective)

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and of all patients in need of palliative care and support irrespective of age. Patients who had reached the age of 75 were informed who their named GP was. The practice had also identified the smoking status of 99% of patients over the age of 16 and actively offered smoking cessation advice to relevant patients.

The practice offered proactive diabetic care. For example 95% patients with diabetes had received a foot examination and risk classification within the preceding 15 months. The practice also held monthly clinics for patients whose diabetes was poorly controlled.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. Information we reviewed showed that the practice performance exceeded the targets set by the local CCG.

The practice's performance for cervical smear uptake was 84%, which was better than other practices compared nationally. There were systems to recall non-attenders. The main GP told us that they were trying to improve the breast screening uptake by using Bengali and Italian speaking staff.

We saw evidence of case management of patients with mental health problems and dementia and the practice operated a call and recall system to monitor these patients. Where patients were unable to attend the surgery the GP visited them at home. Longer appointments were offered for reviews.

The practice nurses had specialised skills and had received specific training to deliver a range of services for example treatment of diabetes, asthma, and chronic obstructive pulmonary disease related care.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. This showed that 97% of patients who saw or spoke with a GP thought that they were good at treating them with care and concern. This score was better in comparison with other GP practices in the local CCG area. The practice also commissioned their own patient satisfaction where of the 46 patients that returned a completed questionnaire over 97% reported the GPs and staff were polite, listened to them and made them feel at ease.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 44 completed cards and 39 of them commented about how the genuinely the GPs, practice nurses and other staff treated them with respect, dignity and compassion. Comments in six cards were less positive and concerned with difficulty in obtaining appointments to see a GP. We also spoke with seven patients on the day of our inspection. All of them expressed satisfaction with the service they had received and told us that staff had treated them with dignity and respect.

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

Patients spoke with reception staff through a glass counter. However we noted that there was no provision should a patient whose circumstances may make them vulnerable wished to discuss their needs in private.

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 and those who completed CQC comment cards told us they felt listened to and that their opinion mattered. They said they were well supported by staff. Treatment options were explained and appointments were not rushed. Patients confirmed they were always asked for their consent before any procedure or treatment was undertaken.

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, the national patient survey showed 93% of practice respondents said the GP involved them in care decisions and 96% felt the GP was good at explaining treatment and results. Both these scores were better in comparison with other GP practices in the local CCG area.

Staff told us that translation services were available for patients who did not have English as a first language. The GPs told us that they used an online translation service which patients and staff found very helpful. The main GP was fluent in Italian, which helped them communicate with Italian speaking patients within their practice population.

Patients were aware of the chaperone service the practice offered.

Patient/carer support to cope emotionally with care and treatment

Information from the national patient survey showed patients were positive about the emotional support provided by the practice and rated it well. For example, 97% of respondents said the last GP they saw or spoke to was good at giving them enough time, and 98% had confidence and trust in the last GP they saw or spoke to. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information and confirmed that staff had responded compassionately when they needed help and provided support when required.

The practice had a proactive approach to engaging with the local community and supporting patients to cope emotionally. The practice was actively seeking to identify patients who were also carers so appropriate support arrangements could be offered to them. We were shown

Good

Are services caring?

the written information available for carers. The practice web site also had a dedicated page on carer support. The website also had information available on winter health care for older people and bereavement support.

The main GP told us that if families had suffered bereavement, they would contact them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people'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 in the way services were delivered.

The main GP told us that they regularly engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to discuss local needs and service improvements that needed to be prioritised. The practice offered a number of services to benefit their patients such as cryotherapy, chlamydia testing, childhood vaccinations and health checks. They provided other health improvement services such as dementia screening and support, and stop smoking services.

The practice had a female and a male GP. Patients told us that this did not present any issues and most indicated that they could always see the female GP if they wanted to. This gave patients choice of being seen by a preferred GP of a specific gender.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Staff we spoke with had a good understanding of equality and diversity.

When patients with a learning disability were invited for their annual review the practice used picture to explain the invitation and the process of the review.

More recently the practice had begun caring for patients in a local refuge for women and children escaping domestic violence which meant their confidentiality was paramount in ensuring their anonymity and in promoting their equality.

There was a large car park with allocated disabled parking. From the car park there was level entry to the surgery which enabled easy wheelchair and pram access. The clinical areas of the practice are situated on the ground and first floors of the building with most services for patients on the ground floor. There was a consultation room and a waiting area on the first floor. The practice manager told us that these facilities were only used by patients who were able to walk up the stairs. Disabled toilets and baby change facilities were available.

