Pendleside Medical Practice

Quality Report

Pendleside Medical Practice
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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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

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 Pendleside Medical Practice on 27 January 2016. Overall the practice is rated as outstanding.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. Evidence of close working with the neighbouring GP practice and other community health service was productive and led to consistent standards of care for patients in the locality.
- Feedback from patients about their care was consistently and strongly positive. Patients described the GP practice as excellent; staff were described as caring and professional.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. For example healthcare professionals told us of the supportive nature of the GP practice by responding quickly to concerns identified with patients.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example it had rearranged the seating in the waiting room to allow patients to sit more comfortably and had taken appropriate action to minimise potential impact on patient privacy as a result of this.
- The practice was had the facilities and was well equipped to treat patients and meet their needs. The practice provided a medicine dispensing service for patients that did not live near a pharmacy.
- Information about how to complain was available on the practice notice board and in their patient brochure.

Summary of findings

- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.

We saw several areas of outstanding practice including:

- The practice worked closely with the other GP practice and the other healthcare professionals located within the building to develop local clinical pathways. A clinical pathway for guidance and management of atrial fibrillation had been agreed and implemented. This ensured patients living in the locality received consistent, evidence based care and treatment for atrial fibrillation.
- Practice staff had the support of the GP partners to identify and review healthcare conditions not routinely reviewed or monitored. For example one practice nurse reviewed the treatment and support provided to patients with Coeliac disease. As a result patients with Coeliac disease were offered an annual review and received a planned consistent standard of treatment and support.

The areas where the provider should make improvement are:

- Review the management of the practice complaints policy and procedures so that complaints are responded to objectively and the policy aligns with recognised guidance and contractual obligations for GPs in England. Final letters to complaints should include the contact details for the Parliamentary and Health Service Ombudsman.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- 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 were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology. They 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.
- Medicines were managed safely by the dispensary.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data showed that the practice was performing highly when compared to practices nationally and in the Clinical Commissioning Group (CCG). Staff assessed needs and delivered care in line with current evidence based guidance.
- A planned programme of clinical audit and re-audit was established. Clinical audits demonstrated quality improvement and were used to develop consistent approaches to clinical care.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.
- The practice used innovative and proactive methods to improve patient outcomes and working with other local providers to share best practice.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services.

- Data from the National GP Patient Survey showed patients rated the practice higher than others for almost all aspects of care. For example 91% of patients surveyed said the last GP

Summary of findings

they spoke to was good at treating them with care and concern (CCG average 85%, national average 85%). 97% said the last nurse they spoke to was good at treating them with care and concern (CCG average 92%, national average 91%) and 98% said they found the receptionists at the practice helpful (CCG average 84%, national average 87%.

- Feedback from patients about their care and treatment was consistently and strongly positive. This reflected the results of the GP patient survey published in January 2016.
- We observed a strong patient-centred culture. Each GP ran a personal patient list. This enabled GPs to develop long term relationships with patients and promoted continuity of care and treatment.
- Patients' comments provided examples of the personal support they received for GPs, for example coping with cancer and at times of bereavement.
- Views of external stakeholders, such as the community healthcare professionals told us that the practice staff responded quickly to any concerns they raised about patients they saw in the community or in living in care homes

Are services responsive to people's needs?

Outstanding ☆

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 meet patients' needs. The practice provided daily (Monday to Friday) GP cover to the local community hospital. This enabled the GPs to admit their own patients quickly if there was a need.
- There are innovative approaches to providing integrated person-centred care. The practice employed a nurse specifically to review and support patients over the age of 75 and who did not have a recognised long term condition. Examples of joint working with the Community Matron for Over 75s with complex needs were provided.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example the patient participation group was consulted on the patients to be included in the patient survey. The outcome of the patient survey resulted in a change in the furniture setting in the patient waiting area.

