Rosebank Surgery

Quality Report

Ashton Road
Lancaster
Lancashire
LA1 4JS
Tel: 01524 842284
Website: www.rosebankmedical.org.uk

Date of inspection visit: 01 October 2014
Date of publication: 22/01/2015

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Rosebank Surgery operates from three sites. The first, Scale Hall, is in the north of the city. The second is in Galgate, three miles south of the city. The final is the main surgery, Rosebank, opposite the Royal Lancaster Infirmary. We visited Rosebank-Lancaster and Rosebank-Galgate sites as part of our inspection on 01 October 2014.

We inspected this practice as part of our new focused, comprehensive, inspection programme. This practice had not been inspected before. We looked at how well the practice provided services for specific groups of patients. These included; older patients, patients with long-term conditions, families, children and young people, working age patients (including those recently retired and students), patients living in vulnerable circumstances and patients experiencing poor mental health (including people with dementia).

During our visit we spoke with staff including GPs, receptionists, administration staff, nurses, the dispensing pharmacy staff and with five patients who used the service. Patients spoken with and the 30 completed Care Quality Commission comment cards from the three sites were all extremely complimentary about the care and treatment being provided. Patients reported that all staff treated them with dignity and respect. They found the doctors and nurses delivered a very personalised service and had an excellent understanding of their needs.

We found that the leadership team was very visible. There were good governance and risk management measures in place. We found that the practice met the regulations and provided services that were caring, responsive, safe, well led and effective.

The overall rating for this practice was good.

Our key findings were as follows:

- The practice provided an effective service for all age groups. GPs, apart from having the overall competence to assess each person attending the service, had particular interest areas. For example one GP is the

Summary of findings

Cardiology Lead for the local Clinical Commissioning Group (CCG) and helps run the Community Heart Failure Service. Care and treatment was being delivered in line with current published best practice.

- The practice had systems in place that reflected best practice in end of life care and demonstrated an ethos of caring and striving to achieve a dignified death for patients. This was actively supported by practice staff and local community initiatives.
- We found that clinicians critically reviewed their practices and this had led to not only changes in their own working practice but also that of other organisations.
- Patients confirmed they were able to contact the practice and speak with a health practitioner and found the service provided was both timely and accessible. The practice operated an all-day triage system for appointment requests. Patients spoke positively about the system. All the patients we spoke with confirmed they would be offered a same day appointment if there was an urgent need.

We saw several areas of outstanding practice including:

- One of the GP partners was appointed as the National Clinical Lead in palliative care by the Royal College of General Practitioners. The GP led a three year national programme working to improve end of life care in primary settings. The practice had systems in place that reflected best practice in this regard and demonstrated an ethos of caring and striving to achieve dignified death for patients. We were told and audits demonstrated that in appropriate cases patients were 'offered' conversations around end of life planning such as advance care plans, preferred care priorities and resuscitation but such discussions were never 'imposed.'
- One GP partner is the Cardiology Lead for the local Clinical Commissioning Group and helps run the Community Heart Failure Service with remote support for their cardiac patients. This enabled patients to remain in the comfort of their own home whilst receiving appropriate monitoring of their condition.
- Staff were consistent in supporting patients to live healthier lives through a targeted and proactive approach to health promotion and the prevention of ill-health. There was for example a nurse led five year development plan in place with clear strategic vision. This included a nurse led initiative reviewing all patients at potential risk of the development of diabetes. The nurses invited patients to attend the practice in October 2014 as a group, for an education and health promotion event to improve the health of their registered population, of all ages.
- The practice had a clear vision and overall strategy regarding the practice and its development. We saw evidence that showed the practice worked with the CCG to share information, monitor performance and implement new methods of working to meet the needs of local people. There was evidence of a good learning culture and appropriate information sharing of significant events.
- The practice's rural community dispensary and practice also provided the addition of a pharmacy in response to meeting the needs of their local community.

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

The provider should:

- Record the recruitment checks they had completed on staffs professional registration details as is appropriate.The practice was unable to provide evidence of some of the recruitment checks they had completed. The recruitment records did not always include all the information as specified in Schedule 3 of the Health and Social Care Act (2008) for the purposes of carrying on a regulated activity.
- Improve the arrangements for the reauthorisation of prescriptions for patients on medicines requiring regular blood tests.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice was rated as good for safe.

Systems were in place to provide oversight of safety of the patients and environment. Staff took action to learn from any incidents that occurred within the practice. Staff took action to safeguard patients and when appropriate made safeguarding referrals. Staffing levels and skill mix were planned, implemented and reviewed to keep patients safe at all times. Some improvement was needed in the recording of serial numbers on prescription sheets, and repeat authorisation prescribing for patients who required regular blood tests. Following our inspection the practice confirmed they had taken appropriate action regarding the improvements suggested. Improvements were also needed in the maintenance of staff recruitment records.

Are services effective?

Good

The practice was rated as good for effective.

Patients' needs were consistently met. Referrals to secondary care were made as soon as the need was identified. Consent to treatment was obtained appropriately. Care and treatment was being delivered in line with current published best practice.

One of the partners was appointed as National Clinical Lead in palliative care by the Royal College of General Practitioners. The GP was involved in leading a three year national program working to improve end of life care in primary settings and worked in partnership with Marie Curie. The practice had systems in place that reflected best practice in this regard and demonstrated an ethos of caring and striving to achieve a dignified death for patients. This was actively supported by the practice staff and local community initiatives such as the successful bid for Lancaster as a Compassionate City.

Collaborative practice was noted with the multi-disciplinary team meetings conducted monthly for palliative care support and through the remote monitoring of heart failure patients which had been rolled out across the Clinical Commissioning Group (CCG). The practice was also involved in sharing information and learning with their peers. The practice team used staff meetings, audits and reviews to assess how well they delivered the service. Staff were

Summary of findings

actively engaged in activities to monitor and improve quality and outcomes for their patients and share their learning with others. The practice was proactive in seeking new ways of improving services for patients.

Staff were consistent in supporting patients to live healthier lives through a targeted and proactive approach to health promotion and the prevention of ill-health. For example there was a nurse led initiative reviewing all patients at potential risk of the development of diabetes. The nurses invited patients to attend the practice as a group in October 2014, for an education and health promotion event to improve the health of their registered population of all ages.

One of the GP partners at the practice was the cardiology lead for the local CCG and helped run the Community Heart Failure Service. This enabled patients to remain in the comfort of their own home whilst receiving appropriate monitoring of their condition.

Staff received support and development opportunities and were able to progress to roles suitable to their skills and knowledge and career aspirations. Examples were seen of staff who had progressed to trainee Nurse Practitioners, and GP partners lead roles outside of the practice, which informed and developed the support and care within the practice for their patients.

Are services caring?

Good

The practice was rated as good for caring.

30 patients who completed the Care Quality Commission comment cards and the five we spoke with during our inspection were very complimentary about the service. They all found the staff to be extremely person-centred and felt they were treated with respect. Patients expressed confidence they were listened to and referred for care and treatment appropriately. They told us they did not feel rushed and felt able to come away from an appointment to think about matters before deciding what they would like to do.

The practice was proactive in seeking new ways of improving services for patients. A GP partner at the practice was the cardiology lead for the local Clinical Commissioning Group and helped run the Community Heart Failure Service. This enabled patients to remain in the comfort of their own home whilst receiving appropriate monitoring of their condition.

