Dr Pulloori Jagadesham

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected the practice of Dr Pulloori Jagdesham on 4 November 2014. The inspection was scheduled as part of our new comprehensive inspection programme and was announced to the practice.

The practice was rated as good overall.

Our key findings were as follows:

- The practice was rated as good for safe. All staff understand and fulfil their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal incidents are maximised to support improvement.
- The practice was rated as good for effective. The practice completed thorough assessment of patients' needs. There were good systems in place to ensure care and treatment was regularly reviewed and continued to be effective.
- The practice was rated as outstanding for caring. We observed a patient centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Patients reported high levels of satisfaction with the way in which they were listened to and involved in planning for their care and treatment.
- The practice was rated as good for responsive. Patients reported good access to the practice and continuity of care.
- The practice was rated as good for well led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. We found a high level of staff satisfaction.

We saw several areas of outstanding practice including:

- The practice approach to anticipating and managing risks to people who use the service. Staff began to plan

Summary of findings

for the impact of the Christmas period in November by contacting potentially vulnerable patients to check on their well-being and ensure they had all necessary medication prior to the Christmas break.

- The approach staff took to ensure patients were treated with respect, dignity, compassion and empathy. We heard examples of particularly caring practice including offering hot drinks and biscuits to patients who had attended for fasting blood tests before they left the surgery.
- The support offered to patients to help them cope emotionally with care and treatment. Feedback from patients consistently showed they felt well supported by the practice and that staff took a real interest in their general well-being.

In addition the provider should:

- Record completion of cleaning tasks to evidence continuity. Review the existing policy on infection prevention and control to ensure it is up to date and reflects best practice.

Review the existing practice business continuity policy to ensure the content remains accurate and up to date.

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. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated to the staff team to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Patients' needs were assessed and care was planned and delivered in line with current legislation. This includes promotion of good health. Staff received training appropriate to their roles and further training needs have been identified and planned. The practice had systems in place for appraisal and personal development of staff. The practice worked with other service providers to meet patient's needs and manage complex cases.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services. Data showed patients rated the practice higher than others for almost all aspects of care. We saw a patient centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Patients reported high levels of satisfaction with the way in which they were listened to and involved in planning for their care and treatment.

We noted staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice's chaperone policy included guidance and instruction for staff including cultural, religious, mental health and ethnicity issues.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had a proactive approach to understanding and meeting the needs of different groups of patients, including those who were in vulnerable circumstances or had complex needs. Patients reported good access to the practice and continuity of care. The practice operated a drop in system for consultations which enabled patients to see their GP on the same day and in a timely manner.

Summary of findings

Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. We found a high level of staff satisfaction. The practice had a number of policies and procedures to govern activity and regular governance meetings took place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from patients and staff and acted upon it.

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

Good

The practice is rated good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments though the drop in system.

People with long term conditions

Good

The practice is rated good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. Longer than average appointments and home visits were available when needed. The practice had systems in place to ensure patients had structured annual reviews to check their health and medication needs were being met.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following up children who were at risk. Immunisation rates were relatively high for standard childhood vaccinations and robust systems were in place to follow up on any non-attendance. Patients told us that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students, had been identified and the practice offered services that were accessible, flexible and offered continuity of care. A range of health promotion and screening services which reflected the needs of this age group were available.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. Systems were in

Summary of findings

place to identify any patients who lived in vulnerable circumstances and ensure annual health checks were offered and any non-attendance followed up. Longer than average appointments were available with both the GP and nurse.

The practice worked with other healthcare professionals in the case management of vulnerable people as necessary. Information was available to signpost vulnerable patients to various support groups and other professional 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 out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had received an annual physical health check. Information was available to signpost patients experiencing poor mental health to various support groups and other professional organisations.

Summary of findings

What people who use the service say

We received 50 CQC completed comment cards and spoke with four patients visiting the surgery on the day of inspection. Patients spoke positively about practice, and the care and treatment they received. We received feedback from males and females across a broad age range. This included patients who had recently joined the practice and those who had been registered for many years, patients with long term conditions such as asthma, and parents with experience of bringing children to the surgery.

