Great Eccleston Health Centre

Quality Report

Raikes Road,
Great Eccleston,
Preston,
PR3 0ZA
Tel: Tel: 01995 670066
Website: www.greateccleston.nhs.uk

Date of inspection visit: 8 July 2014
Date of publication: 10/10/2014

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.

Contents

Summary of findings

Overall summary

Great Eccleston Health Centre is a rural practice located in the village of Great Eccleston.

Most of the patients we spoke with as part of our inspection were very complimentary about the care provided by the service. Patients described staff as polite and caring, and told us they were treated with dignity and respect.

The practice provided care and treatment in an environment which was visibly clean, well maintained and fit for purpose.

Great Eccleston Health Centre is a dispensing practice. There were systems in place to protect patients against the risks associated with unsafe use and management of medicines. Some aspects of medicines management within the practice could be improved.

Care and treatment was delivered in line with current best practice.

Leadership of the practice is visible and accessible. There is a well established management structure with a clear allocation of responsibilities.

The practice is registered with the Care Quality Commission to deliver care under the following regulated activities: diagnostic and screening procedures; family planning; maternity and midwifery services; surgical procedures; and treatment of disease, disorder or injury.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Overall the service was safe. There were systems in place to monitor the safety of patient care and plans to respond to unforeseen emergencies. The practice had policies and procedures regarding safeguarding children and vulnerable adults which provided guidance and instruction to staff. Treatment was provided in an environment which was visibly clean and well maintained. There were systems in place to protect patients against the risks associated with unsafe use and management of medicines. There was an effective recruitment procedure and staff were supported by a programme of training. There were some aspects of medicines management within the practice that could be improved.

Are services effective?

The service was effective. Care and treatment was delivered in line with current best practice. Systems were in place to manage, monitor and review care and treatment to ensure it consistently met patients' needs. Referrals to secondary care were timely. The practice actively promoted health and prevention, and worked with a range of other healthcare professionals to meet patients' needs. Processes were in place to monitor and support staff performance in carrying out their roles.

Are services caring?

The service was caring. Responses received from the patient opinion survey carried out by the practice were positive. Most of the patients we spoke with as part of our inspection were very complimentary about the service and described staff as polite and caring. Patients confirmed their consent was obtained before examinations were conducted. They confirmed they were treated with dignity and respect. Patients felt involved in decisions about their care and treatment was fully explained to them.

Are services responsive to people's needs?

The service was responsive. Patients had opportunities to give feedback about the service they received and there was a well established patient participation group. The practice had a clear complaints policy and responded appropriately to any complaints received. A good range of services were available in house to meet the needs of the patient population and manage chronic conditions. Responses to the patient opinion survey carried out by the practice showed that the clear majority were very satisfied with many of the services provided.

Summary of findings

Are services well-led?

The service was well led. There was a well established management structure with a clear allocation of responsibilities. Leadership of the practice was visible and accessible. The practice was committed to learning from problems, complaints and incidents and staff shared this commitment. There were regular forums to update staff on issues relevant to the service, and for them to make suggestions and express opinion. The practice actively sought feedback from patients on the service they received

Summary of findings

The six population groups and what we found

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

Older people
The service made appropriate provision to ensure care for older people was safe, caring, responsive and effective. All patients aged 75 and over had a named GP. Local care homes were allocated named GPs who routinely visited to review patients and provide care and treatment. We were told that GPs were working with their allocated care homes to ensure each person had a hospital admission prevention care plan in place.

People with long-term conditions
The service made adequate provision to ensure care for people with long term conditions was safe, caring, effective, responsive and effective. Practices nurses led on management of chronic conditions, supported by GPs with special areas of interest. Patients with a chronic conditions were not tied to attending a designated clinic to manage their condition. Management was dealt with through individually timetabled appointments to monitor and review conditions.

Mothers, babies, children and young people
The service made adequate provision to ensure care for mothers, babies and young people was safe, caring, responsive and effective. Suitable arrangements were in place for safeguarding children and one GP acted as lead for the practice in this area. Expectant mothers had access to care, treatment and support from midwives and health visitors. There were regular drop in clinics for mothers and babies. The practice had consulted with their patient participation group regarding suggestions for furthering their engagement with younger people.

The working-age population and those recently retired
The service made adequate provision to ensure care for working age people and those recently retired was safe, caring, responsive and effective. The practice had extended hours which meant that appointments could be accessed at a time to suit most patients. Repeat prescriptions and routine appointments could be arranged using the practice website. The practice ran a virtual patient participation group who corresponded electronically. This avoided the need to attend meetings and meant that working people could readily participate.

Summary of findings

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

There was adequate provision to ensure care for people in vulnerable circumstances who may have poor access to primary care was safe, caring, responsive and effective. The practice had effective procedures in place with regard to safeguarding vulnerable adults. All staff had received training and one GP acted as lead for the practice. There were effective systems in place to support temporary residents visiting the area with care and treatment when it was required. Patients with dementia were allocated a named GP. The practice maintained a carer's register and one of the nurses managed a learning disability group.