The practice participated in a national initiative seeking to develop caring communities. Representatives of Help Direct held a weekly

Summary of findings

clinic at the practice. Help Direct is a support and information service for adults that seeks to assist people with a wide range of issues such as assisting people with learning disabilities, mental health problems and those who had experienced bereavement.

The practice had systems in place that reflected best practice in end of life care for their patients and demonstrated an ethos of caring and striving to achieve a dignified death for patients. Practice staff were involved with local community initiatives such as Lancaster's' Compassionate City status. Staff were committed to working in partnership with their patients to offer care that promoted patients dignity and respected their preferred care choices.

The practice nurses led initiative reviewing all patients at potential risk of the development of diabetes. The nurses invited patients to attend the practice as a group in October 2014, for an education and health promotion event to improve the health of their registered population of all ages.

Are services responsive to people's needs?

Good

The service was rated as good for responsive.

The practice made adjustments to meet the needs of patients, including having a portable audio loop system for patients with a hearing impairment. Staff were knowledgeable about interpreter services for patients where English was their second language.

The practice was responsive to patient feedback. The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint and we saw documentation to record the details of any concerns raised and action taken.

Are services well-led?

Good

The service was rated as good for well-led.

The practice had a clear vision and set of values which were understood by staff and included a commitment to involving patients in their own healthcare and in developing services.

GPs, clinical staff, the practice director and manager led on the individual aspects of governance such as complaints, risk management and audits within the practice. Clinical audits were carried out following significant events, complaints and as a result of national alerts or local prescribing initiatives.

Summary of findings

The six population groups and what we found

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

Outstanding ☆

Older people

The practice was knowledgeable about the number and health needs of older patients using the service. They kept up to date registers of patients' health conditions, carers' information and whether patients were housebound. They used this information to provide services in the most appropriate way and in a timely manner. We found the practice worked well with other agencies and health providers to provide support and access specialist help when needed. 0.578% of the patients registered at the practice resided in nursing homes which the GPs attended.

There was a high percentage of patients aged 65 and older who had received a seasonal flu vaccination. They had a practice plan to reduce avoidable A&E attendance in all groups which included older people. An audit took place October 2012 and the action taken since the audit included: from January 2014 all day telephone triage, a phlebotomist was employed, increased pharmacy practitioner hours and an additional nurse practitioner employee. An audit of afternoon triage during the month of June 2014 demonstrated that 210 calls were received, eight of which the practice believed to have prevented an A&E attendance. A shingles audit was completed in 2014 for 70-79 age groups and they achieved respectively an 83% and 84% take up rate.

The practice had a complete register available of all patients in need of palliative care or support irrespective of age. The practice had regular monthly supportive care meetings to discuss all the patients on the palliative register. Following the inspection we requested the most recent audit on patients preferred choices around end of life planning such as advance care plans, preferred care priorities and resuscitation. The findings from the audit conducted in July 2014 and reported in November 2014. demonstrated best practice with 98% of patients who should be on the palliative care register on the register. They found that 85% of patient's had their preferred place of care documented. Of patients who sadly died 81% died outside of a hospital environment. All patients who died outside of the hospital setting had advanced directives regarding resuscitation in place. The practice devised actions to implement further improvements following this audit which included changing the palliative care register to that of a Supportive Care register to encourage further identification of the frail elderly and those with dementia who may benefit from a more palliative approach.

Summary of findings

People with long term conditions

Outstanding 

The practice was knowledgeable about the number and overall health needs of patients with long term conditions. They worked with other health services and agencies to provide appropriate support. Public Health England found that 57.8% of the practice patients had a long-standing health condition.

We saw that clinical audits were completed and where appropriate, any actions following the findings implemented and reviewed. As an example, in November 2013 they completed an audit of hypertension diagnosis to see if the practice was complying with the 2011 National Institute for Health and Care Excellence (NICE) Hypertension guidelines and making appropriate use of the ambulatory blood pressure monitoring machines available. They found that 66% was reasonable compliance with use of ambulatory or home readings before making a diagnosis of hypertension but was short of the audit standard of 85%, they found that the diagnostics were readily available with short waiting times and not doing either should be an unusual exception. They put in place five learning points for staff to consider and implement following the audit which were implemented following the review.

Staff were skilled in specialist areas which helped them ensure best practice guidance was always being followed. There was a nurse led initiative reviewing all patients at potential risk of the development of diabetes. The nurses invited patients to attend the practice as a group for an education and health promotion event to improve the health of their registered population of all ages.

Families, children and young people

Good 

The practice provided services to meet the needs of this population group. There were comprehensive screening and vaccination programmes which were managed effectively to support patients.

We saw that an audit was conducted into paediatric referral 'zero' length of stay between 01 Jan-31 March 2013 of 0-16 year olds admitted to the Paediatric Admission Unit (PAU). PAU-Zero hours refers to patients admitted for six hours or less. Of those 20 admissions, 17 demonstrated appropriate use of the service and three of the 17 had direct access to ward. The remaining admission findings were that one attended via the out of hour's service and the other via A&E.

We saw that the cervical smear uptake percentage was at 82% and that for chlamydia screening the practice advertised the service at the three sites and took opportunity to encourage 15-25 year olds to consider this screening.

Summary of findings

There was literature available signposting patients to healthy activity programmes at the local YMCA, nearby drop in clinics for children and cancer care therapeutic groups for children aged 9 to 11 years who had experienced bereavement.

Staff were knowledgeable about child protection and a named GP took the lead for safeguarding. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns.

Working age people (including those recently retired and students)

Good

The practice provided a range of services for patients to consult with GPs and nurses, including on-line booking and all day telephone consultations. The practice operated a system based upon "Advanced Access." To enable patients to see a member of the clinical team (this can be either a Nurse Practitioner or Support Pharmacist) within 24 hours and see a GP within 48hrs. Some patients were frustrated at the length of time they had to wait to see their named GP. All the patients we spoke with confirmed they would be offered a same day appointment if there was an urgent need.

63.2%, of the patient population registered at the practice were of working status either paid work or in full-time education. The practice kept their opening hours under review in order to meet the needs of the patient population registered at the practice.

People whose circumstances may make them vulnerable

Good

The practice made adjustments to how they provided the service in order to meet patients' needs. For example, the practice offered longer appointment times for patients with a learning disability and for annual health checks. This helped to ensure patients were given time to be fully involved in making decisions about their health.

The practice maintained a register of patients aged 18 and over with learning disabilities and we saw that patients were invited to attend annual health check reviews. In the year ending March 2014, 67 % of those on the learning disability register attended for their check-ups. They invited patients to attend with their carers at least once annually with the aim for patients to have continuity of care with a named nurse and GP. Those who did not attend where followed up by the nursing staff and GP.

The practice had recorded and identified, via the new Direct Enhanced Service contract, vulnerable patients who were at potential risk of unplanned admissions to hospital, which represented 2% of the practice patient population.

Summary of findings

Staff were knowledgeable about safeguarding vulnerable adults. They had access to the practice's policy and procedures and had received training in the last 12 months.

People experiencing poor mental health (including people with dementia)

Good

GPs worked with other services to review and share care with specialist teams. The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review.

The practice had a named GP who was the Mental Health Lead. We saw evidence that quarterly mental health meetings were held. GPs expressed that there was good communication with the mental health therapists.