Patients describe the practice as first class, effective and efficient. They told us they had good access to consultations with the GP and the nurse. They spoke highly of the drop in system the practice operated which enabled them to see the GP in a timely manner without prior appointment. Patients said they felt listened to and involved in planning their care and treatment. Their descriptions of staff included: friendly, polite, professional, helpful, caring, welcoming and brilliant. They told us they were treated with dignity and respect. Patients were complimentary about the environment and told us it was comfortable, safe, clean and hygienic.

Only three of the responses contained some negative comments. Two people said they did not always feel listened to and one person thought cleanliness in the reception area could be improved.

Areas for improvement

Action the service SHOULD take to improve

- Record completion of cleaning tasks to evidence continuity. Review the existing policy on infection prevention and control to ensure it is up to date and reflects best practice
- Review the existing practice business continuity policy to ensure the content remains accurate and up to date

Outstanding practice

- The practice approach to anticipating and managing risks to people who use the service. Staff began to plan for the impact of the Christmas period in November by contacting potentially vulnerable patients to check on their well-being and ensure they had all necessary medication prior to the Christmas break.
- The approach staff took to ensure patients were treated with respect, dignity, compassion and empathy. We heard examples of particularly caring practice including offering hot drinks and biscuits to patients who had attended for fasting blood tests before they left the surgery.
- The support offered to patients to help them cope emotionally with care and treatment. Feedback from patients consistently showed they felt well supported by the practice and that staff took a real interest in their general well-being.

Dr Pulloori Jagadesham

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The team included a GP advisor and an Expert by Experience.

Background to Dr Pulloori Jagadesham

Hollins Grove Surgery is located in Darwen and is part of the Blackburn with Darwen Clinical Commissioning Group. The total patient population is approximately 1650.

The staff team currently comprises of one male GP, a practice nurse, a practice manager and two reception staff.

The practice population includes significantly lower numbers of patients between the ages of 30 and 40 years, and over the age of 65 years, than the national average. In contrast, there is a significantly higher proportion of patients aged between 40 and 50 years. There are comparatively high levels of deprivation in the area. Information published by Public Health England rates the level of deprivation as three on a scale of one to ten. Level one represents the highest levels of deprivation and ten the lowest.

The practice is open Monday to Friday from 8.00am until 6.30pm, except on Wednesday when the hours are 8.30am until 3.00pm. The GP holds a morning surgery between 9.00am and 10.30am, and an afternoon surgery between 4.00pm and 5.30pm. No appointment is necessary during these times. Later consultations are available by appointment. The practice nurse holds surgeries between 9.00am and 5.00pm by appointment. When the practice is closed the care and treatment needs of patients are met by an out of hours provider, East Lancashire Medical Services.

The CQC intelligent monitoring placed the practice in band 5. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

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

We carried out inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This 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.

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.

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice, together with information the practice had submitted in response to our request. We also asked other organisations to share what they knew. The information reviewed did not highlight any risks across the five domain areas.

We carried out an announced visit on 4 November 2014. During our visit we spoke with the GP, practice manager, nurse, reception staff and patients visiting the surgery. We observed how people were communicated with. We reviewed CQC comment cards where patients and members of the public were invited to share their views and experiences of the service. The CQC comment cards were made available at the surgery prior to inspection.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts, comments and complaints received from patients.

Care and treatment was provided in an environment that was well maintained. Appropriate arrangements were in place with external contractors for maintenance of the building and equipment. Fire alarms and extinguishers were placed throughout the building. The fire exits were well signposted and free from hazards to prevent escape in an emergency. Alarms were tested weekly and the fire systems had been fully serviced in September 2014.

The practice manager was aware of their responsibilities to notify the CQC about certain events, such as occurrences that would seriously reduce the practice's ability to provide care.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. The records kept of significant events that had occurred were made available to us. They were comprehensively documented and we saw all members of staff knew how to record such events and the actions taken in response. Lessons learned were extracted and shared with staff through team meetings. This helped to ensure the practice maintained a regime of continuous improvement.

