Dr Simon John Shaw

Quality Report

Geoffrey Street Surgery
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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.

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Summary of findings

Overall summary

Dr Simon John Shaw is a single handed GP providing primary medical services from the Geoffrey Street Surgery in Preston.

Patients we spoke with during our inspection are happy with the care and treatment they received.

We found the service is provided in a clean and hygienic environment and there are systems in place to ensure the safety of patients.

We found medicines management is safe, with the practice making appropriate checks on medicines.

Patients receive a caring service and told us they were involved in discussions about the health care they received and we saw patients being treated with sensitivity and respect by reception staff.

We found the service is effective in meeting the needs of patient's. They use best practice guidance and work effectively with other health and social care professionals, as well as out of hour's services to provide joined up care for patients.

The practice is responsive to the needs of the majority of patients attending the practice. However provision is not effective in meeting the needs of patients where English was not their first language.

All staff have access to equipment, guidance, protocols and pathways to make clinical decisions and provide safe effective care for patients.

There is strong and visible leadership from Dr Shaw with a culture of openness across the practice.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice was safe. They had a range of measures in place to protect patients from harm. All staff we spoke with were able to tell us how they would respond if they believed a patient or member of the public were at risk. The practice had systems in place to investigate and learn from significant incidents. Safe recruitment processes were in place for staff, which included criminal record checks and checks to ensure staff were registered with their professional bodies and safe to practice. Medicines were stored safely.

Are services effective?

The practice was effective. Care and treatment was being delivered in line with current published best practice. Patients' needs were being met, with patients involved in decision making. We were told assessments of care and treatment were in place and support provided to enable people to self-manage their condition. The practice carried out audits to monitor quality and to ensure treatment was being delivered in line with best practice.

Are services caring?

The practice was overall caring. Patients we spoke with described being treated with respect and dignity and felt involved in decisions about their health care. All staff we spoke with understood the principles of gaining consent, including issues relating to capacity, however there were no policies or procedures in place to support staff where a patient lacked capacity to consent. Staff we spoke with were able to explain to us how they involved patients in the decision making process about their care and treatment. Staff told us where necessary they would book longer consultations to ensure people had the time to make an informed decision.

Are services responsive to people's needs?

The service was responsive. The practice had an understanding of their patient population, and in the main responded to meet people's needs, however systems were not in place to support people where English was not their first language. The service asked for patient feedback on an annual basis through the GP national patient survey. We saw evidence of changes that had taken place in light of the feedback from the survey. We saw there was a complaints procedure in place and we reviewed complaints made to the practice over the past twelve months. We saw that complaints were fully investigated with actions and outcomes documented and learning shared.

Summary of findings

Are services well-led?

The practice was well led. Staff described a service which was supportive and open to learning. Systems had been established to identify, assess and manage risks related to the service provided through a series of internal checks and audits.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people
The practice had provisions in place to ensure care for older people was safe, caring, responsive and effective. The practice had a named GP for all patients who were aged 75 and employed a female GP once a month to work specifically with this population group and had extended nurses hours to support their needs.

People with long-term conditions
We saw that patients with long term conditions were supported to manage their condition. There was a service to recall and review patients with long term conditions which was managed effectively and all patients were monitored appropriately. Patients were referred to other services when required. There was information displayed in the waiting areas explaining different long term conditions.

Mothers, babies, children and young people
The practice provided services to meet the needs of this population group. There were screening and vaccination programmes in place. The practice monitored babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns. Staff were knowledgeable about child protection and Dr Shaw took the lead for safeguarding. There were no specific services for young people.

The working-age population and those recently retired
The practice provided a range of services for patients to consult with the GP and nurses. The practice only provided a surgery during working hours.

People in vulnerable circumstances who may have poor access to primary care
There was adequate provision to ensure care for people in vulnerable circumstances who may have poor access to primary care was safe, caring, responsive and effective. The practice supported patients with learning disabilities and enabled patients living in a nearby hostel to register. However for patients where English was not their first language a formal translation service was not in place.

Summary of findings

What people who use the service say

We received 11 completed CQC patient comment cards and spoke with nine patients on the day of our inspection.

The patients we spoke with were very complimentary about the care provided by the staff. All patients said the staff were friendly and helpful. They said that the service was good and that they were involved in their care. Patients reported that staff treated them with dignity and respect and always allowed them time, they did not feel rushed. All patients were happy with the appointment system and felt they were able to book appointments in a timely manner.

A review of the national GP survey results for 2013 identified the practice was in the main performing as expected, however only 65% of respondents would recommend this surgery to someone new to the area. The survey results highlighted three areas the practice were doing well. We noted 74% of respondents usually wait 15 minutes or less after their appointment time to be seen, 73% of respondents say the last nurse they saw or spoke to was good at involving them in decisions about their care and 84% of respondents say the last nurse they saw or spoke to was good at listening to them. Areas where the survey results showed the practice was performing worse than expected included: 72% of respondents say the last GP they saw or spoke with was good at treating them with care and concern, and 78% of respondents say the last GP they saw or spoke with was good at giving them enough time.

Areas for improvement

Action the service SHOULD take to improve

There was no up to date record of staff who had attended safeguarding training and non-clinical staff had not received any training since 2010. Training records did not show any staff had recently completed infection control training.

The nurses room had a fabric dignity curtain.

We were not provided with evidence of staff having access to policies and procedures or training to enable them to work with patients in line with the Mental Capacity Act 2005.