The practice also participated in the Local Enhanced Service for Dementia patients and records of patients at risk were identified and the practice reviewed the care, treatment and support they provided to patients in partnership with other health and social care professionals.

The practice participated in a national initiative seeking to develop caring communities. Representatives of Help Direct held a weekly clinic at the practice. Help Direct is a support and information service for adults that seeks to assist people with a wide range of issues. We were told that this might include assisting people with learning difficulties, mental health problems and those who had experienced bereavement.

Summary of findings

What people who use the service say

We spoke with five patients on the day of our visit and received 30 Care Quality Commission comment cards. We spoke with women, carers, working age patients and mothers with children. All patients were very complimentary about the care provided by the clinical staff and the positive and friendly atmosphere fostered by all staff at all three sites. They found the doctors, nurses and dispensary staff to be professional and knowledgeable about their treatment and care needs. Patients reported that the whole practice staff team treated them with dignity and respect.

The National GP patient survey results for Rosebank Surgery, published in July 2014, 269 surveys were sent out and 118 were returned, giving a 44% completion rate. The survey results found that 92% of patients would recommend their GP surgery, 79% patients rated their ability to get through on the phone as easy; 79% were satisfied with the surgery's opening times and 95% described their overall experience of the surgery as good.

Areas for improvement

Action the service SHOULD take to improve

The practice need to record the checks completed on staffs professional registration details as is appropriate. The practice was unable to provide evidence of some of the recruitment checks they had completed. Therefore the recruitment records did not always include all the information as specified in Schedule 3 of the Health and Social Care Act (2008) for the purposes of carrying on a regulated activity.

Improve local arrangements for the reauthorisation of prescriptions for patients on medicines requiring regular blood tests.

Outstanding practice

One of the GP partners was appointed as the National Clinical Lead in palliative care by the Royal College of General Practitioners. The GP led a three year national programme working to improve end of life care in primary settings. The practice had systems in place that reflected best practice in this regard and demonstrated an ethos of caring and striving to achieve dignified death for patients. We were told and audits demonstrated that in appropriate cases patients were 'offered' conversations around end of life planning such as advance care plans, preferred care priorities and resuscitation but such discussions were never 'imposed.'

One GP is the Cardiology Lead for the local Clinical Commissioning Group and helps run the Community Heart Failure Service with remote support for their cardiac patients. This enabled patients to remain in the comfort of their own home whilst receiving appropriate monitoring of their condition.

Staff were consistent in supporting patients to live healthier lives through a targeted and proactive approach to health promotion and the prevention of ill-health. There was for example a nurse led five year development plan in place with clear strategic vision. This included a nurse led initiative reviewing all patients at potential risk of the development of diabetes. The nurses invited patients to attend the practice in October 2014 as a group, for an education and health promotion event to improve the health of their registered population, of all ages.

The practice had a clear idea of the vision and overall strategy of the practice and its development. We saw evidence that showed the practice worked with the CCG to share information, monitor performance and

Summary of findings

implement new methods of working to meet the needs of local people. There was evidence of a good learning culture and appropriate information sharing of any significant events.

The practice's rural community dispensary and practice also provided the addition of a pharmacy in response to meeting the needs of their local community.

Rosebank Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, a CQC inspector and included a GP specialist advisor.

Background to Rosebank Surgery

Rosebank Surgery operates from three sites. The first, Scale Hall, is in the north of the city. The second is in Galgate, three miles south of the city. The final is the main surgery, Rosebank, opposite the Royal Lancaster Infirmary. All three sites have been purpose-built and have access and facilities for disabled patients and visitors. It provides a weekday service for 10,820 patients in the North Lancashire area and is part of NHS Lancashire North Clinical Commissioning Group.

Public Health England figures show that 31% of all patients at Rosebank Surgery are 65 years of age or over and the largest percentage of the practice population, 63.2%, are of working status either paid work or in full-time education.

Each practice site opens Monday to Friday from 8am with the exception of Scale Hall which opens at 08.30am. Galgate and Scale Hall sites close at 6pm and Rosebank at 6.30pm each weekday with the exception of the Scale Hall site which closes at 12.30pm on Wednesdays. The practice operates a system based upon "Advanced Access." To enable patients to see a member of the clinical team (this can be either a Nurse Practitioner or Support Pharmacist) within 24 hours and see a GP within 48hrs. When the practice is closed and in the out of hours (OOH) periods patients are requested to contact either the ambulance service for emergencies or telephone 111. The OOH service is operated by Bay Urgent Care.

The practice has nine GP partners, five male and four female, one Nurse Practitioner (NP) partner, a trainee NP, three Practice Nurses, a Healthcare Assistant and a phlebotomist. The practice staff team includes a research nurse, pharmacy manager, pharmacy technician and dispensing staff. The practice also has a practice director and deputy practice manager and all are supported by administration, reception and secretarial staff.

Rosebank Galgate site is situated in the rural village of Galgate and is a dispensing practice. They have dispensed from Galgate for over 25 years to meet the needs of their registered patients. They opened a pharmacy in January 2013 on site, to help extend services to their patients and local community.

The practice use the same locum GP, when required, for continuity of service and support for their patients. The majority of the GP partners who work at the practice have their professional details available for patients to read on the practice website. Clinics run by the practice include amongst others; child development, minor surgery, long term condition management which includes a wide range of conditions, for example; diabetes, heart disease and hypertension (high blood pressure) and travel clinics.

The practice is registered with Care Quality Commission to provide the regulated activities: Treatment of disease, disorder and injury, diagnostic and screening procedures, family planning, maternity and midwifery services and surgical procedures.

Detailed findings

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 01 October 2014. During our visit we spoke with a range of staff and spoke with patients who used the service. We reviewed 30 CQC comment cards collected from the three sites, where patients shared their views and experiences of the service.

We saw that staff appropriately managed patient information received from the out of hour's team and patients ringing the service. We saw the ordering of repeat prescriptions, how patients accessed the service and the accessibility of the facilities for patients with a disability. We reviewed a variety of documents used by the practice to help run the service.

Good

Are services safe?

Our findings

Safe Track Record

Information from the General Practice Outcome Standards (GPOS) showed Rosebank Surgery rated as an achieving practice. The quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2012-2013 the provider was appropriately identifying and reporting incidents. We reviewed records and for example saw that Rosebank Surgery's training policy had been regularly reviewed and was next due a review in December 2015 or sooner should there be updates to staff's professional training requirements. We saw that all staff had been trained to at least a minimum level of basic life support.

In the period between January 2014 and August 2014 there had been ten reported significant events, there were no identified themes or patterns to these events, which were all unrelated. These included clinical and non-clinical issues. We saw that each incident had been analysed to consider what had occurred and why, what lessons had been learnt and whether there were measures that could be put in place to prevent future recurrence. Where appropriate to do so learning from events would be shared with others such as the Clinical Commissioning Group.

There were mechanisms in place using multiple information sources to ensure a shared awareness of key risks with all staff, for example they had systems to promptly manage national patient safety alerts in order to protect patients. The practice pharmacist also produced and circulated a summary analysis of any alerts received relating to medicines. We saw that that any complaints once investigated were analysed, summarised and reviewed to identify trends or recurrent risks.

The dispensary based at their Galgate surgery site holds significant event meetings with the whole Primary Health Care Team (PHCT) in a 'no-blame' cultural setting. They undertake clinical and administration audits on a regular basis and we were informed they implement any learning from them. As an example we saw evidence of the dispensary staff completing records attached to a red clip boards with any noted near misses.