Summary of findings

- Patients could access appointments and services in a way and at a time that suited them. The practice had recently benefited from a Primary Care Foundation audit to review patient access and the provision of urgent care. As a result of the audit the practice had changed its appointment system.
- 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. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding ☆

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

- The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- High standards were promoted and owned by all practice staff and teams worked together across all roles.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.
- The practice carried out proactive succession planning.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction.
- The practice gathered feedback from patients and it had a very active patient participation group which influenced practice development.

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

Outstanding ☆

The practice is rated as outstanding for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population. For example one practice nurse was specifically employed to carry out reviews of patients over the age of 75 years. Close working relationships were established with the Community matron for people over the age of 75 with complex healthcare needs.
- GPs were allocated a specific care home and carried planned weekly visits to the home.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs. GPs had admitting rights to the local community hospital should their patients need to extra support.
- Care plans were in place for those patients considered at risk of unplanned admission to hospital.
- Data supplied by the practice showed they had lower emergency hospital admissions for the over 65s for April to October 2015 with approximately 67 patients per 1000 of the population being admitted compared with the CCG of 105 patients per 1000.
- Monthly palliative care meeting were held and community health care professionals attended these. Patients had care plans in place.

People with long term conditions

Outstanding ☆

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

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Two practice nurses were trained to deliver education packages to patients on how to manage their diabetes and to residential and nursing home staff.
- The practice performed better than the national average in all five of the diabetes indicators outlined in the Quality of Outcomes Framework (QOF). The practice carried out insulin initiation.
- Longer appointments and home visits were available when needed.

Summary of findings

- Two practice nurses were trained in anticoagulant management and held clinics to monitor patients' blood to determine the correct dose of anti-coagulant medicine. The nurses worked closely with health care professionals to ensure patients who required surgical procedures were closely monitored and treated to ensure the optimum anti-coagulation therapy both pre and post operatively.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Outstanding ☆

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were satisfactory for all standard childhood immunisations.
- Quality and Outcome Framework (QOF) data showed that the practice performed better that the national average with 84.06 % of patients with asthma, on the register, who had had an asthma review in the preceding 12 months (National data 75.35%).
- 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.
- Data showed that the practice performed better than the national average for the percentage of women aged 25-64 who had received a cervical screening test in the preceding five years (with 91.26% compared to the national average of 81.83%).
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- Patients had access to weekly sexual health and contraceptive clinics.
- We saw positive examples of joint working with midwives, health visitors and community nurses.

Working age people (including those recently retired and students)

Outstanding ☆

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

Summary of findings

- 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.
- Telephone consultations were available and lunchtime surgeries were available.
- 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.
- The practice offered bi-annual reviews of patients with a cancer diagnosis and offered annual reviews to patients with Coeliac disease.
- The practice offered early morning (Wednesday and Thursday) and later evening appointments (Tuesday and Thursdays) for working patients and those patients who could not attend during normal opening hours.

People whose circumstances may make them vulnerable

Outstanding

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

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice offered longer appointments for patients with a learning disability. Care plans were recorded for patients with a learning disability.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people.
- The practice informed 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)

Outstanding

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

- 84.09% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the national average.

Summary of findings

- 91.38% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan recorded in the preceding 12 months which was above the national average of 88.47%. We saw examples of these.
- The practice regularly worked with multi-disciplinary teams. The Integrated Neighbourhood Team had an attached mental health worker.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- 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 patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results published on 7 January 2016. The results showed the practice was performing above local and national averages. 239 survey forms were distributed and 122 were returned. This represents a 51% completion rate and 1.26% of the practice's patient list

- 90% found it easy to get through to this surgery by phone compared to a CCG average of 72% and a national average of 73%.
- 94% were able to get an appointment to see or speak to someone the last time they tried (CCG average 84%, national average 85%).
- 95% described the overall experience of their GP surgery as fairly good or very good (CCG average 85%, national average 85%).
- 94% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 75%, national average 78%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 20 comment cards which were all positive about the standard of care received. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Comment cards also referred to being able to get an appointment when they needed and consistency of care from the same GP. Many referred to being made welcome on arrival at the surgery.

