

Meadowside Medical Practice

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?

Outstanding



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Meadowside Medical Practice on 18 November 2015. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- 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.

- Patients said they found it easy to make an appointment with a GP or nurse 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.
- The provider was aware of and complied with the requirements of the Duty of Candour.

We saw some areas of outstanding practice:

- The practice cared for a number of patient groups who experienced challenging health needs, and had responded well to these needs. For example they liaised closely with the local Islamic girls' college to ensure their residents health needs were met appropriately. The female nurse practitioner telephoned the college each morning to triage health concerns and had three appointment slots

Summary of findings

each day set aside for these patients to access. The practice had also recognised the difficulties in prescribing medicines presented by dietary restrictions faced by this population group and had acted by raising awareness of medicines appropriate for a Halal diet.

- The GPs provided GP urgent care services at the local accident and emergency department, which allowed a streamlined transition for their patients accessing emergency care back into primary care. The GPs would frequently visit their patients while they were in-patients enabling care plans to be put in place immediately.

The areas where the provider should make improvement are:

- Ensure policy documents and risk assessments fully take into account the role of chaperone for

non-clinical staff. For staff who have not had a DBS check undertaken, documents should clearly state that they will not be left alone with patients, for example should the clinician leave the room.

- Ensure staff receive regular training around infection prevention and control.
- Ensure that the regular checks carried out for medicine stock levels and expiry dates, as well as those to ensure emergency equipment is functioning are documented and recorded.
- Ensure all written responses to complaints include information of whom to contact should the complainant be unhappy with the investigation, and include feedback from complaints in staff meetings in order to maximise learning from them.

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?

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When there are unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Good



Are services effective?

The practice is rated as good for providing effective services.

- Data showed patient outcomes were at or above average for the locality.
- Staff assessed needs and delivered care in line with current evidence based guidance. Staff had access to regular educational meetings where National Institute for Health and Care Excellence (NICE) best practice guidelines were regularly discussed to keep staff up to date.
- Clinical audits demonstrated quality improvement, although audit cycles were not always repeated in a timely manner to maximise learning.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for most staff, and those who had not had an appraisal in the past year had one booked in the upcoming weeks.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of people's needs.

Good



Are services caring?

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.

Good



Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

The practice is rated as outstanding for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patient's needs. For example, liaising closely with the local Islamic girls' college and tailoring health prevention and medication advice to best meet their needs and maximise outcomes.
- There were innovative approaches to providing integrated person-centred care. For example, by the GPs visiting patients when they had been admitted to hospital in order to streamline their transition back into primary care.
- Patients can access appointments and services in a way and at a time that suits them. Through the 'opening doors' pilot scheme patients of the practice were able to access primary care services between 8am and 8pm, seven days a week.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. We saw that learning from complaints was implemented and fed back to the staff members it concerned.
- Patients said they found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day.
- There was a patient participation group with 31 members and we saw that the practice engaged them with surveys and responded to their feedback.

Outstanding



Are services well-led?

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to this.

Good



Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents.
- The practice proactively sought feedback from staff and patients, which it acted on.
- There was a strong focus on continuous learning and improvement at all levels.

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 is rated as good for the care of older people.

Good



- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- It was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- It had recently employed a nurse practitioner for an additional day each week to allow for visits to residential and nursing homes in order to review care plans and medication.
- Flu vaccination rates for the over 65s were 79.5% compared to the national average of 73.24%
- The practice made use of the Gold Standard Framework to identify and care for people approaching the end of life.

People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

Good



- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was better than the national average. For example, the percentage of patients with diabetes on the register who had a record of an albumin:creatinine ratio test in the preceding 12 months was 91.38%, compared to the national average of 85.94%.
- The percentage of patients with diabetes on the register with a record of foot examination and risk classification within the preceding 12 months was 94.92%, compared to the national average of 88.35%.
- The percentage of patients with diabetes on the register who had had influenza immunisation in the preceding 1 September to 31 March was 97.44% compared to the national average of 93.46%.
- Longer appointments and home visits were available when needed.
- All these patients had a structured annual review to check that their health and medicines 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.

Summary of findings

Families, children and young people

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

Good



- 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 in line with local averages for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 80.2%, which was comparable to the national average of 81.88%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students).

Good



- 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.
- A system was in place to offer text message reminders for appointments if a patient had opted in to use this.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

Good



- The practice held a register of patients living in vulnerable circumstances including homeless people and those 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.