Learning and improvement from safety incidents

We found that staff actively reported any incidents and viewed this process as a positive way to ensure they provided a high standard of patient care.

We found that with any changes to national guidelines, practitioner's guidance and any medicines alerts were discussed and that staff met on a regular basis. Staff confirmed these meetings took place. This information sharing meant the GPs, nurses and non-clinical staff were confident that the treatment approaches adopted followed best practice.

We saw that the majority of practice meetings were minuted such as the monthly business meetings, quarterly practice nurse meetings, and weekly staff meetings. Having minutes which outline the content of these meetings improve governance mechanisms and minimise the potential of staff misinformation or error. The GPs informed us that the case reviews and supportive care meetings were input directly into the patient record and the named GP would hold this responsibility.

Reliable safety systems and processes including safeguarding

We saw evidence that health and safety was managed effectively within the practice.

Behind reception there was a staff noticeboard dedicated to health and safety issues. For example: spillage and needle-stick injury protocols; instruction on the location of equipment for use in emergencies such as the crash bag, defibrillator, oxygen and emergency power box. The practice had kits available to deal with spillage of bodily fluids but their expiry dates had passed. The deputy practice manager assured replacement kits would be ordered.

We saw evidence the practice had systems in place to ensure fire alarms and equipment were regularly tested and maintained. Emergency exit routes were clearly signposted. All staff completed training on fire safety as part of their induction with further annual reviews. The practice had recently commissioned an independent provider to carry out a fire risk assessment and the minor recommendations made had been implemented.

We saw evidence that risk assessments were completed in relation to the control of substances hazardous to health

(COSHH), for example cleaning products. We saw products were stored securely in a locked cupboard and the risk assessment of each item included a description of the substance, use, danger and suggested corrective action.

Policies and procedures used to protect people from abuse were appropriate and staff could also access the local authority's safeguarding policy and procedures. The practice had a named GP who took the lead role in safeguarding adults and children. Staff had received training in safeguarding vulnerable adults and children to the professionally appropriate levels required. All reception staff were trained to act as a chaperone. This meant the practice had adequate resource to meet patient requests.

Staff were able to describe what constituted a child and adult safeguarding concern. They demonstrated their awareness of their policy and the local authority safeguarding children and adults policy. These were accessible on their electronic systems and all treatment rooms and reception staff areas had copies of the local authority referral and contact details. Staff we spoke with had a good understanding of the process they would follow if a safeguarding incident occurred. They were able to describe various types of abuse and each member of staff we spoke with showed an understanding of their responsibilities to act on suspected abuse and report any concerns.

We found no concerns regarding the reporting of safeguarding of patients which were passed on to the local relevant authorities as quickly as possible. The practice manager informed us that the GPs had attended a local authority safeguarding board meeting and attended local multi-disciplinary meetings where able to do so. Staff we spoke with had a good understanding of the process they would follow if a safeguarding incident occurred. They were able to describe various types of abuse and each member of staff we spoke with showed an understanding of their responsibilities to act on suspected abuse and report any concerns.

Staff demonstrated how their systems at the practice identified children who were in foster care or young people who were referred to as 'looked after children' and were able to explain how they ensured safe record keeping in respect of consent and data protection.

Each consultation and treatment room was fitted with a panic alarm which could be used to raise an audible alert in reception if a member of staff required assistance in an emergency. Alerts could also be raised using the practice computer system.

Notices were displayed in the practice advising patients they could have a chaperone present during their consultation if they wished. All reception staff were trained to act as a chaperone. This meant the practice had adequate resource to meet patient requests.

Medicines Management

Whilst delegating the delivery of dispensing services to the dispensing staff, the lead GP takes overall responsibility for meeting the dispensary requirements at all times. We saw it was visibly clean and well maintained, with the pharmacy consulting room in the process of refurbishment. The Practice Pharmacist and staff had a clear role to look at prescribing costs and safety issues relating to medicines/ prescribing and supported the clinical staff in keeping up to date with medication and prescribing trends in line with best practice.

The dispensary has a total of six staff responsible for the Dispensary Services Quality Scheme (DSQS) in place, a Practice Pharmacist, Superintendent Pharmacist and an Accuracy Checking Technician (ACT). Three members of staff hold their NVQ Level 2 in Pharmacy Services and three also hold the Accuracy Checking Certificates. The ACT is qualified to NVQ Level 3 with accuracy checking qualification from the National Pharmacy Association (NPA). We saw that there was a copy of the dispensary risk policy in place which was last updated 30 March 2014. There was a staff responsibility sheet for the DSQS in place. There was a Risk Management Protocol in place for their dispensing services in addition to other risk management protocols at the practice.

The repeat prescribing policy was in place and was last updated July 2014. This included a Shared Care protocol. A shared care protocol is for example when a patients consultant specialist sends a shared care pro-forma to the patients GP at the practice. In proposing a shared care arrangement, specialists may advise the patient's general practitioner which medicine to prescribe and communicated to the practice pharmacist.

Atypical medicines such as antipsychotics, for example lithium, also had a template for appropriate monitoring as

per Lancashire Care guidelines. Disease-Modifying Antirheumatic Drugs (DMARDs) are a group of medicines that are used to ease the symptoms of rheumatoid arthritis (RA) and reduce the damaging effect of the disease on the joints. The NP reviewed the patient records on DMARD's and patients who are on specific anti-coagulation medication requiring regular blood tests every month to check they were in line with good practice and have had regular reviews and followed them up if necessary. The nursing team completed these templates although on discussion not all of the GPs spoken with were aware of this practice. We found that there was a potential repeat authorisation prescribing risk for patients whose GP did not see the patient's blood results before reauthorisation and that those patients may also benefit from more than an annual medication review as suggested in the practices repeat prescribing policy. We saw this was an area that required further clarity and the GPs spoken with advised that their medicines management group was set up to identify areas for improvement and they were working towards this. Following the inspection the practice manager informed us that they had been in contact with the local hospital to improve these local arrangements which would be rolled out across the CCG.

Medicine reviews were conducted by GPs, the practice pharmacist, the nurse practitioner and the nursing team. The practice pharmacist, the nurse practitioner and the nursing team completed medication reviews within their areas of competence as identified by clinical oversight.

Security measures were in place for prescriptions access. When making home visits, GPs took suitable precautions to prevent the loss or theft of forms, such as ensuring prescription pads were carried in a locked carrying case and not left on view in a vehicle. However, not all GPs recorded prescriptions serial number data, as suggested best practice, NHS Protect Security of prescription forms guidance, August 2013. The practice director assured us that this would be implemented immediately and would devise a policy to ensure that all staff were aware.

The dispensary had a controlled drugs register in place (these are medicines which require extra administration checks to ensure safety) and regular audits of the controlled drugs took place. These were stored appropriately in locked metal cabinets with controlled access by the authorised key holder only. The dispensary standard operating procedures included the safe disposal of medicines and appropriate record keeping such as any controlled drug denaturing.

The practice regularly checked that patients receiving repeat prescriptions had at least an annual medicine review with the GP. We saw that 85% of patients requiring an annual review for their repeat prescriptions had been seen within the 12 month period. In general, apart from exceptional circumstances, the remaining 15% were invited to attend the practice prior to the next prescription being issued. Over and under usage of patients medicine issues were identified and the GP notified if compliance issues were highlighted. They also checked that all routine health checks were completed for long-term conditions such as diabetes. They used this information to support practice staff coordinate scheduling of regular medication reviews and review GP prescribing patterns in order that GPs had good oversight and understanding of the best treatment for each patient's needs.