We spoke with five patients during the inspection and two members of the patient participation group who were also patients. All praised the quality of care and service they received. Members of the Patient Participation Group gave examples of where they were consulted on the development and improvement of the service. For example the two members told us that they had been consulted on the questions that should be included in the patient survey which was sent out in September 2015.

Areas for improvement

Action the service SHOULD take to improve

- Review the management of the practice complaints policy and procedures so that complaints are responded to objectively and the policy aligns with recognised guidance and contractual obligations for GPs in England. Final letters to complaints should include the contact details for the Parliamentary and Health Service Ombudsman.

Outstanding practice

We saw two areas of outstanding practice:

- The practice worked closely with the other GP practice and the other healthcare professionals located within the building to develop local clinical pathways. A clinical pathway for guidance and management of atrial fibrillation had been agreed and implemented. This ensured patients living in the locality received consistent, evidence based care and treatment for atrial fibrillation.
- Practice staff had the support of the GP partners to identify and review healthcare conditions not routinely reviewed or monitored. For example one practice nurse reviewed the treatment and support provided to patients with Coeliac disease. As a result patients with Coeliac disease were offered an annual review and received a planned consistent standard of treatment and support.

Pendleside 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 included a GP specialist adviser, a specialist adviser with practice management experience and a CQC Pharmacist Inspector. The pharmacist inspector inspected the dispensary for both Pendleside Medical Practice and the neighbouring GP practice.

Background to Pendleside Medical Practice

Pendleside Medical Practice is part of the NHS East Lancashire Clinical Commissioning Group (CCG). Services are provided under a General Medical Services (GMS) contract with NHS England. The practice confirmed they had 9850 patients on their register. The practice jointly provided with the neighbouring practice, a medicine dispensing service for patients that did not live near a pharmacy.

Information published by Public Health England rates the level of deprivation within the practice population group as eight on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. Male and female life expectancy in the practice geographical area reflects the England average for males at 79 years and 83 years for females. These life expectancy ages are higher that other localities within the CCG area.

The patient numbers in the older age groups were higher than the CCG and England averages. For example data from Public Health England for 2015 showed that 21.5%% of the patient population was over the age of 65, 9.9% were over 75 and 3.2% were over 85 years. The CCG averages were 17.6%, 7.5% and 2.2% respectively and the England averages were 17.1%, 7.8% and 2.3% respectively. In addition data showed that the practice had a significantly higher number of nursing home patients 1.1% per GP registered population compared to the England practice average of 0.5%.

The practice has eight GP partners (five male and three female). The practice employs a practice manager, four practice nurses (including two nurse prescribers), two healthcare assistants and 12 reception and administrative staff. In addition, the practice jointly employs with the neighbouring GP practice staff for the dispensary. This includes a dispensary manager, a deputy manager and, eight dispensers and two delivery drivers.

The practice is a training practice for qualified doctors who are training to be a GP. Three GP partners are trainers.

The GP practice provides services from one registered location at Pendleside Medical Centre. However nursing services such as long term condition reviews are also provided from two consultation rooms located in another building (Quex), about 100 metres from the main building. In addition the practice provides GP cover Monday to Friday at Clitheroe Community Hospital.

The practice is open Monday to Friday 8am to 6.30pm. Wednesday and Thursdays early morning appointments are available from 7.15am and later evening appointments until 7.15pm are available on Tuesdays and Thursdays for pre-booked appointments.

Out of Hours services are provided by East Lancs Medical Services (ELMS), and contacted by ringing NHS 111.

The practice provides online patient access that allows patients to book appointments and order prescriptions and review some of their medical records.

Detailed findings

Pendleside Medical Practice is located in Clitheroe Health Centre, a purpose built building. This accommodation is shared with a neighbouring GP practice. In addition a nurse led Treatment Room service is provided and staffed by East Lancashire Hospital Trust. Other healthcare services such as podiatry and community nursing teams are also located within the same building.

The building is accessible to people with disabilities.

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 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 we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 27 January 2016.