We were told for patients where English was their second language, they would bring a member of the family to act as a translator. This is not in line with good practice and does not enable staff to be confident they have gained voluntary and informed consent from the patient.

The practice did not have in place a patient participation group (PPG) and did not have plans to establish a PPG.

Dr Simon John Shaw

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included a second CQC inspector, a GP and an Expert by Experience. Experts by Experience are members of the public who have direct experience of using services.

Background to Dr Simon John Shaw

Dr Simon John Shaw is a single handed GP providing primary medical services from the Geoffrey Street Surgery in Preston. The practice is open Monday to Friday between 8:30am and 6:00pm with the exception of Thursday afternoons when the practice is closed. Dr Simon John Shaw holds morning clinics and afternoon clinics. The practice operates an open surgery for patients on a Monday morning where no appointments are necessary. Dr Simon John Shaw also provides telephone support in emergencies for patients. The practice provides home visits for people who were not well enough to attend the centre.

The practice is led by Dr Simon John Shaw, who is supported by two part time nurses and once a month a female GP who provides a clinic for patients over 75 years of age. The practice has a part time practice manager, a secretary, prescription administrator and reception staff.

The practice has a larger than average patient population, providing care for 1980 patients. The practice has a slightly higher than average proportion of the population aged under 15years old, it has a lower proportion aged over 65 years. The age range between 30 and 49 is higher for males and the age range 25 to 29 is higher for females. The practice is located in an area of Preston which has high levels of deprivation with a Multiple Deprivation (IMD) score of 1 which is the most deprived.

When the practice is closed patients are directed to Preston Primary Care Centre for out of hours service.

Why we carried out this inspection

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

How we carried out this inspection

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

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

We also looked at how well services 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

Detailed findings

- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Before visiting Dr Simon John Shaw, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service.

We asked the surgery to provide a range of policies and procedures and other relevant information before the inspection to allow us to have a full picture of the surgery. We carried out an announced inspection visit on 7th July 2014. During our inspection we spoke with a range of staff including Dr Simon John Shaw, two practice nurses, administration and reception staff and the practice manager. We spoke with nine patients who used the service and reviewed 11 CQC comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

The practice was safe. They had a range of measures in place to protect patients from harm. All staff we spoke with were able to tell us how they would respond if they believed a patient or member of the public were at risk. The practice had systems in place to investigate and learn from significant incidents. Safe recruitment processes were in place for staff, which included criminal record checks and checks to ensure staff were registered with their professional bodies and safe to practice. Medicines were stored safely.

Safe patient care

We found that the practice had systems in place to monitor patient safety. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2012-2013 the practice had a good track record of appropriately identifying and reporting incidents.

A system to report, investigate and act on incidents of patient safety was in place, this included identifying potential risk and near misses, however a log of the investigations and outcomes was not always recorded. Staff were alerted to relevant national patient safety alerts via email and face to face.

The GP outlined recent actions the practice had taken following a safety alert relating to patients prescribed aspirin that had atrial fibrillation. Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate. An audit was carried out of all patients with atrial fibrillation. As a result of this audit, advice was sought from one particular patient's consultant and no action was necessary.

A protocol was in place outlining the practice approach to transferring and acting on information about patients seen by other doctors out of hours ensuring continuity of care between providers.

We saw staff had access to multiple sources of information to enable them to maintain patient safety and keep up to date with best practice.

The practice investigated complaints, carried out audits and responded to patient feedback in order to maintain safe patient care.

The premises were accessible for people with limited mobility such as wheelchair users. All patient areas were clean and well maintained.

Learning from incidents

The practice had an open approach to investigating incidents that occurred within the practice. Arrangements were in place for reporting all incidents to monitor any patterns or trends as well as detailing significant incidents that occurred at the practice. We saw from the practice a significant events log detailed the events provided analysis and action. We noted however one significant event in relation to staff safety which took place six weeks prior to our inspection had only been informally investigated and no records were available apart from details of the event, staff had mixed views on the action the practice needed to take in the future to maintain staff safety following the incident.

Staff told us as they were such a small team, learning from events was done informally and they were able to reflect and discuss openly with colleagues any issues or concerns as a result of incidents. The practice manager told us they were looking at a formal method of communication to staff to share key information and findings to ensure a consistent approach to learning. They told us from July 2014 weekly meetings were being held with the part time nursing staff, and these meetings would be minuted to share learning.

Safeguarding

All staff we spoke with were able to tell us how they would respond if they believed a patient or member of the public were at risk. Staff explained to us where they had concerns they would seek guidance from the safeguarding lead or seek support from a colleague as soon as possible. We were given one example where the prescriptions administrator raised concerns; these were followed up and responded to by the Local Authority safeguarding team.

We saw the practice had in place a child protection policy and procedure which incorporated local contact information for further support and guidance. The practice was in the process of updating their adult safeguarding policy at the time of our inspection to ensure this was up to date with local guidance. We saw procedures and flow charts were in place for staff to follow should they have concerns about a patient. Where concerns already existed about a child, alerts were placed on patient records. These alerts were nationally recognised, so would transfer with a

Are services safe?

child's records to another GP or health provider where appropriate. We spoke with Dr Shaw who had responsibility for safeguarding; they had a clear understanding of their role and responsibility and had attended level three safeguarding training. Wherever possible Dr Shaw attended children's safeguarding conferences or supplied relevant information if unable to attend.