The medicine fridge temperatures were appropriately recorded and monitored and vaccine stocks were well managed. As the nursing and reception staff completed checklists either on line or contained within a folder we found when we cross referenced them a few dates when the records were incomplete. We discussed this with the nurse who suggested they would discuss this at their next practice nurse meeting. There was a clear cold chain protocol in place.

We found that the vaccine fridge was not wired into a switchless socket to avoid them being turned off accidentally, which is considered to be best practice according to NHS England's Protocol for Ordering, Storing and Handling Vaccines March 2014. However, we saw that they were in the process of refurbishment at the Galgate location and the pharmacist was aware of the best practice protocol.

Cleanliness & Infection Control

Cleaners were employed in house to attend each branch on a daily basis. The practice operated a system of room servicing whereby each member of reception staff took responsibility for the checking of a consultation or treatment room. There were set opening and closing procedures to be followed to ensure necessary supplies of equipment such as gloves and aprons were available.

Good

Are services safe?

Clinicians were responsible for ensuring infection prevention and control standards were maintained during surgery between patient appointments. The practice had an up to date infection prevention and control policy in place. This was supplemented by a number of protocols providing guidance and instruction to staff on specific issues. For example, hand-wash procedure, needle-stick injury, handling samples, and dealing with spillage of blood and bodily fluid. Some members of staff were appointed as leads in relation to particular aspects of infection prevention and control. Systems were in place whereby spot checks were carried out to ensure protocols were followed.

We were told that the practice held a meeting every six months specifically for the purpose of considering infection control and health and safety. Minutes of these meetings were recorded. Where actions were identified they were allocated to a named individual for completion. The minutes showed the practice had a formal process in place for bringing matters to the attention of the partners where necessary by adding them to the agenda for the partners Business Meetings. The last meeting had taken place in May 2014 and we noted that a further meeting was due to take place in October 2014.

We saw that supplies of personal protective equipment were available, for example, disposable gloves. There were sharps boxes in consultation and treatment rooms for disposal of used needles. These were stored out of reach of children. Throughout the practice hand wash sinks had touch free taps with sanitizer gels and guidance on hand wash procedure close by.

Protective and single use clinical equipment was stored in a locked cupboard. The practice had a stock control system in place to rotate supplies held and ensure it remained in date.

The practice had contractual arrangements with a registered external provider for weekly collection and disposal of clinical waste. There was no build-up of waste awaiting collection and the arrangements were adequate and timely to meet their needs.

Equipment

The practice had contracts in place for personal appliance tests (PAT) to be completed on an annual basis and for the routine servicing and calibration, where needed, of equipment. The building maintenance contracts were appropriately held and appropriately updated.

The practice had a defibrillator which ensured they could respond appropriately if a patient experiences a cardiac arrest and staff advised that they were appropriately trained in its use. Emergency equipment including oxygen was readily available for use in the event of a medical emergency. This equipment was regularly checked by the nursing staff.

Staffing & Recruitment

The practice employed 30 staff excluding the GP partners, the Nurse Practitioner partner and GP trainees at the practice. The practice had a recruitment policy in place. We looked at the recruitment files of three members of staff who had joined the practice within the last 12 months. The sample included clinical and non-clinical staff. We noted there was not always proof of identity on staff files. There was not always evidence to show that the practice had followed their recruitment policy to ensure staff employed had the skill and experience necessary for their roles and responsibilities. Applicants had been required to provide details of their employment history and of referees but there was no evidence to show that these had been confirmed. The practice manager told us they made pre-employment checks with the Disclosure and Barring Service to ensure members of staff were of good character, where their role would require they have one to one contact with patients. The practice manager was unable to provide evidence that this had in fact occurred. There was not always evidence to show qualifications claimed had been verified. The practice manager explained these checks had been completed but no records maintained. They assured us this would be addressed in future.

The practice manager told us that if a locum GP joined the practice on temporary basis they made checks of the GMC to ensure their registration was valid but records of this were not maintained.

The practice manager agreed there was no formal system in place to ensure that permanent clinical staff continued to hold valid registration with their respective professional bodies on an on-going basis. As an example the Registered Nurses are required to be registered with the Nursing and

Good

Are services safe?

Midwifery Council in order to continue to practice as nurses they are forwarded documents to evidence that their registration is current from the NMC on an annual basis. The GPs were checked against the NHS performers list and General Medical Council (GMC) by the Care Quality Commission lead inspector and all were registered with license to practice. The practice manager assured us this would be addressed in future.

Monitoring Safety & Responding to Risk

The practice manager told us that staff would be notified by email of any actions requiring immediate implementation to ensure they were addressed in a timely manner. Learning for example from significant events was then further discussed at scheduled staff meetings to reinforce messages and ensure actions had been completed. Staff confirmed this process.

The practice team had agreed the requirements for safe staffing levels at the practice and staff worked, in general, regular sessions or agreed set hours and set days each week to consistently maintain the service provided.

There was little staff turnover at the practice. We saw evidence the practice tried to plan ahead for succession if a vacancy was anticipated to minimise any impact upon the service. For example, the early recruitment of a replacement member of reception staff on a part time basis to allow for seamless handover of the role.

Reception staff were trained to enable them to carry out a number of duties. Staff spent time working at both the main site and branch locations. The mix of skills meant the practice had the flexibility to meet unexpected absence.

There was a workforce contingency plan for annual leave and sickness in place, such as locum GP cover. The practice manager informed us that for example the same locum GP would provide cover to maintain where able continuity for patients. We saw that staff succession planning took place in a timely manner.

GPs, Nurse Practitioner and pharmacy took lead roles, for example in supportive care, medicines management, infection control and safeguarding adults and children. If any findings identified emerging risks these were immediately fed back to the staff so action could be taken to improve service delivery.

Patients told us they were happy with their GP and nurse and found them to be competent and knowledgeable. The rotas we reviewed showed that sufficient GPs were on duty to cover the appointments.

Staff received regular basic life support training and training associated with the treatment of anaphylaxis, shock.

Arrangements to deal with emergencies and major incidents

The practice had a business continuity plan last updated September 2013 in place to deal with emergencies that might interrupt the smooth running of the service, such as power cuts, telephone issues and adverse weather conditions. Staff knew what to do in event of an emergency evacuation and staff were aware of which staff member was the fire marshal on the day of the visit and who was responsible for health and safety.

We found all staff were trained to a minimum of basic life support to support patients who had an emergency care need. All emergency equipment was regularly checked and readily available for staff to access in an emergency. We saw that the practice had the 2010 Resuscitation Guidelines in place which are the most current. The practice had awareness of the Resuscitation Council (UK) Equipment and drug lists guidance for cardiopulmonary resuscitation in Primary Care published November 2013.

GPs carried medicines in their bags and the GP dispensary lead informed us that dispensers maintained a spreadsheet of the drugs carried and the expiry dates. The system in place ensured that replacements when due periodically could be planned for in advance. The rationale for the medicines carried was clear, for example one of the areas covered by the practice is very rural and reduced access to local pharmacy support therefore the GPs would carry antibiotics for any late visits.