During our visit we:

- Spoke with a range of staff including four GPs, the practice manager, four practice nurses, six administration and reception staff. We spoke with six patients who used the service and three community health care professionals who work with the practice staff. We spoke with the Pharmacy manager and dispensing staff.
- Observed how people were spoken with and observed the practice's systems for recording patient information.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- 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 were provided for specific groups of people and what good care looked 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.

Good

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 a recording form available on the practice's computer system.
- The practice carried out a thorough analysis of the significant events. Twice weekly team meetings were undertaken and at least monthly reviews of significant events were held.

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. Both GPs and nurses provided examples of significant events and the action taken as result of analysis. Examples included administration of baby vaccines and the signing of a death certificate.

When there were 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.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients 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 chaperones were available if required. All designated staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (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). On rare occasions the nurses employed by East Lancashire Hospital Trust and who worked in the Treatment Room acted as a chaperone for patients.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. 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 and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and appropriate action was taken for any abnormal results.

The practice operated a Doctor Dispensing Service for patients that did not live near a pharmacy. The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Blank prescription forms were handled in accordance with national guidance. These were tracked through the practice and kept securely at all times. A process was in place to ensure prescriptions were signed before medicines were handed out to patients. Procedures were in place for monitoring prescriptions that had not been collected.

All members of staff involved in the dispensing process had received appropriate training. Dispensary staff had opportunities for continued learning and development through attending training courses. Some dispensary staff had not had an annual appraisal but this was being

Good

Are services safe?

addressed and dates had been agreed. Any medicines incidents or 'near misses' were recorded for learning and the practice had a system in place to assess the quality of the dispensing process.

Processes were in place to check medicines were within their expiry dates and this was routinely recorded. The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how these were managed. There were also appropriate arrangements in place for the destruction of controlled drugs.

Two of the practice nurses had qualified as an Independent Prescribers and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The practice had a system for production of Patient Specific Directions to enable Health Care Assistants to administer vaccinations after specific training when a doctor or nurse were on the premises.

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. There was a health and safety policy available. 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 had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- 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. The staff teams reviewed at regular intervals future staff availability and seasonal demand to ensure sufficient staff were available to meet patient demand. All staff teams worked flexibly to cover sudden absences or to enable staff training.

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 annual 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. A first aid kit and accident book were 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 staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with 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.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and 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 99.8% of the total number of points available with 12.2% exception reporting for all clinical indicators. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The practice had consistently achieved over 99% of the points available since 2011 and consistently scored a higher percentage than the local Clinical Commissioning Group (CCG) and the national average. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014-15 showed:

- The practice achieved higher percentages in all the QOF diabetic indicators for 2014-15 when compared to the CCG and the England averages. For example data for diabetic patients and the HbA1C blood tests showed 83.17% of patients had received this compared to the national average of 77.54% The record of diabetic patients with a blood pressure reading recorded within the preceding 12 months was 79.04%. The national average was 78.03%.
- 87.56% of patients with hypertension had their blood pressure measured in the preceding 12 months compared to 85.65% nationally.
- 84.06 % of patients with asthma, on the register had an asthma review in the preceding 12 months compared to national data 75.35%.
- 84.09% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months which was comparable to the national average of 84.01%.
- 91.38% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan recorded in the preceding 12 months which was above the national average of 88.47%.

Clinical audits demonstrated quality improvement.

- The practice had an audit calendar in place for clinical audit and re-audit. Good evidence from clinical audits was available and these were linked to national guidelines such as NICE. Evidence demonstrated that the practice continued to re-audit and review the clinical audit undertaken after two completed cycles. The audit for diagnosing type 2 diabetes resulted in an easy read flow diagram for clinicians to follow for deciding when to undertake blood tests and which blood test to use. The continuity of care audit identified actions to ensure patients on the Gold Standard Framework pathway received a continuity of care from the same GP for consultations and that alerts were put on patients records so that staff quickly identified these patients with this specific need.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- The practice worked closely with the other GP practice and the other healthcare professionals located within the building to develop local clinical pathways to ensure patients received consistent, evidence based and personalised health care reviews that included all co-morbidities. Examples of clinical pathways already developed following the first cycle of clinical audit included a dementia care pathway and an atrial fibrillation guidance and management pathway.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.