The waiting area and corridors were sufficiently wide to accommodate wheelchairs and pram access. The reception desk was not assessable to a patient in a wheel chair as the reception counter was set high, designed for a person who could communicate standing. The practice may wish to consider options so patients in wheelchairs could communicate with the receptionist without being overheard.

The practice had a mix of white British and patients from ethnic minority groups, mostly of Italian and Bengali backgrounds, although there had also been a recent increase of eastern European patients. The practice had access to online translation services. In addition the main GP was fluent in Italian, one receptionist spoke Sicilian and another receptionist spoke Bengali.

Access to the service

Appointments with the GP were available from 08.30 am to 11.50 am and from 3.30 pm to 6.30 pm in the afternoon on weekdays. Extended opening hours were available on Thursdays till 8 pm. The practice also offered a telephone advice service with either a GP or the practice nurse. Between 1.30 pm and 3.30 pm the practice operated a number of nurse run clinics. Patients could book appointments in person, or by telephone.

Comprehensive information was available to patients about appointments on the practice website. Information provided included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Out of hours care when the surgery was closed was through BEDOC (a GP co-operative service). Patients were diverted to this service by telephoning the normal surgery contact.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. A small number of comments received indicated that it can be difficult to obtain pre bookable appointments. The receptionist told us that if all appointment slots were gone, then they would be referred to a GP or a nurse for a telephone consultation if their need was urgent.

Longer appointments were available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Home visits were made by the main GP to patients living in local care homes, housebound patients, older people and people with long-term conditions and others who needed one.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice.

We saw the practice had a poster displayed in the main waiting area which explained how patients could complain. Patients told us they were aware of the practices complaints procedure and knew how to make a complaint. Patients knew they could make a complaint in person, over the telephone or in writing. There was comprehensive information available on how to complain on the practice website.

We looked at the practices summary of complaints for the last complete year and noted that the practice had investigated, analysed and communicated the outcome of each complaint in a timely manner to all parties. We saw the practice had documented any learning achieved as a result of the complaint. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon.

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

Being a single handed practice, the team was small and had an ethos of putting patients first. GPs and staff we spoke with had a clear vision to deliver best possible patient care and good outcomes for patients in a safe environment. They told us that they enjoyed being part of such a cohesive, welcoming and caring team. This vision and strategy was demonstrated clearly by the achievement of 99.6 QOF points out of a possible 100.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 5 of these policies at random and found that these had been reviewed and were up to date.

The leadership structure consisted of the main GP taking lead supported by other named staff. For example, the practice nurse led on infection control and the practice manager took responsibility for complaint management. We spoke with five 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 with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice nurse told us about a local peer support system whereby the practice nurse worked jointly with the community specialist nurse, for example in the diabetes clinic which offered the practice nurse learning opportunities as well as a forum to discuss practice issues and source peer support.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Examples seen included audit of atypical antibiotic prescribing, audit of hypnotic prescribing and audit of high dose inhaled corticosteroids in asthma. However we did not see formal repeat audit dates identified for some of the audits shown to us to check the effectiveness of any improvements made.

The practice had a health and safety policy potential risks were assessed and rated and mitigating actions recorded to reduce and manage the risk. There were arrangements for identifying, recording and managing clinical risks. Clinical risks were discussed during practice team meetings.

The practice held monthly governance meetings.

Leadership, openness and transparency

The leadership structure consisted of the main GP taking lead supported by other named staff. For example, the practice nurse led on infection control and the practice manager took responsibility for complaint management. Staff we spoke with were clear about their roles and responsibilities. They told us they felt valued, well supported and knew who to go to if they had any concerns.

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

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example their recruitment policy and whistle blowing policy which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through practice commissioned patient surveys, national patient surveys and complaints process. We looked at the results for the annual patient survey and noted that the practice was currently reviewing comments regarding making an appointment and ease of getting through on the telephone.

The practice gathered feedback from staff through a variety of methods such as practice meetings appraisals, and one to one supervisory meetings. Staff told us they were content to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they were aware of the whistle blowing procedure and would feel comfortable to implement it.

Are services well-led?

Good

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

The practice did not have an active patient participation group (PPG). The practice manager told us that they were actively seeking to convene one in the near future.

The practice had a whistleblowing policy which was available to all staff in the staff handbook.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files and saw that regular appraisals took place which included a development plan. Newly employed staff completed a period of induction and had more frequent appraisals during the first year of their employment.

The practice completed reviews of significant events complaints and other incidents. Practice documentation showed evidence of learning being shared across the practice where appropriate.