The part time nursing staff told us they had received safeguarding training with other NHS employers; however the practice manager only held a record for one of the nurses. The reception and administrative staff had not received any training since 2010. The practice manager told us they would arrange update training for support staff and ensure any relevant training staff attend with other NHS providers, they would request copies of certificates to maintain up to date records and ensure all staff are up to date with safeguarding training.

Monitoring safety and responding to risk

As a single handed practice the accountability was with the GP, with the support of the practice manager. The GP was the lead for safeguarding, infection control and medicines management.

Staff spoken with and records seen confirmed that all staff had received training in medical emergencies including resuscitation techniques. All staff were trained to a minimum of basic life support.

All the building maintenance, cleaning and clinical waste was managed by external NHS trust and not the practice. The practice manager told us, any maintenance or repairs required to maintain safety were reported to the buildings manager and this was responded to in a timely manner. The cleaning company carried out cleaning audits and the results of these were shared with the practice.

The practice manager had clear staffing levels identified and procedures in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness; this was recorded within the business continuity plan. We saw where the GP was not available arrangements were in place with the local clinical commissioning group (CCG). Staff told us as they were such a small team, they worked together to manage staff shortages and plan annual leave so as not to leave the practice short of staff.

Medicines management

The practice held medicines on site for use in an emergency or for administration during consultations such as administration of vaccinations, there were no controlled drugs kept at the practice. Medicines administered by the nurses at the practice were given under a patient group direction (PGD), a directive agreed by doctors and pharmacists which allows nurses to supply and/or administer prescription-only medicines. This had also been agreed with the local Clinical Commissioning Group.

We saw emergency medications were checked to ensure they were in date and safe to use. We checked a sample of medicines including those used by the GP for home visits and found these were in date, stored safely and where required, were refrigerated. Medicine fridge temperatures were checked and recorded daily to ensure the medicines were being kept at the correct temperature.

We saw an up to date policy and procedure was in place for repeat prescribing and medication review. The practice employed a prescriptions administrator whose role included a link between patients and the GP, the Clinical Commissioning Group (CCG) and the pharmacy team. Speaking with the prescriptions administrator they explained to us the system in place to ensure where changes to prescriptions had been requested by other health professionals such as NHS consultants and/or following hospital discharge, the changes were reviewed by the GP daily and the changes implemented in a timely manner. We were shown the safety checks carried out prior to repeat prescriptions being issued and where there were any queries or concerns these were flagged with the GP before any repeat prescriptions were authorised.

Prescription pads and repeat prescriptions were stored securely. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them.

Patients we spoke with spoke highly of the prescription services and appreciated the link they had to the prescription administrator who helped them to often resolve issues and concerns.

Cleanliness and infection control

The practice was found to be clean and tidy. The GP was the lead for infection control and all the staff we spoke with were clear about their roles and responsibilities in maintaining a clean and safe environment.

Are services safe?

Training records showed that staff had not completed training in infection control. One nurse told us they had received an update, but this had not been recorded within the training record. The infection control policy clearly stated 'Ensure that all clinical staff receives regular mandatory training update on infection control and that records are kept for CQC inspection.'

The practice had an infection control policy and procedures in place. The policy stated 'The Practice Manager has the responsibility for ensuring that the Self Audit Tool is completed at least annually.' The nurses completed and audit on a monthly basis with the last being completed in June 2014.

The policy included protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance for sharps, needle stick and splashing incidents which were in line with current best practice.

We looked in three consulting rooms and a treatment room. The treatment room was used by the practice where patients required any treatment or minor surgery. All the rooms had hand wash facilities and work surfaces which were free of damage, enabling them to be cleaned thoroughly. The nurses room had a fabric dignity curtain, we were not provided with evidence of routine cleaning of the curtains. We raised this with the GP who agreed to remove the fabric curtain.

We saw rooms were well stocked with gloves, aprons and alcohol gel, and hand washing guidance displayed by the sinks. The practice only used single use instruments, we saw these were stored correctly and stock rotation was in place.

Cleaning was provided externally by a cleaning company contracted to clean the whole building. Speaking with the practice manager, any issues they had with the cleaning were raised with the buildings manager and resolved in a timely manner. None of the staff raised any concerns over the quality of cleaning. The cleaning company audited the cleaning and the practice manager received a copy of the audit.

An independent waste disposal contractor had been appointed who were registered carriers of waste.

Staffing and recruitment

The practice had an up to date recruitment policy and process in place, staffing within the practice was static and most staff had been employed for a number of years. All appropriate checks were carried out before the staff member started working within the practice.

Clinical staff had recent criminal records bureau / disclosure and barring checks (CRB/DBS) and these were recorded in staff files. An informal risk assessment had taken place for administration and reception staff and the decision had been taken not to carry out DBS checks. The practice manager told us they would formalise the risk assessment for any future employees and ensure this was recorded. We noted the practice did not have a record of the regular locums CRB, the practice manager told us they had requested a copy and would ensure this was recorded in staff records.

Where relevant, the practice also made checks that members of staff were registered with their professional body and on the GP performer's list. We saw these checks had taken place for the regular locum GP. This helped to evidence that staff met the requirements of their professional bodies and had the right to practice.

Dealing with Emergencies

There were plans in place to deal with emergencies that might interrupt the smooth running of the service. Within the business continuity plan there was clear guidance, with staff roles and responsibilities being clearly defined. We noted that alternative premises had been identified so that if the practice was unable to open for any reason, patients would still receive a service.