Good

Are services effective?

(for example, treatment is effective)

- The practice could demonstrate how they ensured role-specific training and updating for relevant staff for example, for those reviewing patients with long-term conditions. Staff administering vaccinations and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccinations could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings. In addition, two practice nurses were nurse prescribers who were trained in insulin initiation and monitoring anti-coagulation therapies and treating patients accordingly. Regular audit of blood results and calibration of equipment was undertaken and closely monitored by the nurses and GPs.
- 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 their 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 revalidating GPs. Nurses were reviewing how they could support each other with nurse revalidation. All staff at the GP practice had had an appraisal within the last 12 months and a schedule to complete appraisals for dispensary staff was in place.
- 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. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. For example health care professionals, employed through the CCG including the Advanced Nurse Practitioner for Care Homes, the Community Matron for over 75s and the Clinical Coordinator for the Integrated Neighbourhood team, said they had supportive productive working relationships with the GP practice. They told us there was good communication and that the duty GP always responded concerns about patients, and they were invited to the practice clinical meetings and the palliative care meetings.

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, recorded the outcome of the assessment.

Supporting patients to live healthier lives

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. In addition the practice employed a practice nurse specifically for patients over the age of 75 years. The practice nurse for the over 75s invited patients in for a healthcare review or visited patients at home as per their preference. Following the review appropriate support and advice was provided as required.
- The health care assistant was trained in providing dietary advice was available on the premises and smoking cessation advice was available from a local support group.

Good

Are services effective?

(for example, treatment is effective)

The practice's uptake for the cervical screening programme was 91.26% which was above the national average of 81.83%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were on the whole comparable to CCG. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 53.3% to 92.4% and five year olds from 52.8% to 96.9%. Flu vaccination rates for the over 65s were 81.4% and at risk groups 59.23%. These were higher than the national averages.

The practice had admitting rights to Clitheroe Community Hospital and GPs worked closely with community health care nurses to respond quickly to the healthcare needs of patients. The effectiveness of these interventions was demonstrated by low emergency admission rates to hospital. Data supplied by the practice indicated that rates of attendance at A&E and emergency admissions were lower that the CCG and GP practice locality averages. For example A&E attendance for April to October 2015 for all ages was approximately 115 patient per 1000 of the population compared to the CCG average of 200 per 1000, and emergency admissions for the over 65s for April to October 2015 was approximately 67 per 1000 of the population compared with the CCG average of 105 per 1000.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Outstanding ☆

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with 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; 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 20 patient Care Quality Commission 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. Comment cards detailed specific experiences of personalised support they received from GPs at times of bereavement, following a cancer diagnosis and explanations of test results. All cards consistently described the staff as taking time to listen, being responsive to their concerns and to providing help and support compassionately. We spoke with four patients who all confirmed they were very happy with the quality of service they receive. They told us they could get appointments when they wanted and that all staff were pleasant and they were made to feel welcome at the practice. We heard repeatedly that reception staff greeted them with a smile.

The practice's patient participation group (PPG) was a joint PPG with the neighbouring GP practice. The PPG was named the Clitheroe Health Centre User Group. We spoke with two members of the patient participation group, both were patients registered with Pendleside Medical Practice. They also told us the service they received was excellent. They said the quarterly PPG meetings were very useful, the GP practices updated them on the changing NHS and potential impact to services and they said the invited speakers were interesting. They confirmed they were consulted and listened to about how to improve services.

Results from the national GP patient survey reflected the comments cards and conversations we had with patients. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 91% said the GP was good at listening to them compared to the CCG average of 87% and national average of 89%.
- 91% said the GP gave them enough time (CCG average 87%, national average 87%).
- 96% said they had confidence and trust in the last GP they saw (CCG average 94%, national average 95%).
- 91% said the last GP they spoke to was good at treating them with care and concern (CCG average 85%, national average 85%).
- 97% said the last nurse they spoke to was good at treating them with care and concern (CCG average 92%, national average 91%).
- 98% said they found the receptionists at the practice helpful (CCG average 84%, national average 87%).