People experiencing poor mental health

The service made adequate provision to ensure that care for people experiencing a mental health problem was safe, caring, responsive and effective. The practice's consent policy provided clear guidance and instruction for staff on meeting the legal requirements where a patient lacked capacity to consent.

Summary of findings

What people who use the service say

Before we visited the practice we spoke with five members of the Patient Participation Group by telephone. On the day of our inspection we received one completed CQC comment card and spoke with thirteen patients visiting the practice. We spoke with men and women from different age groups including patients with experience of bringing children to the practice. The patients we talked with had been registered with the practice for varying lengths of time and had varying contact with it.

The patients we spoke with were very complimentary about the care provided by the service. Patients described staff as polite and caring. They told us they were treated with dignity and respect. Patients told us of their confidence in clinical staff and contentment with their consultations. They said they were not rushed during their appointments and felt involved in their treatment and care. Patients spoke positively about their ability to access the services available.

Responses to a patient opinion survey carried out by the practice in November 2013 showed clearly the majority were very satisfied with many of the services provided, including ease of access and their overall appointment experience.

Areas for improvement

Action the service SHOULD take to improve

- Staff used a specialist clinical electronic system called INRstar to help them control and manage the care and treatment of anticoagulation patients. The software package was not currently large enough to enable them to include the records of all patients requiring anticoagulants on the electronic system. Staff only had access to the INRstar electronic system in some of the treatment rooms. This meant that staff were not always able to update a patient's records immediately after their consultation.
- In the dispensary we found the practice carried out some tasks manually which was labour intensive as they could have been completed electronically. Arrangements for handling dispensing error reports with individual members of staff were informal which meant that there were no records to show that actions had been planned and completed. The practice did not have arrangements in place to ensure medicines remained at the correct temperature whilst they were being transported from the practice to patients' homes. There was no standard operating procedure in relation to handling of methotrexate injections. There was no system in place to audit the stock of blank prescription pads the practice held.
- Some references and contact details contained within practice policies and procedures were out of date. For example, some policies contained references to PCTs which are now obsolete. Periodic checks and inspections carried out in line with the Infection Prevention & Control Policy were not recorded to evidence their completion. There were no practice policies in relation to Equality & Diversity, and Privacy & Dignity.
- The practice did not have systems in place to ensure that proof of identity, including a recent photograph, were obtained for all staff recruited in the future.
- There was no follow up process to check agreed actions from significant event meetings had been completed.

Outstanding practice

Our inspection team highlighted the following areas of good practice:

The patient population for the practice covered a wide geographical area. GPs told us they tried to prevent excess travelling for patients by linking an individuals appointments and services on the same day wherever possible. Patients we spoke with confirmed this to be the case. One person gave an example of reception staff working with them to schedule appointments round bus arrival times as they travelled from an outlying area.

Great Eccleston Health Centre

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, a practice manager, a pharmacist and an expert by experience.

Background to Great Eccleston Health Centre

Great Eccleston Health Centre is part of the Greater Preston Clinical Commissioning Group (CCG). This CCG comprises of 35 practices. Great Eccleston Health Centre is one of a few rural practice locations within the CCG and is approximately 13 miles from Preston centre. There were 7403 patients registered at the practice as at 1 April 2014. The practice population includes a significantly lower number (18%) of people under the age of 18, and a significantly higher number (25%) of people over the age of 65, in comparison with the national and CCG average. There are comparatively low levels of deprivation in the practice area.

Great Eccleston Health Centre is a training practice for doctors who wish to become GPs. At the time of our inspection there was GP trainee attached to the practice. Four of the five GP partners are qualified trainers. Working alongside the GPs are five practice nurses, a healthcare assistant, a practice manager and deputy, and a reception and administration team. The practice is a dispensing practice. The dispensary is run by a pharmacist superintendent who is supported by a pharmacist and a team of dispensing managers.

Surgery opening times are between 8am and 1pm, and from 2pm until 6pm on weekdays. On Mondays the surgery remains open until 7pm. There is a Saturday morning surgery from 8.30am until 12noon for emergencies. An out of hours service is provided by the Preston Primary Care Centre.

Why we carried out this inspection

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

How we carried out this inspection

Before the inspection, we reviewed a range of information we held about the practice, together with information the practice had submitted. We also asked other organisations to share what they knew about the practice. We held a listening event and placed CQC comment cards in the practice inviting patients and members of the public to share their views and experiences. We received one

Detailed findings

completed comment card. We spoke by telephone with five members of the practice Patient Participation Group. The information reviewed did not highlight any areas of risk across the five key question areas.