We saw fire safety checks were carried out, the fire alarm was tested weekly and full fire drills were scheduled every six months. This ensured that in the event of an emergency staff were able to evacuate the building safely.

Consulting rooms and behind reception panic buttons had been installed which were linked to the police in the event of an emergency.

Equipment

The practice had a plan in place to ensure all equipment was effectively maintained in line with manufacture guidance and calibrated where required. Calibration was carried out by the GP on an annual basis. Checks were carried out on portable electrical equipment in line with legal requirements.

Are services safe?

We spoke with the practice nurses who told us they had access to the necessary equipment and were skilled in its use.

Are services effective?

(for example, treatment is effective)

Our findings

The practice was effective. Care and treatment was being delivered in line with current published best practice. Patients' needs were being met, with patients' involved in decision making. We were told assessments of care and treatment were in place and support provided to enable people to self-manage their condition. The practice carried out audits to monitor quality and to ensure treatment was being delivered in line with best practice.

Promoting best practice

Staff completed assessments of patients' needs and these were reviewed when appropriate, speaking with one practice nurse they explained to us how they reviewed patients with chronic diseases such as Asthma on annual basis, and were able to make direct referrals to specialist services where required. We also saw patients' with learning disabilities had access to annual reviews using the nationally recognised Cardiff Health Check Template, recognised by the Royal College of General Practitioners (RCGP) and The Royal College of Nursing (RCN).

We saw information available to staff, minutes of meetings and by speaking with staff, that care and treatment was delivered in line with recognised best practice standards and guidelines. Staff told us they received updates relating to best practice or safety alerts they needed to be aware of via emails and nursing staff told us they received regular updates as part of their on going training.

Staff referred to Gillick competency when assessing young people's ability to understand or consent to treatment. Ensuring where necessary young people were able to give informed consent without parents' consent if they are under 16 year of age.

We were not provided with evidence of staff having access to policies and procedures or training to enable them to work with patients in line with the Mental Capacity Act 2005.

We were told for patients where English was their second language, they would bring a member of the family to act as a translator. This is not in line with good practice and does not enable staff to be confident they have gained voluntary and informed consent from the patient.

The GP discussed with us using National Institute for Health and Care Excellence (NICE) guidelines to treat and review patients, one example related to patients presenting at surgery with a cough which had lasted longer than three weeks and were referred for a chest X-ray.

The practice held monthly multi-disciplinary team meetings with a range of health and social care professionals these included district nurses, health visitors, advanced mental health nurse, community matron, social workers and palliative care team. We were shown evidence of outcomes from these meeting which included additional support for vulnerable patients and continuity of care of people receiving palliative care.

Prior to the inspection, we received data which highlighted the practice may not be in line with national indicators such as higher than average patient attendance at Accident and Emergency (A&E) with 161.6 attendances per 1000 population compared with other local practices average of 124.9) As a result the practice audited the A&E attendance and highlighted a small number of patients with either Chronic disease or who were vulnerable, these patients were then included as part of the monthly Multi Disciplinary team (MDT) meetings to look at additional support arrangements to prevent unnecessary attendance at A&E.

Management, monitoring and improving outcomes for people

Speaking with clinical staff, we were told assessments of care and treatment were in place and support provided to enable people to self-manage their condition. A range of patient information leaflets were available for staff to give out to patients which helped them understand conditions and treatments.

Staff said they could openly raise and share concerns about patients with colleagues to enable them to improve patient's outcomes. The practice participated in peer group meetings monthly with other GPs in the local area. Speaking with the nurses and practice manager they told us of the benefit of newly introduced weekly nurse meetings to share knowledge and discuss patient care.

The practice used the information they collected for the Quality and Outcomes framework QOF and their performance against national screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided. The report from 2012-2013

Are services effective?

(for example, treatment is effective)

showed the practice was supporting patients well with conditions such as, asthma, diabetes and heart failure. QOF information for 2013-2014 indicated the practice had maintained this high level of achievement with 99.2% of outcomes achieved.

The practice monitored patients who were prescribed Azathioprine and other disease modifying agents. Azathioprine is an immunosuppressant, used to help prevent rejection following organ transplant operations and also to treat a variety of chronic (long-term) inflammatory and autoimmune conditions. The practice maintained a register of all patients prescribed warfarin (warfarin is used to prevent and treat the formation of harmful blood clots within the body) to help manage and monitor patients care and treatment.

The practice were introducing care plans for patients with core morbidities and long term health conditions in partnership with the community matron.

The practice had systems in place to monitor and improve the outcomes for patients by providing annual reviews to check the health of patients with learning disabilities, patients with chronic diseases and patients on long term medication. Patients were invited for reviews, reception staff told us they attempted to contact patents three times to arrange appointments for a review followed up by a letter if contact was not made.

Patients told us they were happy the doctors and nurses at the practice managed their conditions well and if changes were needed they were fully discussed with them before being made.

Staffing

Speaking with staff and reviewing training records we saw all staff including locum GP's were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice. The GP was revalidated in October 2013. GP revalidation is the process where doctors demonstrate they are up to date and fit to practice.

New and temporary staff including locum GPs participated in an induction programme. We saw an induction checklist was in place to ensure all areas were covered.