National patient safety alerts were reviewed by both the practice manager and the GP on receipt to ensure they were acted upon appropriately. Copies of those relevant to the practice were also posted on a noticeboard in the reception area.

Reliable safety systems and processes including safeguarding

The practice had policies in place in relation to safeguarding vulnerable adults and children. Staff were aware of them and they were readily accessible. All staff had completed safeguarding training and the GP as lead had completed this to a more advanced level 3. The practice population was small and the practice manager told us that safeguarding issues were infrequent. There had been no child protection issues reported within the last 12 months. When such issues occurred the GP led on the matter and made personal contact with the relevant agencies, for example, the local authority safeguarding team.

A notice was displayed in the waiting area advising patients they could have a chaperone present during their consultation if they wished. The practice had a chaperone policy which provided appropriate guidance and instruction to staff, including how the offer and attendance of a chaperone should be recorded in patient notes. When a chaperone was requested the role was fulfilled by either the nurse or practice manager who had been trained in this process.

Medicines management

The practice processed repeat prescriptions within one working day. Patients confirmed requests for repeat prescriptions were dealt with in a timely way. Systems were in place for reviewing and re-authorising repeat prescriptions, providing assurance that they always reflected the patients' current clinical needs. Prescription pads were stored securely and all prescriptions were signed by a GP before being given to the patient.

The practice had a procedure to ensure the GP was made aware of test results received as soon as possible, for example INR test results (anticoagulant blood tests) for patients on high risk medicines such as warfarin. This meant that timely action could be taken to respond to any abnormality detected or changes necessary. Where changes were made to a patient's medicines, for example following a stay in hospital, the records were amended by either reception or the GP. All amendments were checked against the discharge letter by the GP.

Medicines kept on the premises were stored securely. We looked at records to see if medicines requiring refrigeration had been stored appropriately. They showed that regular checks were made to ensure these medicines were held within acceptable temperature ranges and so were safe to administer. The practice had stock control measures in place to ensure that medicines remained in date. Expiry dates were monitored by the practice nurse. We found that the GPs bag was well maintained and all items viewed were in date.

The practice manager held level 3 qualification in medicines management and worked with the nurse in the management of medicine at the practice.

Good

Are services safe?

Cleanliness and infection control

The practice appeared visibly clean and tidy. There was a comprehensive cleaning schedule in place which described the tasks to be completed and the frequency with which they should be done. The schedule included instruction on how tasks should be achieved, for example, the products and equipment to be utilised on floors, high surfaces, when dealing with urine or vomit, and on pieces of equipment such as the blood pressure monitor. All cleaning duties were shared amongst the staff. There were no formal records kept to document when tasks had been completed. The practice manager explained that as both the practice and staff team were small they were able to maintain a good oversight of activity.

Staff had received training on infection prevention and control. The practice manager acknowledged they needed to review their existing policy. At the time of inspection the policy comprised of generic guidance issued by the Primary Care Trust prior to its abolition in March 2013 when their work was taken over by Clinical Commissioning Groups. We saw that this included guidance on issues such as hand wash technique, needle-stick injury, and dealing with spillage involving blood or bodily fluids. The practice manager showed us an action plan that had been prepared for the Clinical Commissioning Group in August 2014 which included development of an in house policy.

Supplies of personal protective equipment were available for staff to use, including disposable aprons gloves. There were designated kits to deal with spillage of blood should they be required. In the consultation and treatments rooms, and toilets, there were hand washing sinks with hand soap and paper hand towels. Signs promoting hand hygiene technique were displayed next to sinks and supplies of hand gel were available.

There were systems in place for collection and segregation of clinical waste. An external contractor collected the waste on a fortnightly basis. We saw that any full bags or sharps boxes were securely stored in a designated area away from the public pending collection.

Equipment

Staff told us they had sufficient equipment to enable them to carry out examinations, assessments and treatments as required. Records confirmed that equipment was tested and maintained regularly. We saw evidence that portable electrical equipment was routinely tested. Stickers were displayed on equipment indicating the last test date. The practice had a contract in place with an external provider for annual testing and maintenance of medical equipment on site, such as the blood pressure monitor.