We carried out an announced inspection on 8 July 2014 and spent a total of eight and a half hours at the practice. During our inspection we spoke with a range of staff including the practice manager, GPs, pharmacy superintendant, practice nurses, healthcare assistant, reception and administration staff. We spoke with 13 patients who were using services on the day of our inspection. We observed how people were cared for and we examined practice policies and procedures.

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Are services safe?

Our findings

Overall the service was safe. There were systems in place to monitor the safety of patient care and plans to respond to unforeseen emergencies. The practice had policies and procedures regarding safeguarding children and vulnerable adults which provided guidance and instruction to staff. Treatment was provided in an environment which was visibly clean and well maintained. There were systems in place to protect patients against the risks associated with unsafe use and management of medicines. There was an effective recruitment procedure and staff were supported by a programme of training. There were some aspects of medicines management within the practice that could be improved.

Safe patient care

The practice had systems in place to monitor safety of patient care. Information from data sources we reviewed indicated the practice had a good record for maintaining patient safety. The practice manager was aware of their responsibility to notify the CQC about certain events. For example, if there was an occurrence that would seriously reduce the practice's ability to provide care.

Arrangements were in place to identify patients who required annual review of their medicines to ensure their treatment continued to be safe and effective.

Care and treatment was provided in an environment that was well maintained. Appropriate contracts were in place for maintenance of the equipment and building. Fire alarms and extinguishers were placed throughout the building and checks were in date. Fire exits were well signposted and free from any hazards to prevent escape in an emergency.

Learning from incidents

The practice had an effective system in place for recording and reviewing significant events. This helped ensure any learning was extracted and the practice maintained a regime of continuous improvement. We were shown minutes of Significant Event Analysis (SEA) meetings where such issues had been discussed.

The practice had systems to promptly manage national patient safety alerts in order to protect patients. The practice manager reviewed all incoming alerts. Concerns related to medicines were directed to the pharmacy superintendent in the dispensary and those related to clinical issues were dealt with by GPs. We discussed a recent medicines alert with the pharmacy superintendent and found appropriate action had been taken.

Safeguarding

The practice had policies in place regarding safeguarding vulnerable adults and children. Signs were displayed around the practice to remind staff of their responsibilities, the referral process and telephone numbers they should use to contact other agencies. All staff completed training on safeguarding vulnerable adults and children annually. The staff mandatory training log showed that safeguarding training was up to date. Trainee GPs who worked at the practice received regular training on safeguarding and child protection as part of their placement.

One of the partner GPs acted as the safeguarding lead for the practice and liaised with the local safeguarding board over any issues. The provider had an effective system for identifying child patients who may be considered vulnerable as identified by the Local Authority. The GPs were able to access this information from their computers during consultation and could then feed back any relevant information to the Local Authority should it relate to safeguarding that child.

Notices were displayed in the practice advising patients they could have a chaperone present during their consultation if they wished. There was a chaperone policy which provided guidance and instruction to staff on carrying out this role. We were told that, wherever possible, a patient requesting a chaperone would be supported by a member of the clinical team.

Monitoring safety and responding to risk

We were told that after morning surgery each day the GP partners had an informal meeting. This provided a forum to update each other on current patient issues, for example, to discuss discharge from hospital and seriously ill patients. There were regular meetings of all clinical staff to discuss clinical issues and to ensure best practice guidance had been utilised.

There were no vacancies at the practice at the time of our inspection. Many staff worked part time hours and had a mix of skills which enabled the practice to respond to unexpected absence using the regular staff team.

Are services safe?

Medicines management

The practice had effective standard operating procedures for all aspects of medicines handling, with the exception of methotrexate injections. These were recently reviewed and accessible to all staff. A pharmacist was employed to manage the dispensary and provide prescribing support to practice staff. Staff who dispensed medicines were trained and received an annual appraisal. All dispensed medicines were double checked by a pharmacist or a technician who held the appropriate qualification for the task. The pharmacist audited dispensing errors and reviewed the results with individual dispensing staff. However, there was no evidence to show individual action plans had been formulated with staff to reduce errors.

In the dispensary we found the practice carried out some tasks manually that could have been completed electronically to make them less labour intensive.

Arrangements were in place to manage repeat prescribing systems safely. Prescriptions were checked and signed by GPs before medicines were dispensed and issued to patients. Changes to patients' medicines records, such as following discharge from hospital, were made by GPs to ensure that changes were appropriate and correct.

The monitoring and prescribing of the blood thinning medicine Warfarin was well managed. Staff who ran the warfarin clinic were knowledgeable and had received training in the task. They were assisted in this task by a computer programme. The programme had reached its capacity for the number of patients it could handle so records for some patients were not available on the system. The programme was also not available in each consulting room and some records had to be updated retrospectively so were not always up to date.

Supplies of emergency drugs were available on site to respond to medical emergencies such as the collapse of a patient or anaphylaxis (a severe reaction of sensitivity). We saw that supplies were stored appropriately and in date.