The practice had a system for supervision and appraisal in place for all staff. We saw appraisals were up to date and all the staff we spoke with confirmed appraisals had taken place. Speaking with one nurse they told us they had a joint appraisal with Dr Shaw and the practice manager ensuring both clinical and non-clinical areas were covered.

All staff we spoke with told us they were happy with the support they received from the practice.

Staff told us they were able to access training and received updates, with time protected to undertake learning for the nursing staff. We saw staff had access to training as part of their professional development with nurses attending training in which updates on key issues was provided. One nurse told us they had attended training which included fundaments of asthma & chronic obstructive pulmonary disease (COPD) education. We saw from records the second nurse had completed training in advanced diabetes in primary care.

Working with other services

We found the GP and the nurses at the practice worked closely as a team, and with staff in the treatment room. Staff worked closely with other providers such as district nurses, health visitors, social workers and advanced mental health nurses and met monthly as a multi-disciplinary team to ensure information was shared effectively.

A midwife provided appointments for patients at the practice once a week and a podiatrist once a month. A physiotherapist had started to provide a service to patients within the practice; this was also accessible to patients from other GP practices. The practice were piloting a counselling service for patients once a week, the service was provided by a student counsellor, supported and supervised by the University of Central Lancashire.

The practice provided support to a homeless hostel; they registered people living in the hostel and provided new patient health checks on registration. The practice also worked closely with a provider of supported accommodation for young people with learning disabilities. Annual health checks were carried out. Reception staff told us they knew the residents and their carers well and had knowledge of how to support and make the young people feel safe during a visit to the practice.

Details of out-of-hours consultations that patients had attended were shared with the practice by the out of hours provider each morning. These were reviewed and where follow up action was required this was allocated to the GP.

Are services effective?

(for example, treatment is effective)

The practice had a system with the out of hours provider which allowed them to share information relating to any complex patients or patients receiving end of life care. The system allowed both creating and altering an electronic record for a patient, to ensure records were kept up to date.

Health, promotion and prevention

New patients looking to register with the practice were informed by the receptionists, the practice only had a male GP to enable them to make an informed choice whether to register. New patients were provided with an appointment with a member of the nursing team for a health check.

The practice had a range of written information for patients in the waiting area, including information they could take away on a range of health related issues, local services and health promotion.

We were provided with details of how staff actively promoted healthy lifestyles during consultations. The clinical system had built in prompts for clinicians to alert them when consulting with patients who smoked or had weight management needs. The nurses provided lifestyle advice to patients this included, dietary advice for raised cholesterol, alcohol screening and advice, weight management and smoking cessation.

A children's immunisation and vaccination programme was in place as well as a Meningitis C vaccination programme for new students and MMR for young people aged 16 years and over. For older patients there was a shingles vaccination catch-up scheme for patient's 71-79years of age.

Patients who were receiving care at the end of life had been identified and joint arrangements were in place as part of a multi-disciplinary approach with the palliative care team. We were told for all patients who were bereaved the GP would make contact to provide support where required. Bereavement leaflets and booklets were available to patients and patients were able to self-refer or be referred for bereavement counselling.

Are services caring?

Our findings

The practice overall was caring. Patients we spoke with described being treated with respect and dignity and felt involved in decisions about their health care. All staff we spoke with understood the principles of gaining consent including issues relating to capacity, however there were no policies or procedures in place to support staff where a patient lacked capacity to consent. Staff we spoke with were able to explain to us how they involved patients in the decision making process about their care and treatment. Staff told us where necessary they would book longer consultations to ensure people had the time to make an informed decision.

Respect, dignity, compassion and empathy

During our inspection we observed staff to be kind, caring and compassionate towards patients. We saw reception staff taking time with patients and trying where possible to meet people's needs.

We spoke with nine patients and reviewed 11 CQC comment cards received the week leading up to our inspection. All were positive about the care and treatment they had received from staff. Patients we spoke with told us the GP and nurses were patient, listened and took time to explain their condition and treatment options.

We observed staff speaking with patients, with respect. We spent time with reception staff and observed courteous and respectful face to face communication and telephone conversations. Staff told us when patients arriving at reception wanted to speak in private; they would speak with them in one of the consultation rooms. All the patients we spoke with were complimentary about the reception staff and this was also reflected in the national GP Patient Survey where 85% said the receptionists at this practice were helpful.

We found all rooms were lockable and there were appropriate dignity screens in place to maintain patients' dignity and privacy whilst they were undergoing examination or treatment.

We saw patients' had access to a chaperone service when they underwent an examination, chaperoning was carried out by staff in a treatment room employed by NHS Lancashire Care Foundation Trust, this was a historical arrangement. Staff in the treatment room told us they did not document they had witnessed treatments in patients notes but kept an independent log. We noted there were no notices informing patients' of the availability of a chaperone. The Practice manager told us they would ensure signs were displayed in the waiting area.

Staff were able to clearly explain to us how they would reassure patients who were undergoing examinations, and described the use of modesty sheets to maintain patient's dignity.

Involvement in decisions and consent

The practice had a confidentiality statement, which was recorded within the practice leaflet and made available to patients. A consent policy was in place for staff, which set out how consent should be obtained and recorded from patients. The policy included guidance on seeking consent from patients under 18 years of age in line with the Gillick competency. Gillick competency allows professionals to demonstrate they have checked the persons understanding of the proposed treatment and consequences of agreeing or disagreeing with the treatment. We saw consent was recorded in patient notes.