Summary of findings

- The practice offered health care services for residents at a local drug and alcohol rehabilitation centre and there was a lead GP identified to coordinate their care.
- The practice 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)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- One of the GPs held Section 12 approval for assessment and diagnosis under the mental health act. This meant they were able to advise whether a patient needed detaining in hospital due to mental health concerns.
- The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.
- The practice offered an enhanced service to facilitate a timely diagnosis of dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support people with mental health needs and dementia.

Good



Summary of findings

What people who use the service say

The national GP patient survey results published on 2 July 2015 showed the practice was performing in line with local and national averages. The number of survey forms distributed was 295 and 107 of these were returned. This gave a response rate of 36.3% and represented 1.5% of the patient population.

- 74% found it easy to get through to this surgery by phone compared to a CCG average of 67.2% and a national average of 73.3%.
- 91.8% found the receptionists at this surgery helpful (CCG average 85.9%, national average 86.8%).
- 91.7% were able to get an appointment to see or speak to someone the last time they tried (CCG average 84.1%, national average 85.2%).
- 90.2% said the last appointment they got was convenient (CCG average 93.8%, national average 91.8%).
- 78.2% described their experience of making an appointment as good (CCG average 71.8%, national average 73.2%).

- 81.6% usually waited 15 minutes or less after their appointment time to be seen (CCG average 73.1%, national average 64.8%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 26 comment cards which were all positive about the standard of care received. Many of the comments mentioned specific staff members by name to praise the care being delivered. While being positive overall about the practice, two comment cards did highlight some difficulties getting through to the surgery by telephone while one pointed out that conversations with receptionists could be overheard in the waiting area.

We spoke with nine patients during the inspection. All nine patients said that they were happy with the care they received and thought that staff were approachable, committed and caring. They told us that staff explained treatment options and risks to them and that they felt involved in decisions about their care.

Areas for improvement

Action the service **SHOULD** take to improve

The areas where the provider should make improvement are:

- Ensure policy documents and risk assessments fully take into account the role of chaperone for non-clinical staff. For staff who have not had a DBS check undertaken, documents should clearly state that they will not be left alone with patients, for example should the clinician leave the room.
- Ensure staff receive regular training around infection prevention and control.

- Ensure that the regular checks carried out for medicine stock levels and expiry dates, as well as those to ensure emergency equipment is functioning are documented and recorded.
- Ensure all written responses to complaints include information of whom to contact should the complainant be unhappy with the investigation, and include feedback from complaints in staff meetings in order to maximise learning from them.

Outstanding practice

We saw some areas of outstanding practice:

- The practice cared for a number of patient groups who experienced challenging health needs, and had responded well to these needs. For example they

Summary of findings

liaised closely with the local Islamic girls' college to ensure their residents' health needs were met appropriately. The female nurse practitioner telephoned the college each morning to triage health concerns and had three appointment slots each day set aside for these patients to access. The practice had also recognised the difficulties in prescribing medicines presented by dietary restrictions faced by this population group and had acted by raising awareness of medicines appropriate for a Halal diet.

- The GPs provided GP urgent care services at the local accident and emergency department, which allowed a streamlined transition for their patients accessing emergency care back into primary care. The GPs would frequently visit their patients while they were in-patients enabling care plans to be put in place immediately.

Meadowside Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor, a specialist advisor who was a practice manager, a second CQC inspector and an Expert by Experience (someone with experience of using GP services who has been trained in our inspection methodology).

Background to Meadowside Medical Practice

Meadowside Medical Practice is located in the city centre of Lancaster. In addition to the Lancaster practice, the provider is also responsible for a separate location registered in Heysham following a recent merger of the two practices. The Heysham practice has a branch surgery in Morecambe Health Centre. Patients registered with the practice are able to access services at any of the provider's locations. The total patient list size across all sites is 14092. This inspection looked at the Lancaster site only, and data quoted in this report relates to the list size of 7174 patients that were registered with the Lancaster location prior to the merger and patient lists being combined.

The practice population includes a slightly higher proportion of patients under the age of 18 (17.6%) compared to the national average (14.8%). The practice has a lower percentage of patients with health related problems in daily life (39.2%) compared to the national average of 48.8%, as well as a lower percentage of patients with caring responsibility (13.5% compared to the national average of 18.2%).

The practice is staffed by six GP partners (five male and one female) and three salaried GPs (two female and one male). The GPs are supported by a clinical staff consisting of three nurse practitioners, four practice nurses, a treatment room nurse, a health care assistant, phlebotomist and a pharmacist. Non clinical staff consist of a practice manager, assistant practice manager and 25 administration and reception staff. Staff are shared across the different locations operated by the provider. The practice is a training practice, and currently has two trainee GPs.