Medicines were stored appropriately, including in refrigerators where this was necessary to ensure they remained effective. Arrangements were in place to manage controlled drugs safely. Prescription pads were locked away but there was no audit trail in place to monitor them.

There were arrangements in place for the delivery of medicines to patients' homes. Patients, or their representatives, were required to sign for delivery of medicines to reduce the risk of medicines being delivered to the wrong person or being diverted. At the time of our inspection the practice did not have a system to ensure that medicines requiring cold storage remained at the correct temperature during transportation. The pharmacist told us this was currently under review.

Cleanliness and infection control

We looked at consulting rooms, treatment rooms, the waiting area and other areas of the practice. They appeared visibly clean, tidy and uncluttered throughout. An external cleaning company was contracted to service the practice on a daily basis. A supervisor at the cleaning company carried out monthly audits to monitor their performance. The practice manager was supplied with a copy and relied on it as assurance.

One of the GPs acted as the lead on infection prevention and control. The lead nurse provided annual training for all staff and monitored procedures on an on-going basis. There was a comprehensive policy in place regarding infection prevention and control providing guidance and instruction to staff and procedures to be followed. This included consideration of matters such as clinical waste management, hand-washing and dealing with spillage of blood and bodily fluids. The policy referred to periodic checks and inspections that were to be carried out by designated members of staff to ensure the policy was adhered to. We found that not all checks were being documented.

We saw there were measures in place to prevent and control infection. For example, there were hand-wash sinks in treatment and consulting rooms. Treatment couches were lined with disposable paper roll which could easily be changed between patients. Supplies of disposable personal protective equipment such as gloves and aprons were available. Separate colour coded cleaning equipment was used for clinical and non-clinical areas. In the treatment and minor operations room the floor was covered with an easy clean surface. The practice had systems in place to segregate and dispose of clinical and non-clinical waste. Dedicated spillage kits were available in the treatment rooms to enable staff to appropriately deal with any spillage of bodily fluids. In treatment and consultation rooms there were posters displayed reminding staff of procedures to be followed, for example,

Are services safe?

in the event of spillage and for disposal of used needles. Throughout the practice there were supplies of antibacterial hand gel available and posters displayed to remind people on the importance of hand hygiene.

Staffing and recruitment

The practice had an up to date recruitment policy. We looked at the recruitment records of six members of staff. The sample included clinical and non-clinical members of the team. Staffing within the practice was static and most staff had been employed a number of years. We looked at the files of those most recently employed. We saw there were effective recruitment procedures to ensure staff employed had the skill and experience necessary for their roles and responsibilities. Pre employment checks were made with the Disclosure and Barring Services (DBS) to ensure that members of staff were of good character. The DBS was formed in December 2012 when the Criminal Records Bureau and Independent Safeguarding Authority merged. References were requested and followed up. The practice made enquiries to establish that people were physically and mentally fit for the work.

We noted there was not always proof of identity on staff files. The practice manager assured us this would be addressed in future.

Dealing with Emergencies

There was a business continuity plan which set out procedures to be followed in the event of an emergency that might stop the routine function of the practice. The plan was comprehensive but in need of some amendment to bring it up to date, for example, to contact details.

All staff received annual training in life support. Training records showed that non clinical staff completed this to a basic level and clinical staff to an advanced level.

The practice carried out regular fire drills and administration staff checked the alarm system on a weekly basis.

Equipment

A supply of oxygen was available on site to respond to medical emergencies. We saw that it was stored appropriately and in date.

We saw records and certificates showing equipment was tested and serviced properly through a planned annual maintenance programme. For example, we saw evidence external contractors had carried out portable appliance testing, equipment calibration and fire extinguisher checks. Administration staff carried out weekly tests of the fire alarms and there were regular fire drills. Staff tested the refrigerators used to stored medicines on a daily basis to ensure the temperature remained appropriate. Supplies of medical gases such as oxygen and liquid nitrogen were managed by an external contractor.

Are services effective?

(for example, treatment is effective)

Our findings

The service was effective. Care and treatment was delivered in line with current best practice. Systems were in place to manage, monitor and review care and treatment to ensure it consistently met patients' needs. Referrals to secondary care were timely. The practice actively promoted health and prevention, and worked with a range of other healthcare professionals to meet patients' needs. Processes were in place to monitor and support staff performance in carrying out their roles.

Promoting best practice

Great Eccleston Health Centre had a stable experienced team of GP partners who were actively involved in the training and appraisal of others. One partner was the training coordinator for the Greater Preston Clinical Commissioning Group (CCG). Some of the partners had areas of special interest in which they acted as lead for the practice. For example dermatology, minor surgery, cancer care and women's health.