The practice carried out a patient survey in September 2015 and the responses from the feedback were analysed and an action plan developed and implemented. A number of areas identified referred to issues about the building and the waiting room layout potential compromising patient confidentiality. The building is owned and maintained by a landlord (NHS Property Services) which limited the GP practice's ability to adapt the patient waiting room. A solution was identified and an opaque film was used to cover glass along the corridors. This allowed the practice to change the direction of the patient chairs without compromising patient privacy and maintained confidentiality at reception.

A twice yearly patient newsletter was provided for patients. This was colourful and informative and covered areas such as partnership changes, information on services such as access, the over 75 service, health care initiatives such as dementia screening and health care tips.

Other healthcare professionals we spoke with were overwhelmingly positive about the practice responsive in meeting patients' needs.

Care planning and involvement in decisions about care and treatment

Each GP ran a personal patient list. This enabled GPs to develop long term relationships with patients and promoted continuity of care and treatment. We saw that

Are services caring?

care plans were recorded for patients with long term conditions, learning disabilities, mental health, dementia, palliative care and unplanned admissions. Patients with asthma and chronic obstructive pulmonary disease (COPD) had personalised management plans and were provided (if required with medicine rescue packs for antibiotics and steroids). Patients told us 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.

Community healthcare nurses we spoke with confirmed the GPs responded very quickly to any concerns they identified with patients living in the community. GPs were described as going the extra mile to ensure patients received the right care.

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 in line with local and national averages. For example:

- 85% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%.
- 86% said the last GP they saw was good at involving them in decisions about their care (CCG average 82%, national average 82%).
- 90% said the last nurse they saw was good at involving them in decisions about their care (CCG average 87%, national average 85%).

Staff told us that the majority of patients spoke English; however translation services were available for those who did not have English as a first language.

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. There were 87 patients identified as a carer. Monthly reviews were undertaken of the patients identified as a carer and they were invited to an annual health care review and signposted to available support services.

Staff told us that if families had suffered bereavement, their usual GP contacted sent them a sympathy card. A telephone call was also made to the bereaved to offer support and advice on how to find a support service.

Outstanding ☆

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.