The practice is open between 8:00am and 6:30pm Monday to Friday. It closes each Wednesday lunch time between 12:00 and 1:00 to allow for staff training, but a GP remains available during this time in case of emergencies. Extended hours surgeries are offered between 6:30pm and 9:00pm on a Monday evening and between 7:00am and 8:00am on Tuesday mornings. In addition, the practice's patients can access primary care services offered between 6:30pm and 8:00pm Monday to Friday and between 8:00am and 8:00pm at weekends as the practice participates in the 'opening doors' pilot project in conjunction with four other local GP practices.

When the practice is closed, patients are advised to access out of hours care offered locally by Bay Urgent Care.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal

Detailed findings

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.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 18 November 2015. During our visit we:

- Spoke with a range of staff including GPs, the nurse practitioner, treatment room nurse and administration staff as well as spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

- Is it safe?

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

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

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

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.

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, following a patient being diagnosed with Lyme disease a learning outcome identified was that the practice needed to procure a tick remover to ensure effective treatment should any future cases arise.

When there were unintended or unexpected safety incidents, people received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs were trained to Safeguarding level 3.
- A notice in the waiting room advised patients that staff would act as chaperones, if required. All staff who acted as chaperones were trained for the role. However, not all non-clinical staff who performed chaperone duties had

received a disclosure and barring (DBS) check (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). When questioned about the nature of the chaperone role, administration staff were able to tell us that they would leave the room if the clinician did, so as not to be on their own with the patient. However, we noted that the practice's chaperone policy did not specifically stipulate this. The practice had carried out risk assessments to justify whether staff members required a DBS check, however these risk assessments did not mention chaperone duties as part of the job role.

- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy and saw records demonstrating that cleaning procedures were regularly checked. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place. However, staff training records indicated that not all staff were up to date with infection prevention and control training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Nursing staff had been identified as having responsibility for checking medicines held on site were in date and that there were sufficient in stock. While they were fully aware that this was part of their role and could describe the schedule and process for these checks being carried out on a weekly basis, written documentation recording these checks was not kept.
- We reviewed four personnel files and found that appropriate recruitment checks had been undertaken prior to employment. For example, proof of

Are services safe?

identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as infection control and legionella (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty at any time.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received regular basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. Nursing staff told us that the emergency equipment was checked regularly for functionality; there was a nominated staff member who carried out these checks. However, these checks were not recorded or documented. There was also a first aid kit and accident book available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for contractors and utility companies, and identified alternative sites the practice could operate from should the premises become unusable. The GPs and practice manager held hard copies of the document.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs. Staff told us of regular meetings where NICE guidance was discussed to ensure continued best practice.
- The practice monitored that these guidelines were followed through audits and peer review.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99.9% of the total number of points available, with 5.8% exception reporting. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed;

- Performance for diabetes related indicators was better than the national average. For example, the percentage of patients with diabetes on the register who had a record of an albumin:creatinine ratio test in the preceding 12 months was 91.38%, compared to the national average of 85.94%. The percentage of patients with diabetes on the register with a record of foot examination and risk classification within the preceding 12 months was 94.92%, compared to the national average of 88.35%. The percentage of patients with diabetes on the register who had had influenza immunisation in the preceding 1 September to 31 March was 97.44% compared to the national average of 93.46%.
- Performance for mental health related indicators was also above the national average. For example the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a

comprehensive, agreed care plan documented in the record in the preceding 12 months was 96.43% compared to the national average of 86.04%. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months was 97.47% compared to the national average of 88.61%.

- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding nine months was 150/90mmHg or less was 90.11% compared to the national average of 83.11%.

Clinical audits demonstrated quality improvement.

- There had been four clinical audits completed in the last two years, two of these were completed audits where the improvements made were implemented and monitored, although in some cases there was a significant amount of time elapsed between audit cycles.
- The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, action taken as a result of an audit of treatment for patients with ADHD included making sure that records of height and pulse rate were documented at review appointments. In 2010 no records of pulse were being documented and only 50% of reviews documented the patient's height. When re-audited in 2015 the percentage of reviews documenting these characteristics had risen to 92%.

Information about patients' outcomes was used to make improvements such as modifications to the practice's repeat prescribing protocols in light of a recent repeat prescribing review that found not all medications added to a patient record had been done so with a review date set. Specific action plans had been formulated as a result to mitigate this occurring again. The practice informed us that 87% of patients on a repeat prescription had had their medication reviewed in the previous 12 months.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

Are services effective?