Clinical staff and a trainee GP we spoke with told us they felt their clinical supervision and training was excellent. Staff followed clinical guidance from the National Institute for Health and Care Excellence (NICE). Clinical staff benefitted from peer review by colleagues in house and through arrangements to work cooperatively with another rural practice in the CCG to ensure recognised guidance, standards and best practice were followed.

Management, monitoring and improving outcomes for people

The practice carried out routine reviews of care and treatment through comprehensive clinical audits. Audits had been completed across a wide range of areas including: minor surgery, prescribing, chronic kidney disease, contraception, nurse triage, management of deaths, hypertension, asthma and data recording.

Two of the practice nurses led on management of chronic conditions. They were able to draw on support from GPs knowledge in their specialist areas where required. For example, one GP specialised in diabetes. Patients with a chronic condition were not tied down to having to attend a designated clinic to manage their condition. Management was dealt with through individually timetabled appointments to monitor and review conditions.

Staffing

We found staff joining the practice received a comprehensive role specific induction which was fully documented and signed by the staff member and their mentor. The induction covered a wide range generic topics such as practice policies and procedures.

All staff were required to complete mandatory training in basic life support, information governance, safeguarding vulnerable adults and children, and fire awareness. The practice arranged annual refresher training for staff in these subjects to ensure their knowledge remained up to date. A well managed educational programme was in place which provided staff with access to additional training relevant to their role. A record of completed training was maintained on each individual's file. The practice nurses played a leading role in the management of chronic conditions and had additional specialist training to enable them to do so.

At the time of our inspection there was a trainee GP working at the practice. Four partners were qualified as trainers. We spoke with the trainee GP who told us they were well supported and all GPs were willing to help and facilitate their learning. They spoke very positively about their experience and described the clinical supervision they received as excellent.

We saw from a review of staff files that annual appraisals were completed for all nursing, healthcare and administrative staff. Appraisals were completed with the person's line manager and included: the individual's review of their own performance, feedback from the line manager, and planning for future development. Staff were given the opportunity to comment on their progress and training needs for the coming year. We saw evidence that where training needs were identified they were acted upon.

GPs must meet the requirements of the national GP revalidation scheme operated by their governing body, the General Medical Council. Revalidation is the process by which doctors demonstrate they are up to date and fit to practice. As part of the revalidation process GPs must have annual appraisals carried out by approved GP appraisers. We found that revalidation arrangements for GPs working at the practice were timetabled and well managed. Two of the GPs at the practice were approved appraisers under the scheme and carried out revalidation appraisals of GPs at other practices.

Are services effective?

(for example, treatment is effective)

Working with other services

A range of healthcare practitioners visited the practice on a regular basis. These included podiatrists, district nurses, community psychiatric nurses, health visitors and counsellors. GPs were able to refer their patients to clinics held on the premises.

There were systems in place to deal with incoming post. The administration team prioritised scanning, coding and distribution of incoming daily post on receipt to it was available for review by clinicians at the earliest opportunity.

The practice had systems to follow up on urgent patient referrals to secondary care. All referrals were made to the central referral management centre at the health board and allocated to the appropriate hospital from there.

The practice benefitted from an in house pharmacy which stocked a range of goods for sale including over the counter medicines, health care, dental and hygiene products. The pharmacy provided a 'medicines use review' service by appointment whereby the pharmacist could provide information about medication and confirm patients were taking the correctly. Patients were able to use the in house pharmacy to obtain their prescriptions if they wished and a home delivery service was available.

The practice website signposted patients to other healthcare services in the locality, for example, opticians, chemists, dentists and local hospitals.

When the practice was closed an out of hours service was available through the Preston Primary Care Centre. Information about the service and contact details were displayed in the practice, published on the website and included in the practice patient information leaflet.

There were three care homes in the locality which accommodated 50, 20 and 12 people respectively. People living at the homes used the services of the practice. Each home had a nominated lead GP. who routinely visited the home weekly or fortnightly to see their patients to ensure the care homes had good continuity of care.

Health, promotion and prevention

New patients joining the practice were asked to complete a health and wellbeing questionnaire. We noted patients were asked about matters such as their medical history, current medication, allergies, chronic conditions and family history. Information about social and lifestyle issues such as smoking, alcohol use and carer support was also requested to inform the practice of the needs of its patients.

The practice offered a range of services aimed at health promotion and prevention. Examples included men and women's health checks, dietary advice and smoking cessation. Patients aged over 75, and those with complex needs such as cancer and dementia, were allocated a lead GP.

A wide range of information was available to patients. There were several noticeboards which displayed information on various health and well being topics. The practice website was also a source of information. We saw there was general guidance available to promote good health, together with information about specific conditions and signposts to support organisations.

Are services caring?

Our findings

The service was caring. Responses received from the patient opinion survey carried out by the practice were positive. Most of the patients we spoke with as part of our inspection were very complimentary about the service and described staff as polite and caring. Patients confirmed their consent was obtained before examinations were conducted. They confirmed they were treated with dignity and respect. Patients felt involved in decisions about their care and treatment was fully explained to them.