The nurses maintained checks on the emergency drugs, oxygen and equipment and we saw that the list of the checks of the drugs and intravenous fluids contained within the emergency bag was maintained. We saw that adult pulse oximeters were available for staff to use. The Nurse Practitioner informed us that they had hoped to have a pulse oximeter child probe from the CCG, they were

aware of the need to obtain this piece of equipment. Oxygen was stored in a treatment room. We saw that staff could access the oxygen and the cylinder was full, in date and ready for use.

Each consultation and treatment room was fitted with a panic alarm which could be used to raise an audible alert in reception if a member of staff required assistance in an emergency. Alerts could also be raised using the practice computer system.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice provides a service for all population groups. GPs, apart from having the overall competence to assess each person attending the service, had particular interest areas. For example one GP also worked in palliative care in the hospice and is the National lead in palliative care with the RCGP and Marie Curie with a special interest in diabetes. Another GP is the Cardiology Lead for the local Clinical Commissioning Group and helps run the Community Heart Failure Service.

We saw that the practice followed national strategies relating to caring and treating patients. For example they ensured that all people who they treated aged over 75 years of age had a named GP. The practice kept up to date disease registers for patients with long term conditions such as asthma and chronic heart disease and staff completed annual health reviews.

They also provided annual reviews to check the health of patients with learning disabilities and patients on long term medication, for example for mental health conditions. We saw that 67% of patients with learning disabilities attended for review. We discussed what happened when patients with learning disabilities did not attend for review. The staff told us that letters were forwarded to remind patients of the appointment and reminder phone calls could be made. We were told that where the patient does not attend on three occasions the GP makes contact with them. Staff told us of occasions when GPs complete a home visit to ensure the patients well-being following three attempts at encouraging an annual review.

Quality Outcomes Framework (QOF) was used to monitor the quality of services provided. The report from 2012-2013 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 level of achievement.

Management, monitoring and improving outcomes for people

The Practice had a system in place for completing clinical audit cycles. We saw that a variety of clinical audits had been completed and the finding disseminated to all staff. For example an audit of hypertension diagnosis was completed in November 2013 to see if the practice was complying with the 2011 NICE Hypertension guidelines and making appropriate use of the ambulatory blood pressure monitoring apparatus. Following the completion of the audit there were clear learning points identified and implemented. A pain clinic referral audit was completed which set out clear aims, objectives, methods and results with summary findings which included evidence that no patients exceeded the 18 week waiting time and 33% of patients were seen within 28 days. In the audit proposals included in-house peer reviews of pain clinic referrals to assist in standardising the referral threshold.

Two GPs at the practice undertake minor surgical procedures in line with their CQC registration and following the National Institute for Health and Care Excellence (NICE) guidance. An audit was completed in March 2013 regarding joint Injections of ''Knees and shoulders" between February 2012 and July 2012 and followed up for six months. Failure rate was calculated if the patient did not improve in the 6 week period and therefore required specialist referral and patients who had a second injection in less than 6 weeks from the first. The results showed the practices success rate to be 85.5%.

Effective staffing

The practice had policies and procedures in place to support staff in carrying out their work. For example, newly employed staff were supported and supervised in the first few weeks of working in the practice to help confirm they were able to effectively carry out their role. An induction programme included time to read the practice's policies and procedures and meetings. Staff, including trainee doctors, and locum GPs had easy access to a range of policies and procedures via the computers systems, to support them in their work.

Clinical staff took responsibility to maintain their appropriate professional refresher training in a timely manner; this included the training expectations in line with national guidance, as well as those of the local Clinical Commissioning Group (CCG). A training policy was in place and training included in-house training, external training courses and on-line in the form of E-Learning. The mandatory training included, for example annual fire safety, moving and handling as well as training every two years in information governance and confidentiality. The practice maintained a training log for all staff other than the GPs and nurse practitioner.

Good

Are services effective?

(for example, treatment is effective)

The majority of GPs at the practice had completed their revalidation within the last 12 month period. One of the GPs informed us that practice learning times (PLT) occurred quarterly often addressed by the CCG as well as the team in house learning sessions. We were told that initially the GP trainees at the end of surgeries get to review all the patients they had seen with a GP trainer as a form of 'hot' training.

GPs, practice managers GP trainees and nurse practitioners have a 'practice away day' a half day opportunity to look at goals set, review achievements and set new goals.

The practice offered all staff annual appraisals to review performance at work and identify development needs for the coming year. Records confirmed annual staff appraisals took place. Staff received support and development opportunities and were able to progress to roles suitable to their skills and knowledge, examples were seen where staff had progressed to trainee Nurse Practitioners.

Although no formal staff supervision was recorded staff felt they received appropriate support. Nursing staff told us they worked well as a team and had good access to support from each other and their GP colleagues. The Nurse Practitioner informed us that clinical supervision was provided for the trainee Nurse Practitioner. The practice has placement trainee nurses.

We discussed with the practice that all staff groups' refresher training should be in line with staffs' professional body requirements as well as local and mandatory requirements. This included staff training for Mental Capacity Act (2005) and "best interests" decisions and nurses completing Infection Prevention and Control in line with professional and local recommendations.

Working with colleagues and other services

The practice staff worked with the local community nursing team, midwives, health visitors, and for patients with learning disabilities, the community disability team. We found that the clinicians appropriately referred patients to community teams, for example pregnant women were seen for their ante-natal appointments by the community midwives.

We spoke to the practice director and a GP about whether the GPs provided any domiciliary visits to patients in nursing or residential care homes and how the practice worked with the home's staff to provide a seamless service. It was clear that each GP had responsibility for the care of their patients and had allocated care homes which they attended regularly. Nursing home patients represented 0.578% of the patient population on the practice patient list. The practice were considering setting up a form of 'ward rounds' at one of the new nursing homes to provide additional patient support.

The nursing staff told us contact was made when appropriate with the out of hours (OOH) provider to make sure there was a full exchange of information about patients' needs, which would include any patients receiving palliative care.

The practice kept a register of patients with a learning disability and offered annual health checks. Reviews for patients with a learning disability were arranged in such a way as to support them to become fully involved in their care and in making decisions.

It was clear that the practice worked with other agencies such as Help Direct who held a weekly clinic at the practice. Help Direct is a support and information service for adults that seeks to assist people with a wide range of issues. We were told that this might include assisting people with learning difficulties, mental health problems and those who had experienced bereavement.

Well-women services were provided to patients and this was individually tailored to the needs of the patient.

One partner told us they had struggled recently with access to mental health provision due to the local health economy. This was something they were constantly reviewing and feeding back to the local Clinical Commissioning Group (CCG). For example the CCG area is significantly worse than the England average for the rates of hospital stays for self-harm. The CCG has a rate of 318.4 per 100,000 compared with the England average of 207.9. Whilst the England average has improved in recent years the CCG rate has deteriorated.

The practice completed an audit and produced a practice plan to reduce avoidable accident and emergency attendances in 2012. 52% of attendances were due to accidents, 32% emergencies, and 16% were considered to be inappropriate. The practice introduced all day triage (patient telephone consultations) from January 2014, and an additional Nurse Practitioner was employed in order to do this. A phlebotomist was employed and the Pharmacist Practitioner had increased their hours. The practice completed an audit to ascertain if the measures

Good

Are services effective?

(for example, treatment is effective)

implemented had been effective. In the month of June 2014 the audit demonstrated that 210 calls were received, 8 of which were believed to have prevented an A&E attendance.