The consent policy stated a patient should understand a proposed treatment, immunisation or investigation before they were able to consent. However the policy did not provide staff with guidance on what to do if they did not feel patients had the capacity to consent or wished to make an advanced decision.

There was no policy and procedures in place for staff to ensure appropriate action was taken where people did not have the capacity to consent in line with the Mental Capacity Act 2005. However all staff we spoke with understood the principles of gaining consent including issues relating to capacity. Staff told us where they had concerns about a patient's capacity; they would refer patients to the GP. The GP explained this was an area he was looking at as part of his personal development plan for his annual appraisal.

We were told for patients where English was not their first language, they would bring a member of the family to act as a translator.

Staff explained how they involved patients in the decision making process, about their care and treatment. Staff told us where necessary they would book longer consultations

Are services caring?

to make sure people had the time to come to an informed decision. The patients we spoke with confirmed that they had been involved in decisions about their care and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The service was responsive. The practice had an understanding of their patient population, and in the main responded to meet people's needs, however systems were not in place to support people where English was not their first language. The service asked for patient feedback on an annual basis through the GP national patient survey. We saw evidence of changes that had taken place in light of the feedback from the survey. We saw there was a complaints procedure in place and we reviewed complaints made to the practice over the past twelve months. They were fully investigated with actions and outcomes documented and learning shared.

Responding to and meeting people's needs

The practice had an understanding of their patient population, and responded to meet people's needs.

The practice has a slightly higher than average proportion of the population aged under 15years old, it has a lower proportion aged over 65 years. The age range between 30 and 49 is higher for males and the age range 25 to 29 is higher for females.

The practice had in place enhanced services which reflected the patient population these included, a shingles vaccination services programme for patients over 70 years old to prevent cases of the disease, facilitating timely diagnosis and support for people with dementia, vaccination programmes for pregnant women to prevent Pertussis commonly called whooping cough, MMR vaccination programme for those aged 16 and over, Meningitis C (fresher) vaccination programme and Hepatitis B vaccination programme for newborns. The practice also provided minor surgery onsite for patients.

The practice manager told us they were also participating in the national scheme to ensure all patients over 75 had a named GP. Letters had been sent out to 120 patients informing them of who their named GP was. The practice employed an additional GP and had increased nursing hours as part of a local scheme to work specifically with patients over 75, these staff were available for appointments in surgery and home visits.

The practice made reasonable adjustments to meet people's needs. Staff and patients we spoke with provided a range of examples of how this worked, such as accommodating home visits, joint working with a local hostel and supported accommodation for young adults with learning disabilities. The practice provided extended appointments where necessary and arranged appointments at times convenient to patient's needs. We noted the practice only opened during working hours with Mondays offering appointments between 9:10am and 5:30pm. The rest of the week they were only open for appointments until 4:30pm and 3:30pm on a Friday

The practice did not have a formal translation service in place, despite acknowledging they had a new and increasing Polish population and a large Asian community locally. Where translators were required the practice relied on patients relatives. One receptionist told us on occasions patients present at reception that did not speak English and just had to leave. We saw no information written in another language for patients, apart from information used by the nurses to help with child immunisation programme.

We saw where patients required referrals to another service these took place in a timely manner via a choose and book system. One nurse told us when carrying out reviews of patients with diabetes or COPD for example, they were able to directly refer patients back to specialist services. The majority of patients told us they were happy with the referrals made.

A repeat prescription service was available to patients over the phone or at reception. All the patients we spoke with were happy with the repeat prescription service and told us if they had any queries they were able to speak with staff at the surgery.

Access to the service

The practice was accessible for people with mobility difficulties. The consulting rooms were all on one level, the rooms were large with easy access for patients. There was also a toilet for disabled patients. We noted a hearing loop was in use for people with hearing problems.

The practice had responded to the results of the GP National Patient survey in relation to accessing appointments, and following an audit identified Monday mornings were an issue. As a result the practice operated an open surgery on a Monday morning where no appointment was necessary.

The practice had responded to the results of the GP National Patient survey in relation to accessing appointments and following an audit identified same day appointments were an issue. As a result two more same

Are services responsive to people's needs?

(for example, to feedback?)

day appointments were made available making a total of eight available appointments altogether (four for the morning surgery and four for the afternoon surgery). We were shown that on a daily basis eight appointments were available for same day appointments and extra appointments were available for emergencies. Routine appointments could be booked in advance up to two months. The practice offered an open surgery on Monday mornings.

All the patients we spoke with told us in the event of an emergency they were able to get same day appointments and for routine appointments these were normally available within a couple of days.

Home visits were available for patients each day by telephoning the practice before 11am.

To reduce the number of patients who do not attend appointments the reception staff contacted patients by phone two days prior to booked appointments to remind patients and or make alternative arrangements if they were no longer able to attend.

The practice had a clear, accurate and up-to-date practice leaflet containing information about services provided at the practice. The leaflet highlighted how to access out of hours services and promoted other local services such as the pharmacy first minor ailment scheme.

Concerns and complaints

We saw there was a complaints procedure in place. We reviewed complaints made to the practice over the past twelve months and found they were fully investigated with actions and outcomes documented. Where relevant outcomes were shared with staff during team meetings. Informal complaints were logged by staff and reviewed by the practice manager to see if any action was required.

Complaints leaflets were available to patients at reception; however patients were required to ask for a complaints form from reception staff. Patients we spoke with told us they would know how to make a complaint if they felt the need to do so.

Are services well-led?