Respect, dignity, compassion and empathy

Most of the patients we spoke with described staff as polite and caring. This was consistent with our observations on the day. In the last patient opinion survey over 95% of patients felt their greeting at reception was good or excellent.

In the survey 94% of patients had rated the outcome of their consultation as good or excellent. Almost 70% had indicated that they found staff on the prescription line very helpful. Patients we spoke with told us of their confidence in the GPs and contentment with their consultations. Patients told us they did not feel rushed during their appointment and felt able to explain their problem, receiving good explanations back from GPs about diagnosis, treatment and rationale. Most patients spoke equally positively about nursing staff although two mentioned that on occasion they felt they had been dealt with in an 'abrupt' or 'sharp' manner. Patients told us they thought the triage and appointment system was very effective and expressed confidence in the nursing staff dealing with triage. One patient told us of their experience of bringing children to the practice. They said the GP had been very good with their children, always looking at and engaging with them during consultation, their children had appreciated this.

There was a line on the floor in front of reception and people were asked to stand behind this whilst waiting to give privacy to the patient being seen at the desk. Patients were able to request to speak with a member of reception staff in private if they preferred to do so. All but one of the treatment and consultations rooms had privacy curtains around the couch. A nurse explained that when a curtain was not available they left the room whilst a patient was changing.

The website contained pages of information to guide patients who had experienced a bereavement on how to obtain a death certificate.

Involvement in decisions and consent

Staff followed the requirements of the Mental Capacity Act 2005. Clinical staff knew how to make 'best interests' decisions for people who lacked capacity. GPs told us that in many cases they had longstanding relationships with their patients and good knowledge of their families as well which helped them to confidently make such decisions when they were required to do so.

Staff followed the requirements of the Children Act 1989 and 2004. Gillick competency assessments of children and young people were an integral part of clinical staff practices. Gillick competency assessments check whether children and young people have the maturity to make decisions about their treatment.

A policy was in place regarding patient consent to care and treatment detailing the circumstances in which it would be appropriate to act upon a patient's implied, verbal or written consent to care and treatment. The circumstances in which the practice required written consent included procedures carrying a degree of risk, such as minor surgery. Patients were asked to complete and sign forms to document their consent. These were then scanned into the computer system as a record. We found that clinical staff sought appropriate approval for treatments such as vaccinations from children's legal guardians.

Patients we spoke with confirmed their consent was always obtained before any examinations were conducted. They confirmed they were involved in decisions about their care and their treatment had been fully explained to them. This demonstrated a commitment to supporting patients to make informed choices about their care and treatment by using prompts or language appropriate to their understanding.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The service was responsive. Patients had opportunities to give feedback about the service they received and there was a well established patient participation group (PPG). The practice had a clear complaints policy and responded appropriately to any complaints received. A good range of services were available in house to meet the needs of the patient population and manage chronic conditions. Responses to the patient opinion survey carried out by the practice showed that the clear majority were very satisfied with many of the services provided.

Responding to and meeting people's needs

The practice had a good understanding of the demographics of people in the area it provided services to. One of the GPs acted as lead with regard to communications with the Clinical Commissioning Group (CCG), reviewing and disseminating all incoming information appropriately. An effective communication system was in place between the practice and its commissioners, contributing to implementing changes in patient care when appropriate.

The practice was level throughout with corridors and doorways sufficiently wide to allow access for wheelchairs and prams. We saw the patient participation group (PPG) had raised a concern with the practice about accessibility for patients through double doors leading from the waiting area to the clinical rooms. These were fire doors and considered difficult to manage for people using sticks or crutches. The practice's action plan included researching the feasibility of using magnet catches on the doors to address this. There were dedicated toilets for disabled patients and baby change facilities were available. There was some parking including disabled spaces on site. Patient feedback suggested there was not as much as they would like but the provider had done their best to maximise the available space.

Patients could book in for an appointment using an electronic touch screen monitor or by notifying staff at the desk. There was an adequate supply of seating in the reception area for patients whilst they waited. One member of the PPG we spoke with told us that the practice had recently met the groups' request for some chairs in the waiting area with arms for ease of use by those patients with reduced mobility. Supplies of reading material were available, including children's books. The reception was fitted with an induction loop system, offering assistance for patients who were hard of hearing.

The practice offered a good range of services in house to meet the needs of the patient population including the management of chronic conditions. For example, asthma, coronary heart disease, diabetes, blood tests, wound care management, well baby and child development clinics, vaccinations and travel immunisations. Several of the GPs had areas of special interest such as care of the cancer patient, child and family health, diabetes, minor surgery and dermatology.

Where patient referrals to secondary care were categorised as urgent the provider received a fax notification to acknowledge receipt. Secondary care is healthcare provided by hospital clinicians. One of the GPs maintained a log of urgent referrals and checked them off as confirmation of receipt by the hospital was received. Where referrals were non urgent patients were given a leaflet with instruction on following up their referral if they needed to and contact telephone numbers to enable them do so.