(for example, treatment is effective)

- The practice had an induction programme for newly appointed non-clinical members of staff that involved shadowing more experienced staff members and covered such topics as fire safety and health and safety issues.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff e.g. for those reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. Most staff had had an appraisal within the last 12 months, and those who had not had one booked in the upcoming weeks.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring people to other services. Patients confirmed to us that referrals on to secondary care were made quickly. We also saw that robust methods of information sharing practice were in place with other organisations such as out of hours care and accident and emergency, with these organisations having direct access to elements of the patients' electronic record with the patients' consent. This process of information sharing was audited regularly to ensure that information was being used appropriately by the other organisations.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a six weekly basis and that care plans were routinely reviewed and updated.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.
- The practice actively sought the consent from parents of pupils at the local Islamic college, many of whom lived abroad, in order to ensure treatment was delivered with appropriate permission.

Health promotion and prevention

The practice identified patients who may be in need of extra support.

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.
- A physiotherapist attended the premises each Friday morning and the GPs were able to book their patients into assessment slots.

The practice's uptake for the cervical screening programme was 80.2%, which was comparable to the national average of 81.88%. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Are services effective?

(for example, treatment is effective)

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 90.5% to 95.9% and five year olds from 83.8% to 91.9%. Flu vaccination rates for the over 65s were 79.5%, and at risk groups 59.86%. These were slightly above the national averages of 73.24% and 59.29% respectively.

Patients had access to appropriate health assessments and checks. These included health checks for new patients, NHS health checks for people aged 40–74 as well as ‘well person health check’ which covered advice around a patient’s smoking, alcohol intake and diet. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that members of staff were courteous and very helpful to patients and treated people dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity 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.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 26 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We also spoke with nine patients who attended the practice on the day of inspection. They also told us they were satisfied with the care provided and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 95.7% said the GP was good at listening to them compared to the CCG average of 89% and national average of 88.6%.
- 93.7% said the GP gave them enough time (CCG average 86.3%, national average 86.6%).
- 95.3% said they had confidence and trust in the last GP they saw (CCG average 96.3%, national average 95.2%)
- 92.1% said the last GP they spoke to was good at treating them with care and concern (CCG average 86.1%, national average 85.1%).

- 91.2% said the last nurse they spoke to was good at treating them with care and concern (CCG average 90.9%, national average 90.4%).
- 91.8% said they found the receptionists at the practice helpful (CCG average 85.9%, national average 86.8%).

Care planning and involvement in decisions about care and treatment

Patients told us that they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were again above local and national averages. For example:

- 91% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87.1% and national average of 86%.
- 91.8% said the last GP they saw was good at involving them in decisions about their care (CCG average 83.8%, national average 81.4%)

Staff told us that translation services were available for patients who did not have English as a first language, and we also saw evidence that sign language interpreters were used if a patient had hearing difficulties.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 13.5% of the practice list as carers. Written information was available to direct carers to the various avenues of support available to them.

Are services caring?

Staff told us that if families had suffered bereavement, their usual GP contacted them and the practice sent them a sympathy card. Feedback we received from patients confirmed that comprehensive bereavement care was offered by the practice to support families.



Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice 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.

- In addition to offering extended hours itself on a Monday evening and Tuesday morning, the practice was currently working as part of the 'opening doors' pilot scheme and was offering appointments to patients from its list and those of neighbouring practices between 8am and 8pm and at weekends. This was in conjunction with other GP practices to ensure patients had access to a GP when they needed it.
- Patients were able to access services such as ordering their repeat prescriptions online.
- The practice acknowledged the challenging health needs of a number of patients groups on its list and responded appropriately to maximise outcomes. For example it provided services for 428 patients resident at a local Islamic girls' college. The nurse practitioner contacted the college each morning by telephone to triage any health concerns, and had three appointment slots each day ring-fenced for pupils at the college. The female nurse practitioner and one of the female GPs also attend the college annually to meet with the headteacher to discuss the health needs of the pupils. Practice staff had engaged in relevant health promotion around vitamin D deficiency prevalent in this population group, and in response to poor use of medication the practice pharmacist had compiled a document identifying Halal certified medicines for clinicians at the practice in order to maximise the outcome of any medicine prescribed to this group.
- The practice also offered services to 22 residents at a local drug and alcohol rehabilitation unit, and had identified a lead GP to coordinate their care.
- The GPs had developed procedures for working with patients with complex mental and physical health needs. This included agreeing access contracts for them, and they could demonstrate this support had directly reduced attendance at secondary care. Many of

these patients had previously moved from practice to practice but the GPs were clear that finding ways to work with these patients and keep them on their list was critical to good patient care.