- GPs had personal patients' lists to promote continuity of care and treatment. However patients were able to see a GP of choice or of their preferred gender.
- The practice offered early morning (Wednesday and Thursday) and later evening appointments (Tuesday and Thursdays) for working patients and those patients who could not attend during normal opening hours. Longer appointments and same day appointments were available for patients with complex or urgent care needs.
- The practice provided weekday GP cover from 8am to 6.30pm at Clitheroe Community Hospital. This facility provided 32 in-patient beds for people living in the East Lancashire area who required short term focused rehabilitation. One of the advantages for the practice in providing this service was that the practice GPs could admit their own patients directly to the community hospital if there was a need. This allowed practice patients to be treated and supported nearer to home and enabled continuity of patient care.
- The practice employed a dedicated practice nurse to support patients over the age of 75 years. The practice nurse offered all patients over the age of 75 years who did not have an existing long term condition the opportunity to have a comprehensive review of their health wellbeing and social care needs. When patients were unable to attend the practice for the review the practice nurse visited them at home.
- Good evidence with examples were provided where the practice nurse for the over 75s had worked closely with the community matron for older people to ensure the care needs of the older people were met, plans of care and support agreed and implemented.
- Two practice nurses were nurse prescribers and trained to undertake Anticoagulant Management. Twice weekly clinics were held where patients' bloods were tested and their anti-coagulant medicine reviewed and dose changed as required. The nurses explained they worked closely with health care professionals to ensure patients who required surgical procedures were closely monitored and treated to ensure the optimum anti-coagulation therapy both pre and post operatively.
- The practice actively screened patient blood test results to identify those that were pre-diabetic. Those identified were invited in to an appointment to discuss the risk of developing diabetes and review lifestyle choices to mitigate this risk.
- The practice initiated insulin therapy on-site, so patients received treatment and support locally without having to travel to the nearest hospital.
- Two of the practice nurses were trained in delivering a patient education programme for the self-management and understanding of diabetes (X-pert Diabetes). The practice nurses worked closely with two practice nurses (also trained in X-pert Diabetes) employed by the neighbouring GP practice. Together they delivered a rolling six week training programme to patients of both practices. Courses were held five to six times per year on average.
- The practice nurses also provided training in understanding and managing diabetes to nursing and care home staff who cared for the practice's patients (and who lived in nursing or residential care homes).
- One practice nurse was a the lead for offering patients diagnosed with cancer a health and wellbeing review every six months.
- One practice nurse, with the support of the GP partners initiated in 2015 a search of registered patients with Coeliac disease. The nurse identified there was no standardised approach to treating patients with this disease. As a result of the review, patients were offered an annual review of their health care needs. This ensured that the practice patients received a personalised and consistent standard of care, treatment and support.
- Dedicated GP leads were allocated to nursing and residential care homes. Planned weekly visits were undertaken to the care homes. This reduced the number of requests by the care home for home visits and ensured continuity of care for patients.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities, a passenger lift, a hearing loop and translation services available.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Extended surgery hours were offered on Wednesday and Thursday mornings from 7.15am and later evening appointments until 7.15pm were available on Tuesdays and Thursdays. The Primary Care Foundation had recently carried out an Access and Urgent Care Audit of Pendleside Medical Centre. The result of the audit identified areas where the practice could improve patient access to appointments. The practice had followed the recommendations of the audit and now offered more pre-bookable appointments and had reduced the number of urgent appointments available each day. It also provided GP telephone appointments, a lunch time surgery and both nurse prescribers were trained to treat minor illness and held open time slots each day to see patients as required.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was higher than local and national averages.

- 77% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 75%.
- 90% found it easy to get through to this surgery by phone compared to a CCG average of 72% and a national average of 73%.
- 71% patients said they always or almost always see or speak to the GP they prefer (CCG average 58%, national average 59%).

People told us on the day of the inspection that they were able to get appointments when they needed them and the completed patient comment cards also indicated high levels of satisfaction in getting an appointment.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns. We looked at sample of complaints received in the last 12 months and these were satisfactorily handled, dealt with in a timely way, openness and transparency. However the complaints policy and procedures did not align completely with recognised guidance and contractual obligations for GPs in England. For example some of final letters sent to complainants were completed by the person the complaint was about and did not always include the contact details for the Parliamentary and Health Service Ombudsman should the complainant wish to pursue their complaint further.

Information about how and who to complain to was displayed on the notice board in the waiting room and in the patient's information leaflet. The practice reviewed held regularly teams meetings and complaints were reviewed regularly. However a periodic analysis of complaints to identify themes and trends was not undertaken.

Are services well-led?

Outstanding ☆

(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 clear vision to deliver high quality care and promote good outcomes for its patients. The practice's mission statement 'Quality Personal Care Delivered through Team work' was recorded at the top of the patient information brochure. The practice values were driven by the management team and embraced by all practice staff we spoke with. The GPs ran personal patient lists and believed that continuity of care and long term relationships between the patient and their GP improved quality of care and was fundamental to patient satisfaction. Feedback from staff, patients and the meeting minutes we reviewed showed regular engagement took place to ensure all parties knew and understood the vision and values.
- There was a commitment by all the practice staff to deliver a quality service. The practice had achieved the Royal College General Practice (RCGP) Quality Practice Award in 2001, 2006 and 2012. This underpinned the practice's robust strategy and supporting business plans and reflected the vision and values. A five year business plan was in place and this included a supporting action plan with short term 1-2 year aims and objectives and longer term objectives demonstrating a commitment to provide patient centred care. The practice held twice weekly meetings that were attended by GPs, practice nurses, the practice managers and representatives from the administration and receptions teams. A rolling programme of planned topics were discussed at these meetings. Community healthcare professional were invited to all clinical and palliative care meetings.