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

Our findings

The practice was well led. Staff described a service which was supportive and open to learning. Systems had been established identify, assess and manage risks related to the service provided through a series of internal checks and audits.

Leadership and culture

The practice was a single handed GP service that was led by Dr Shaw and supported by nurses, a practice manager, secretary, administrator and reception staff. Speaking with staff, they all described to us an open and supportive work environment. Staff told us they would have no hesitation in speaking with the practice manager if anything was troubling them as they knew they would be supported, and where appropriate, action would be taken.

The GP was the lead for the practice and took the lead role for safeguarding and infection control and governance.

The practice had a mission statement in place. Observing staff and speaking with staff and patients we found the practice clearly demonstrated a commitment to compassion, dignity, respect and equality.

The GP participated in a peer review process with other GP's in the areas. This was a system where GP's checked each other's patient records for accuracy and appropriate treatment and referrals. Monthly multi-disciplinary team meetings were held, with a range of health and social care professionals these included district nurses, health visitors, advanced mental health nurse, community matron, social workers and palliative care team. From minutes of meetings and speaking with staff we saw vulnerable patients and joint working arrangements were discussed with actions and best outcomes for patients discussed.

Governance arrangements

The GP took the lead for governance.

We saw the practice made use of data provided from a range of sources including the Preston Clinical Commissioning group (CCG), General Practice Outcome Standards (GPOS) and the national patient survey. We saw from records, audits and speaking with Dr Shaw and the practice manager they had taken action to improve outcomes for patients, for example providing enhanced services for avoiding unplanned admissions, employing a GP and extra nursing hours to meet the needs of those patients over 75 and having open appointments on a Monday morning.

Staff had access to a range of policies and procedures which had recently been updated or were in the process of being reviewed by the practice manager. We looked at several of the policies and saw where these had been updated they were comprehensive and reflected up to date guidance and legislation.

Systems to monitor and improve quality and improvement

The practice participated in the quality and outcomes framework system (QOF). This was used to monitor the quality of services in the practice. Prior to the inspection, we received data which highlighted the practice may not be in line with national indicators such as higher than average patient attendance at Accident and Emergency (A&E). As a result the practice audited the A&E attendance and highlighted a small number of patients with either Chronic disease or who were vulnerable, these patients were then included as part of the monthly MDT meetings.

We were provided with a list of audits which had been carried out during 2013/14 these included, minor operations, hormone replacement therapy (HRT), patients attending accident and emergency and medicine management audits. We saw clear outcomes were recorded and where appropriate changes made to improve outcomes for patients. For example an audit was carried out on patients prescribed HRT (a treatment used to relieve symptoms of menopause) to establish if any patients had not attended annual reviews. A small number of patients were identified and contacted, and all attended reviews to discuss treatment options and changes made where required.

The practice manager told us the premises were well maintained and any issues which arose were reported to the building manager and were quickly resolved. A monthly audit of cleaning was carried out by a cleaning company and copies were supplied to the practice manager.

The practice manager provided us with details of the equipment checks which had been carried out in the past twelve months. This guaranteed equipment was safe to use and maintained in line with manufacture guidelines.

Are services well-led?

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

Patient experience and involvement

Feedback was sought from patients through the national GP patient survey, this is a national survey carried out annually. We saw the results from the survey carried out in 2013. Results from the 2013 survey gave mixed results, for example to practice were above regional average for patients waiting 15 minutes or less after their appointment time to be seen and 84% of patients said the last nurse they saw or spoke to was good at listening to them. However they were below the regional average with 71% of patients describing their experience of making an appointment as good.

We saw action had been taken to address issues which had been raised from the survey, with changes to the appointment system, which included open appointments on a Monday morning.

Patients were able to provide feedback on-going through a suggestion box located at reception. The practice manager told us they do not receive many suggestions through the box and any that they did receive were reviewed by the GP. We were not provided with details as to what action if any was taken as a result of the suggestions made.

A formal complaints procedure was in place, with details provided in the practice leaflet and complaints leaflets were available to patients at reception; however patients were required to ask for a complaints form from reception staff. Informal complaints were logged by staff and reviewed by the practice manager to see if any action was required.

The practice did not have in place a patient participation group (PPG) and did not have plans to establish a PPG, We were told the systems they had in place provided sufficient opportunities for patients to give comments and feedback.

Staff engagement and involvement

All staff we spoke with told us they felt supported and involved in the practice keeping up to date informally on a daily basis.

The practice nurses met weekly with the practice manager, this was a new initiative as the nurse both worked part time. We were told these meeting were beneficial to share knowledge and learning and to improve outcomes for patients.

When speaking with staff they were aware of the whistleblowing policy and aware of actions they would take should they have concerns about other professional practice.

Learning and improvement

As a small single handed GP practice with an established staff team they told us learning and improvement was informal and on-going on a daily basis. The practice manager told us they have established weekly meetings with the nurses to formalise this process and reception staff told us they had a staff meeting on a monthly basis, however these were not always minuted.

From the summary of significant events we were provided with and speaking with staff we saw learning had taken place and improvements were made. We noted however one significant event in relation to staff safety which took place six weeks prior to our inspection had only been informally investigated to date and no records were available apart from details of the event, staff had mixed views on the action the practice needed to take in the future to maintain staff safety.

We were provided with a training log for staff, but this did not provide details of the training the part time nurses had completed with other providers such as infection control and safeguarding. The practice manager told us they would ensure in the future any relevant training, details would be recorded in staff files.