- The practice was proactive in monitoring its patient's admissions to hospital. We saw evidence that showed for one patient once an appropriate care plan had been implemented in response to frequent secondary healthcare visits their number of attendances dropped from 15 between February and July to just 2 between August and November.
- Three of the GPs provided an urgent care GP session at the local accident and emergency department on a weekly basis. This facilitated streamlining the practice's ability to follow up on any emergency admissions and meant GPs often visited patients in hospital if they had been admitted allowing a smooth transition back into primary care.
- Routine appointments were 15 minutes long to ensure patients were given enough time
- There were longer appointments available for people with a learning disability.
- Home visits were available for older patients / patients who would benefit from these.
- Same day appointments were available for children and those with serious medical conditions.
- There were disabled facilities and translation services available.
- While there was a chair lift in the practice, staff reported that it was not functioning and that it was planned for it to be removed. Clinicians saw patients in ground floor treatment and consultation rooms if they had difficulties managing stairs.
- There was a 'virtual' patient participation group (PPG) that liaised with the practice mainly via email. There were 31 members at the Lancaster site and the practice asked them to offer feedback via surveys. We saw that the practice had responded to feedback that PPG members were uneasy about the merger with other practices so had arranged a face to face meetings to discuss the merger and reassure patients. Contact with PPG members following this meeting indicated that all were happy with the explanations given.

Access to the service

The practice was open between 8:00am and 6:30pm Monday to Friday. It closed each Wednesday lunch time between 12:00 and 1:00 to allow for staff training, but a GP



Are services responsive to people's needs?

(for example, to feedback?)

remained available during this time in case of emergencies. Extended hours surgeries were offered between 6:30pm and 9:00pm on a Monday evening and between 7:00am and 8:00am on Tuesday mornings. In addition, the practice's patients could access primary care services offered between 6:30pm and 8:00pm Monday to Friday and between 8:00am and 8:00pm at weekends as the practice participated in the 'opening doors' pilot project in conjunction with four other local GP practices.

In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. The next routine appointment was available three days after the inspection to see a GP and nine days later to see the nurse. Urgent appointments remained available on the day.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to or above local and national averages. People told us on the day that they were able to get appointments when they needed them.

- 77.2% of patients were satisfied with the practice's opening hours compared to the CCG average of 76.5% and national average of 74.9%.
- 74% patients said they could get through easily to the surgery by phone (CCG average 67.2%, national average 73.3%).
- 78.2% patients described their experience of making an appointment as good (CCG average 71.8%, national average 73.3%).
- 81.6% patients said they usually waited 15 minutes or less after their appointment time (CCG average 73.1%, national average 64.8%).

Listening and learning from concerns and complaints

The practice had an effective 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.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system; written information was available in reception as well as on the practice website.

The practice had received 19 complaints in the last 12 months. We examined one of these in detail and found that it was investigated fully and an appropriate apology offered to those concerned. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. Staff told us that feedback was given as needed, but we noted that feedback from complaints was not included on staff meeting agendas in order to maximise learning outcomes. It was also noted that the written response did not always signpost the complainant to the Parliamentary Health Service Ombudsman should they be unhappy with the outcome. We were told by the practice manager that this was the case in the example examined due to the complaint being made by email. This meant an email response had been sent offering an apology and offering to meet the patient face to face. It would have been at this meeting that other options would have been explained. However, the patient was satisfied with the response and did not take up the offer of a meeting.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a patient charter and set of standards which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities
- Practice specific policies were implemented and were available to all staff
- A comprehensive understanding of the performance of the practice
- A programme of continuous clinical and internal audit which is used to monitor quality and to make improvements
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents

When there were unexpected or unintended safety incidents:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- They kept written records of verbal interactions as well as written correspondence.
- There was a clear leadership structure in place and staff felt supported by management.
- Staff told us that the practice held regular team meetings.
- Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which had previously met and provided feedback to the practice. However, staff did tell us that due to the pressure of the merger the PPG had not met since March 2015. Staff told us that a handrail had been put in place outside the building in response to patient feedback.
- The practice had also gathered feedback from staff through staff meetings, appraisals and discussion. For example, in response to the requests of a number of staff who cycle to work, the practice had installed a shower. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Are services well-led?

Good 

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

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area such as the 'opening doors' pilot scheme to improve access to primary care services.

One of the nursing staff who had recently been recruited reported that when she had a clinical query, one of the GPs offered to put on a training tutorial for her, a recent example being around diabetes care.