Information Sharing

All staff completed the practices' mandatory training which included; Information Governance (IG), equality and diversity and confidentiality training. We saw that the practice staff completed on line IG training which included amongst others; records management and the NHS Code of Practice, access to health records, secure transfers of personal data and password management.

Access to patient information was dealt with in accordance with NHS guidelines. The practice follows the guidelines of Caldicott principles, the Data Protection Act (1998) and Freedom of Information Act (2000). This supported staff to ensure that only appropriate and secure information sharing took place when appropriate to do so and that information would not be given to any other bodies without first gaining the patient's consent.

There were processes and safeguards in place for the safe transit of patients paper and electronic records and reception staff were able to clearly explain the processes and checks that took place.

Information sharing took place appropriately, such as within multi-disciplinary team meetings, best interest decision meetings, safeguarding adults and children, advanced directives, palliative/supportive care meetings and shared care such as hospital referrals and discharges and community team involvements.

Consent to care and treatment

Staff informed us they had access to interpreter translation services for patients who needed it. There was guidance about using interpreter services and contact details available for staff to use. A portable hearing loop was also available for staff to use to assist patients.

Nursing staff were aware of how to locate the practice policy which dealt with the Mental Capacity Act (MCA) and best interest decisions but had received no formal training. These pieces of legislation are legal requirements that need to be followed to ensure decisions made about patients who do not have capacity are made in their best interests.

Capacity assessments and Gillick competency of children and young people, which check whether children and young people have the maturity to make decisions about their treatment, were an integral part of clinical staff practices. We found that clinical staff understood how to ascertain and consider whether 'best interest' decisions for patients who lacked capacity were required and the nurse or GPs sought approval for treatments such as vaccinations from the child's legal guardian.

The practice had a named Caldicott Guardian. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing.

Health Promotion & Prevention

All new patients were asked to complete a health questionnaire and offered a consultation. We found that staff proactively gathered information on the types of needs patients had and understood the number and prevalence of different health conditions being managed by the practice.

We saw that staff knowledge of patients' needs led to targeted services being in place such as childhood immunisation schedules being followed and long term condition management such as reviews of patients health for example patients with respiratory conditions.

In addition one of the GPs leads the Community Heart Failure Service offering remote support to their patients together with the support from the nurse practitioner. Patients registered at the practice who were at potential risks of diabetes were invited to attend the practice for a health promotion and education event in October 2014.

Staff were consistent in supporting patients to live healthier lives through a targeted and proactive approach to health promotion and the prevention of ill-health. This included a nurse led initiative reviewing all patients at potential risk of the development of diabetes. The nurses invited patients to attend the practice in October 2014 as a group, for an education and health promotion event to improve the health of their registered population, of all ages.

At the time of inspection the practice was promoting flu vaccination. The practice planned to open for additional hours on a Saturday to ensure that the needs of the patients regarding flu vaccinations could be met.

Good

Are services effective?

(for example, treatment is effective)

We saw that there was a range of health promotion information on display in the waiting areas patients used and leaflets explaining different conditions were also freely available in the treatment rooms of the practice. This meant that preventative work could be completed with all these groups to assist them to improve their health and wellbeing. In the reception area we saw a display of information dedicated to carers which provided signposting to support on a wide variety of issues. For example, dealing with dementia or bereavement. The practice participated in a national initiative seeking to develop caring communities.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients spoke positively of their dealings with both clinical and non-clinical staff. We observed staff speaking with patients attending the practice and heard them engaged in conversation with patients on the telephone. Patients we spoke with described staff as helpful and friendly. They confirmed they were treated kindly and with dignity and respect. We observed that staff were warm, polite and respectful in dealing with patients.

There was a booth at one end of the reception desk where people could speak with staff in privacy if they wished. Consultation rooms had lockable doors and privacy curtains. We saw that doors were closed during patients' appointments and patients confirmed curtains privacy curtains were drawn.

The computer system included flags on patient records to alert staff to patient needs that might require particular sensitivity. For example, learning disability or recent bereavement.

Care planning and involvement in decisions about care and treatment

Patients confirmed that they felt involved in decisions about their care and treatment. They told us diagnosis and treatment options were clearly explained. One patient told us they liked to take time to make decisions about treatment options and their GP supported them in doing so. They told us they did not feel rushed and felt able to come away from an appointment to think about matters before deciding what they would like to do and returning.

Patients confirmed they were able to contact the practice and speak with a health practitioner in a timely and accessible manner. The practice operated an all-day triage system for appointment requests. Patients spoke positively of the system. They expressed confidence they were listened to and referred appropriately. They told us that if they were advised they would receive a telephone call back from a clinician they received one in a timely manner. One patient told us they had received particularly quick responses when concerns related to her children.

Patient/carer support to cope emotionally with care and treatment

One of the GP partners was appointed as National Clinical Lead in palliative care by the Royal College of General Practitioners. The GP led a three year national programme working to improve end of life care in primary settings. The practice had systems in place that reflected best practice in this regard and demonstrated an ethos of caring and striving to achieve dignified death for patients. We were told that in appropriate cases patients were 'offered' conversations around end of life planning such as advance care plans, preferred care priorities and resuscitation but such discussion were never 'imposed'.

Multi-disciplinary supportive care meetings were held on a monthly basis to discuss the needs of those approaching end of life. Systems were in place to prioritise support according to estimated prognosis. Clinical staff were supported by in house training on matters relevant to end of life care. For example, how to best approach discussions with patients about resuscitation. Patient preferences were shared electronically with appropriate healthcare partners to ensure they were met, for example, out of hours services.

One patient told us the care and treatment she and her husband had received from their GP whilst her husband had been terminally ill was excellent. They told us they had been treated with sensitivity and compassion and felt they couldn't have asked for any more. Another patient told us the GPs they had seen were very good with their young children and put them at ease.

Behind reception, not visible to patients visiting the practice, was a notice board of recent deaths and births which provided an immediate visual prompt for staff. In the reception area we saw a display of information dedicated to carers which provided signposting to support on a wide variety of issues. For example, dealing with dementia, bereavement, prostate cancer and issues related to military discharge.

The practice participated in a national initiative seeking to develop caring communities. Representatives of Help Direct held a weekly clinic at the practice. Help Direct is a support and information service for adults that seeks to assist people with a wide range of issues. We were told that this might include assisting people with learning disability, mental health problems and those who had experienced bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice ran a personal list system which meant that patients were registered with a particular GP. We were told that usually members of the same family would also be registered with the same GP. Some patients were frustrated at the length of time they had to wait to see their named GP. In addition to Rosebank Surgery the practice had two other locations. Patients were able to attend the location most convenient for them and those we spoke with were aware of this. Two patients told us they had attended branch surgeries in order to see the GP of their choice. All the patients we spoke with confirmed they would be offered a same day appointment if there was an urgent need.

The practice had chlamydia testing kits available for patients. Posters were displayed in the waiting room targeting the 15-24 year old age group most at risk in this regard. Staff confirmed interpreter services could be arranged for appointments though they were rarely required.

At the time of inspection the practice was promoting flu jabs. One patient had an appointment with the nurse. They saw the promotion literature and decided to ask the nurse if it would be possible for them to have the flu jab whilst they were there. They told us the nurse had been able to accommodate that request.

During our inspection a patient with learning disabilities visited the practice. The patient said staff always had time for them, they were clearly known to members of staff and it was obvious that they had developed an excellent rapport.