Identification and management of risk

Risks were identified and managed by systems in place and through discussion. For example staff were encouraged to attend at practice meetings and log any informal complaints or incidents that had been brought to their attention. Significant incidents in the main were recorded and reviewed in a timely manner and staff were asked for their feedback.

We saw that health and safety risk assessments had been carried out by an external NHS Trust.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice had provisions in place to ensure care for older people was safe, caring, responsive and effective. The practice had a named GP for all patients who were aged 75 and employed a female GP once a month to work specifically with this population group and had extended nurses hours to support their needs.

The practice manager told us they were participating in the national scheme to ensure all patients over 75 have a named GP. Letters had been sent out to 120 patients informing them of who their named GP is. The practice employed an additional GP once a month and had increased nursing hours as part of a local scheme to work specifically with patients over 75, they were available for appointments in surgery and home visits.

The practice had in place enhanced services for older people which included a shingles vaccination programme for this population group to prevent cases of the disease, and facilitating timely diagnosis and support for people with dementia. The enhanced service is designed to reward GP practices for undertaking a proactive approach to the timely assessment of patients who may be at risk of dementia.

Patients who were receiving care at the end of life had been identified and joint arrangements were in place as part of a multi-disciplinary approach with the palliative care team. We were told for all patients who were bereaved the lead GP would make contact to provide support where required. Bereavement leaflets and booklets were available to patients and patients were able to self-refer or be referred for bereavement counselling.

A safeguarding procedure was in place for staff to follow should they have concerns about an older person's welfare. Staff were clear of their roles and responsibilities in protecting vulnerable adults.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

We saw that patients with long term conditions were supported to manage their condition. There was a service to recall and review patients with long term conditions which was managed effectively and all patients were monitored appropriately. Patients were referred to other services when required. There was information displayed in the waiting areas explaining different long term conditions.

Patients told us they felt safe and they were very complimentary about the treatment they received. The practice was delivering care and treatment in line with current best practice. There was a range of information displayed in the waiting areas explaining different long term conditions and signposting access to other services.

Patients we spoke with told us they were regularly recalled for follow up visits. Reception staff told us they attempted to contact patents three times to arrange appointments for a review followed up by a letter if contact was not made. The practice nurses held regular asthma, diabetes and well person appointments for patients with long term conditions.

The practice monitored patients who were prescribed Azathioprine and other disease modifying agents to monitor their medication and the patient's progress. Azathioprine is an immunosuppressant, It is used to help prevent rejection following organ transplant operations and also to treat a variety of chronic (long-term) inflammatory and autoimmune conditions. The practice maintained a register of all patients prescribed warfarin (warfarin is used to prevent and treat the formation of harmful blood clots within the body) to help manage and monitor patients care and treatment.

A repeat prescription service was available to patients over the phone or at reception. All the patients we spoke with were happy with the repeat prescription service and told us if they had any queries they were able to speak with staff at the surgery.

A podiatrist was available for patients to book appointments once a month and to carry out foot checks for patients with diabetes.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice provided services to meet the needs of this population group. There were screening and vaccination programmes in place. The practice monitored babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns. Staff were knowledgeable about child protection and Dr Shaw took the lead for safeguarding. There were no specific services for young people.

A midwife provided appointments for patients at the practice once a week. The practice worked closely with health visitors who attended monthly multi-disciplinary meetings.

A children's immunisation and vaccination programme was in place. There were enhanced vaccination programmes for pregnant women to prevent Pertussis commonly called whooping cough, MMR vaccination programme for those aged 16 and over, Meningitis C (fresher) vaccination programme and Hepatitis B vaccination programme for newborns.

A consent policy was in place for staff, which set out how consent should be obtained and recorded. The policy included guidance on seeking consent from patients under 18 years of age in line with the Gillick competency.

A safeguarding policy and procedure was in place for staff to follow should they have concerns about a child. Staff were clear of their roles and responsibilities in protecting children from abuse.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice provided a range of services for patients to consult with the GP and nurses, these including screening and vaccination programme, minor surgery and healthy living advice and support.

The practice only opened during working hours with Mondays offering the latest bookable appointments between 9:10am and 5:30pm. Dr Shaw was available from 8.00am-6.30pm Monday to Friday if required.

Reception opened 8.30am-6.00pm Monday to Wednesday, 8.30am-1.00pm Thursdays and 8.30am-5.30pm Fridays.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

There was adequate provision to ensure care for people in vulnerable circumstances who may have poor access to primary care was safe, caring, responsive and effective. The practice supported patients with learning disabilities and enabled patients living in a nearby hostel to register. However for patients where English was not their first language a formal translation service was not in place.

There was a system in place to support vulnerable patient though monthly multi-disciplinary meeting with a range of health and social care professionals these included district nurses, health visitors, advanced mental health nurse, community matron, social workers and palliative care team. We were shown evidence of outcomes from these meeting which included additional support for vulnerable patients.

The practice worked closely with a provider of supported accommodation for young people with learning disabilities. We saw patients with learning disabilities had access to annual reviews using the nationally recognised Cardiff Health Check Template, recognised by the Royal College of General Practitioners (RCGP) and The Royal College of Nursing (RCN).

The practice provided support to a homeless hostel; they would register people living in the hostel and provided new patient health checks on registration.

We were told for patients where English was their second, they would bring a member of the family to act as a translator.