The practice computer system enabled staff to place an alert on the records of patients who had particular difficulties so the GP could make adjustments. For example, carer support, learning or hearing difficulties.

The information we reviewed prior to inspection suggested the practice was an outlier in relation to other practices in the CCG with higher levels of Cephalosporins and Quinolones being prescribed. These are both forms of high impact antibiotics. GPs provided an explanation and rationale which demonstrated understanding of the patient demographic group and commitment to providing high quality treatment and care. They explained that in their experience the predominantly elderly patient population had a reluctance to return to the practice for review if a condition persisted. Use of high impact antibiotics in the first instance was the most effective way to manage their conditions.

There were several camping sites in the locality. Staff told us they regularly received requests to register temporary patients. Information was available in the practice and on the website explaining this facility. Staff described the process they followed when registering a temporary resident which included liaison with their usual practice.

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

The practice held a number of appointments open on a daily basis to accommodate emergencies. Patients were requested to telephone between 8.00am and 9.30am if they required an urgent or same day appointment. The nurses operated a triage system to direct these requests to the most appropriate healthcare professional to deal with them. Patients were able to speak with a GP directly by prior arrangement. If they telephoned before 11.00am a GP would return their call after morning surgery. Home visits could be arranged for patients who were housebound or too ill to visit the practice.

There were several telephone lines into the surgery so calls could be taken consecutively to minimise waiting time. Patients were also able to make routine appointments using a booking facility on the practice website.

Patients we spoke with told us they were able to get through to the practice by telephone without difficulty. They reported that they received prompt return calls from a nurse or GP as appropriate. Patients said they were able to get urgent and same day appointment where necessary. The waiting time for a non urgent appointment was approximately two to three weeks. Patients were able to request an appointment with a GP of their choice if they so wished but this could increase the delay in appointment availability.

Each year the practice carried out a survey of patient opinion. This included asking patients to rate the ease with which they could access the surgery and book appointments at suitable dates and times. Patients were also asked to rate certain aspects of their surgery experience, including how long they waited to see a doctor. The last survey was completed in November 2013 when responses were received from 183 patients and analysed by the NHS Lancashire Commissioning Support Unit.

The report concluded that overall the results were very positive. Few patients felt they had a poor experience and the clear majority were very satisfied with many aspects of the services provided by the practice. The wait before seeing a GP and the ease with which appointments could be booked, especially to see a GP of choice came in for some criticism but dissatisfaction levels continued to be low as compared with the previous survey in 2012. Eighty five percent of respondents had rated the ease with which they could access the surgery as good or excellent. Patients rated ability to make an appointment at a suitable time and date as good or excellent in the percentages of 74% and 60% respectively. Seventy three percent rated the time they waited in surgery to see a doctor as good or excellent.

The survey results were typical of the feedback we received from patients we spoke with as part of our inspection.

Concerns and complaints

Leaflets were available in the waiting area which explained how people could comment or complain about the practice. Information was also posted on the website. The practice had a comprehensive complaints policy and procedure in place. One of the GPs led on handling any clinical complaints received, whilst the practice manager responded to any non clinical concerns. The provider maintained a log of complaints received and categorised the nature of them so they were able to easily identify any developing themes.

We reviewed the complaints log and found complaints were managed appropriately and within expected time frames. Actions were identified and described to the complainant in the response. In the first instance the practice tried to resolve matters internally. Patients were advised if they remained dissatisfied with the outcome after internal investigation they had the right to refer the matter onwards to the Parliamentary and Health Services Ombudsman. The contact details they would need to do so were provided. Information about independent advocacy and support agencies that might provide a patient with support in making a complaint was also available.

Are services well-led?

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

Our findings

The service was well led. There was a well established management structure with a clear allocation of responsibilities. Leadership of the practice was visible and accessible. The practice was committed to learning from problems, complaints and incidents and staff shared this commitment. There were regular forums to update staff on issues relevant to the service, and for them to make suggestions and express opinion. The practice actively sought feedback from patients on the service they received.

Leadership and culture

Staff told us the leadership of the practice was visible and accessible. They knew who to contact for specific advice and support. Staff expressed confidence that they would get help if they required it. They told us there was an open culture and sharing of information and learning was encouraged.

Staff had contracts of employment and job descriptions which clearly set out their role and responsibilities. New staff benefitted from a comprehensive induction programme. All staff were supported by annual appraisal and opportunities for continued learning and development. Staff described colleagues as supportive and expressed views indicating it was a happy and cohesive team.

The practice was committed to learning from problems, complaints and incidents and staff shared this commitment. There was a culture within the practice of striving to provide quality care and promote good health outcomes for patients. Staff and patient participation group (PPG) representatives we spoke with expressed confidence that their views were listened to and valued by the management team.