One of the notice boards in reception was dedicated to Child Health. We saw that it contained information on subjects such as breastfeeding and meningitis. Literature available signposting patients to healthy activity programmes at the local YMCA, nearby drop in clinics for children and cancer care therapeutic groups for children aged 9 to 11 years who had experienced bereavement.

At the time of our inspection the practice did not have an active patient participation group. The practice manager told us one group had been established to cover all branches but this had not proved particularly effective. The practice population was spread across a wide geographical area. The practice manager said they had concluded it would be better to set up a patient participation group at each of the branches and this was work in progress.

We received 30 completed Care Quality Commission comment cards and spoke with five patients. All were very complimentary about the care provided by the clinical staff and noted the overall friendliness and attitude of all staff. They all found the GPs and nurses to be competent and knowledgeable about their treatment needs. They felt that the service was exceptionally good and that their views were valued by the staff.

There was evidence of an extended hour's service between 8am and 9am and 6pm-6.30pm at Rosebank Surgery Lancaster site to meet the needs of the working age population. We discussed this with the practice manager and some of the GPs as the largest percentage of the practice population, 63.2% were of working status either paid work or in full-time education. We were informed that this was something the partners at the practice regularly reviewed to ensure they could meet the needs of their registered patients. Two of the thirty CQC comment cards received suggested that obtaining appointments had, in recent months, been more problematic.

Tackling inequity and promoting equality

Staff received appropriate training in equality and diversity. The new patient list was open and staff were able to offer appointments to patients, for example patients with no fixed abode. Clinical staff had awareness of the NHS Lancashire North Clinical Commissioning Groups' Equality and Inclusion Strategy 2013-2016. This was designed to tackle current health inequalities, promote equality and fairness and establish a culture of inclusiveness using the equality delivery system (EDS) to drive improvement. The main purpose of the EDS is to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010.

Public Health England's data found that the practice's average male life expectancy of 77.9 and female life expectancy 81.2, compared to England's national average is 78.9 for males and 82.9 for females. Clinical staff held a

Good

Are services responsive to people's needs?

(for example, to feedback?)

number of regular clinics at the practice to review for example chronic disease management, immunisation and vaccination, smoking cessation and diabetes to provide health promotion information and advice.

Access to the service

The practice was purpose built and was visibly clean and well maintained. There was a car park with dedicated disabled bays closest to the door. There was level entry to the building. All consultation and treatment rooms were on the ground floor. A disabled toilet and baby change facility was available. Reception was fitted with a hearing induction loop. Corridors and doorways were wide enough to accommodate wheelchair access. The reception area was spacious and well furnished with ample seating.

We saw the action plan from the former patient participation group (PPG) following an annual survey which highlighted changes made as a result of patient feedback. This included an increase in the 15 minute appointments available at the practice and all day triage service. The practice also had online appointment access for those who required this service.

Home visits and urgent on the day appointments were available every day. All surgery opening times were detailed in the practice leaflet which was available in the waiting room for patients and website.

Listening and learning from concerns & complaints

Over a 12 month period the practice had been in receipt of 11 complaints both clinical and non-clinical. A system was in in place for handling complaints and concerns. The practice complaints policy was 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 complaint investigations were thorough and impartial. Areas where lessons could be learnt were identified. They analysed all of the complaints and produced actions plans where appropriate to do so, these were implemented and shared with the staff.

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 idea of the vision and overall strategy of the practice and its development. We saw evidence that showed the practice worked with the CCG to share information, monitor performance and implement new methods of working to meet the needs of local people.

GPs attended prescribing, palliative/supportive care meetings, medicines management and safeguarding meetings and shared information within the practice. Monthly business meetings highlighted the progress being made with clinical staffs involvement with the discussions around the setting up of their GP Federation. The practice had clear awareness of the CCG's 'Better Care Together' engagement programme.

There was a nurse led five year plan in place with a clear strategic vision in respect of staff roles, responsibilities, career progression, education and training and increased staffing hours.

Staff told us the various meetings helped them keep up to date with new developments and concerns. It also gave them an opportunity to make suggestions and provide feedback. Staff told us they were committed to providing a good service for patients and they were enthusiastic about their contribution.

Governance Arrangements

GP had lead roles and took responsibility for a number of clinical areas. GPs were involved in training and supporting trainee GPs. The practice partners were responsible for decisions in relation to the provision, safety and quality of care and worked with the practice director and deputy manager to ensure identified risks were acted upon. Individual aspects of governance such as complaints, risk management and audits within the practice were allocated to appropriate staff, for example the practice director held responsibility for the oversight of complaints. The practice submitted governance and performance data to the CCG.

The practice were aware to notify the Care Quality Commission (CQC) of GP partnership and Registered Manager (RM) changes as required. We saw that enquiries had been made in respect of a recent RM change, but had yet to be completed. The practice manager assured us that this process would be completed.

Leadership, openness and transparency

The practice had systems to identify, assess and manage risks related to the service. We saw the practice's health and safety policy which included clear guidance for staff we saw evidence of staff involvement and the cascaded information.

Procedures were in place to record incidents, accidents and significant events and to identify risks to patient and staff safety. The results were discussed at practice meetings and if necessary changes were made to the practice's procedures and staff training.

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

We saw from minutes of meetings that appropriate staff members attended these meetings and contributed to the running of the practice. Staff told us they were encouraged to make suggestions and contribute to improving the way the services were delivered.

The 30 CQC comment cards received confirmed that patients felt involved in decisions about their care and treatment. Patients told us diagnosis and treatment options were clearly explained.

The practice were in the process of reintroducing the patient participation groups at the individual sites to gather site specific information to enable then respond appropriately to local practice concerns.

The practice carried out an annual patient survey across all branches. Patients were asked for their feedback on a limited number of issues. This included asking whether they felt the length of their appointment was sufficient, if they had been able to book an appointment when they needed to and whether they had to travel to another site to see a particular GP. We saw that the practice analysed feedback received. One element of the survey in 2013 showed that 66% of patients felt a longer consultation time would be better and would prevent a further appointment having to be made. The practice responded to this by providing a third of all appointments for 15 minutes, and that patients could book double appointments where required.

Are services well-led?

Good

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

Management lead through learning & improvement

Staff told us about how the practice learned from "significant events" and the improvements and reviews following any change implementation that took place. These were recorded in the significant event audit structured reflective templates.

The practice partners and managers were very supportive of staff's personal development and provided staff with extra support to achieve qualifications which would increase the staff member's effectiveness and that of the service provided to their patients.

There were a range of staff meetings to support staff, as a form of effective communication, provide learning opportunities and to case review. Practice Nurse meetings were held quarterly. Staff meetings held weekly after a break in the summer. Educational/clinical meetings were timetabled for the year, these included; monthly palliative/ supportive care meetings, monthly business meetings, GP development days, quarterly mental health meetings, significant events meetings and included education meetings on a variety of topics including external speakers.

The practice carried out audits and checks to monitor the quality of services provided. For example they had completed a Shingles vaccination audit for those patients eligible of ages between 70-79 years between September 2013 and August 2014. They found that they had an 83%, and 84% update respectively and planned to follow the same protocol for 2014 based on the uptake results. We saw that the practice had considered the low figures on the Chlamydia screening rates for 15 to 25 year olds. They determined that the main reason was that young people tended to have been already screened at their school or in Genito-Urinary Medicine clinics.