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 and how they contributed to the practices vision of delivering patient centred care.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained through twice weekly meetings.
- A programme of continuous clinical and internal audit which was used to monitor quality and to make improvements. The practice worked closely with the neighbouring practice and within the locality to develop clinical pathways of care and treatment to promote quality and consistency of care to patients living in the locality.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. These were reviewed regularly. A clinical risk self-assessment workshop was carried out in 2013.
- GPs had lead clinical responsibilities and also for other areas such as dispensary/pharmacy lead, medical training and education lead and premises lead.
- The practice held twice weekly meetings which were planned in advance. Separate business and partners' meetings were held every month.
- The practice nurses held at least weekly meetings to discuss any clinical issues and the nurses met monthly with the lead GP responsible for the nursing team.
- Community healthcare professionals were invited to all palliative care and multi-disciplinary meeting and we heard that the meeting agenda had been adapted to provide health visitors with a dedicated timeslot to enable them to attend meetings specifically for safeguarding issues.
- The practice engaged with the Clinical Commission Group (CCG) and attended meetings to contribute to wider service developments. One GP partner was the palliative care lead within the CCG.

Leadership and culture

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 they were approachable and always took the time to listen to all members of staff.

Are services well-led?

Outstanding ☆

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

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 the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so and felt supported if they did. We noted team away days were held every year and these included review of the practice's aims and objectives, the practice's achievements, future challenges and a team building exercise.
- 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 gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The practice sent out their own survey in September 2015. Thirty questionnaires were given out to a sample of patients for each named GP. There results were collated and specific feedback given to the respective GPs. Feedback showed that patients rated the service they received similarly to the independent results of the GP Patient Survey published in January 2016. An action plan, as a result of the feedback was also developed to respond to specific areas. For example feedback identified patients were not happy with the available space in the patient waiting area. The building landlord and the CCG were being consulted to identify solutions to this.
- There was an active PPG, the Clitheroe Health Centre User Group which was a joint patient group for both Pendleside Medical Practices and the neighbouring GP practice. We heard that the group met every two to three months and were consulted on a range of topics. The group were consulted on the questions to be asked as part of the patient survey undertaken in September 2015.
- The practice had also gathered feedback from staff through staff meetings, appraisals and discussion. In 2014 a staff survey –Safety Culture 360 was undertaken. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and the management team. Staff told us they felt involved and engaged to improve how the practice was run. They confirmed they attended away days and were provided with opportunities to attend training and develop their skills.

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. For example:

- The practice was a long standing teaching and training practice, three partners were trainers and as a result of training the practice had been able to recruit GP partners from the scheme.
- The practice provided Monday to Friday GP cover from 8 am until 6.30pm to Clitheroe Community Hospital. The enabled the practice patients to be admitted to the hospital if required and so received continuity of GP care with access to physiotherapy and occupational therapy.
- The practice employed a nurse specifically to review the needs of patients over the age of 75 years. The practice nurse employed for this role was able to develop the role for this supportive service through undertaking research. This included spending times with community healthcare support services such as the Fall's team, the district nurses and AgeUK.

Are services well-led?

Outstanding ☆

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

- The practice enabled and supported staff to develop screening initiatives to improve the quality of care for patients. One practice nurse had initiated a review of the quality and consistency of service provided to patients with Coeliac disease.
- The practice taught and supported patients and care home staff on how to self manage diabetes.
- Care homes were supported with dedicated GP leads and planned weekly visits.
- There was close working productive relationships with the neighbouring GP practice and other healthcare professionals such as the Advanced Nurse Practitioner for Care Homes and the Community Matron for 75s for the benefit of patients living in the locality.
- Patients and GPs valued the personal patient lists; however vigilance should be maintained to ensure consistency and objectivity in the management of the practice policies and procedures.
- The practice was aware of and preparing for future challenges such as the expansion of the local population due to the building of new residential homes and the need for succession planning.
- One of the practice partner GPs supported and mentored two community healthcare nurses with their university studies.