Governance arrangements

There was a well established management structure with a clear allocation of responsibilities. One of the GPs acted as governance lead for the practice. They engaged with the local Clinical Commissioning Group (CCG) as required to discuss performance issues and how to adapt the practice to meet demands of local people. GPs described a democratic approach to partnership. Each partner had their own areas of responsibility in which they led the practice.

The partners held an annual strategy meeting and monthly partners meetings throughout the year.

All members of staff received training on information governance and signed a confidentiality agreement when they joined the practice. The practice had arrangements in place with an external contractor for shredding and disposal of confidential waste. The practice did not operate a clear desk policy but the practice manager told us the staff who worked for the external cleaning company that serviced the practice also had to sign a confidentiality agreement.

Systems to monitor and improve quality and improvement

The practice carried out a wide range of clinical audits. Results were reviewed and analysed to ensure the assessment, care and treatment provided by the clinical team was in line with recognised guidance, standards and best practice.

The practice participated in the Quality and Outcomes Framework (QOF) which is a system for performance management and payment of GPs. Participation is voluntary and one of the benefits of the QOF system is that it enables individual practices to identify and prioritise practice developments.

GPs followed the appraisal and revalidation requirements of their governing body, the General Medical Council. Trainee GPs were supported by four experienced GP partners who were qualified trainers. Clinical staff benefitted from an appraisal by their line manager and peer review by colleagues in house. Non clinical staff had annual appraisals with their line manager. The practice had arrangements in place to work cooperatively with their peers at another rural practice in the CCG to ensure recognised guidance, standards and best practice were followed.

Patient experience and involvement

The practice had an established virtual patient participation group (PPG) comprising 25 members. Group membership was predominantly female. Four percent of members were aged 0-20 years and 8% 21-40 years. The age brackets 41-60 years and over 61 accounted for 44% of membership each.

Practice policy stated there would be regular consultation with the PPG regarding incidents and service delivery. The practice consulted with the PPG before the annual survey

Are services well-led?

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

to determine what questions should be asked and what the key priorities should be in looking at the services they provided. Results of the patient survey were shared with the PPG for comment and feedback before publication. The practice produced an action plan to address the issues raised. Responsibility for particular actions was allocated to named individuals and time frames for completion were set. One of the actions identified in order to improve performance in keeping patients waiting when a surgery was running late was to display a poster in reception asking patients to alert reception if they had been waiting longer than 15 minutes. We saw that this had been done.

The practice website and patient leaflet encouraged people to provide suggestions and feedback on the service.

Staff engagement and involvement

There were regular team meetings for clinical and non-clinical staff. These provided a forum to update staff on issues relevant to the service, and for them to make suggestions and express opinions. They also provided a formal route to ensure staff received feedback on learning from incidents that had occurred.

The provider had a whistleblowing policy in place. Whistleblowing is defined as the disclosure by an employee of confidential information, which relates to some danger, fraud or other illegal or unethical conduct connected within the workplace, be it of the employer or a fellow employee. The policy provided guidance and instruction on how to raise a concern and the action that should be taken to investigate it. Staff we spoke with confirmed their awareness and understanding of the procedures.

Learning and improvement

Staff spoke positively about their opportunities for training and development. In addition to in house training sessions staff had opportunity to attend external training sessions provided by the CCG.

The practice held periodic Significant Event Analysis (SEA) meetings for the purpose of improving the service that was delivered. The meetings included consideration of any complaints that had been received. We looked at the minutes of SEA meetings. Staff analysed any incidents that had occurred and discussed whether there was anything that could have been done differently by the practice. All were encouraged to comment on the incidents. Lessons learned were shared with staff not present through team meetings.

All staff were invited to attend SEA meetings and had the opportunity contribute and make suggestions. Staff used root cause analysis and incident review to fully explore the events leading up to an incident. Minutes of meetings were circulated to all staff and stored on the shared drive to ensure learning was shared across the practice. There was no follow up process to check agreed actions from some significant event meetings had been completed.

Identification and management of risk

The practice had a number of policies and procedures in place to support staff in their role and provide guidance on how to identify and manage risk. Staff told us they felt confident about raising any issues and felt if incidents did occur they would be investigated and dealt with appropriately. Regular partner, management and team meetings provided a formal structure for issues to be raised and discussed.

The practice manager described arrangements for review and monitoring several aspects of the service. Not all the quality assurance and risk management measures that we would expect to see were evidenced by documentation. For example, quarterly infection control audits as referred to in the practice policy. There was no documentary evidence to reflect the procedure carried out to prepare the minor surgery room or clean equipment such as the spirometers had been completed. A spirometer is a machine that patients may be asked to breath into. Results can help diagnose various lung conditions. Significant events were appropriately recorded and reviewed. Learning points were identified and actions to address them formulated.