Staffing and recruitment

The practice recruitment policy included completion of appropriate pre-employment checks. For example, proof of identification, references, qualifications, and checks with the disclosure and barring service (DBS) to ensure people were of good character. The practice had a stable team of permanent staff who had each worked there for several years, with no new staff recruited for at least six years. Appropriate checks were made when members of the existing staff team had been recruited.

The practice manager had systems in place to check that clinicians, including any locums used, maintained medical indemnity insurance and continued to hold valid registration with their relevant professional bodies, namely the General Medical Council or Nursing and Midwifery Council.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors. These included regular checks of the building, the environment, medicines management and equipment.

The practice had a health and safety policy under which named staff had responsibilities for ensuring health and safety risks were identified, assessed and managed. Substances potentially hazardous to health, such as cleaning materials, were stored securely. Two members of the staff team were appointed as first aiders.

Patients were encouraged to take responsibility for their health. The practice nurse trained patients in use of equipment to enable them to self-manage their conditions where possible. For example, blood sugar monitoring for diabetics and use of inhalers for patients with asthma.

Staff were able to identify and respond to changing risks to patients including deteriorating health or medical emergencies. Systems were in place to provide out of hours providers with regular updates in relation to patients receiving palliative care. The practice had a policy on dealing with medical emergencies to support staff in responding to such situations.

Good

Are services safe?

Rather than wait for appointments to be scheduled by the health authority, the practice initiated contact with mothers of new babies to ensure they were booked in for child vaccinations at the earliest opportunity.

The practice manager told us that each November they made contact with potentially vulnerable patients to check on their wellbeing and ensure they had all necessary medication prior to the Christmas break. For example, to check on the wellbeing of patients who suffered depression, and to ensure patients with cardiovascular obstructive pulmonary disorder (COPD) had a rescue pack of antibiotics and steroids available to them in case their condition deteriorated. There was very low usage of the out of hours service by the practice population which staff attributed to their pro-active approach. During the Christmas period 2013/14 only one patient had need to contact the out of hours service which had been in relation to a fracture and so unavoidable.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. There was a medical emergency policy in place which provided guidance and instruction to staff on responding to emergency situations. We saw records showing that staff received training in basic life support annually. Emergency equipment was available including access to oxygen and a defibrillator. Staff knew the location of the equipment and it was readily accessible. Records showed that emergency equipment was checked regularly.

Emergency medicines were available in a secure area of the practice and staff knew of their location. Processes were in place to check emergency medicines were within their expiry date and suitable for use. All the emergency medicines we checked were clearly labelled, in date and fit for use.

The practice had a business continuity plan in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were rated and mitigating actions recorded to reduce and manage the risk. We saw that further review of the business continuity plan had been included on the action plan prepared for the Clinical Commissioning Group to ensure the content continued to be up to date and appropriate.

Systems were in place to regularly test the fire alarms and equipment. Staff completed fire training annually and a further course had been booked for 13 November 2014.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidelines from the National Institute for Health and Care Excellence and from local commissioners. Monthly practice meetings provided a formal forum for sharing information with the staff team. We found from our discussions with the clinical staff that they completed thorough assessments of patients' needs and these were reviewed as appropriate. For example, the nurse actively screened patients for diabetes.

There were systems in place to ensure referrals to secondary care (hospitals) were made in line with national standards. The patient list was small and consequently the referral rate generally low. Referrals were personally dictated by the GP then passed to staff to submit by using the choose and book system, or where urgent, an electronic fast track system. Staff followed up on each referral to ensure that it had been received, was progressed in a timely manner, and the result received back at the practice. If a patient was admitted to hospital the GP personally made contact with the hospital the following day to establish the condition of the patient.

Requests for home visits were referred to the nurse for triage. The GP then attended if necessary.

Management, monitoring and improving outcomes for people

We looked at examples of some of the clinical audits carried out at the practice in the last 12 months. Clinical audits were often linked to medicines management information or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example, in September 2014 the practice had audited their prescribing for Type 2 diabetes. The GP had carried out a medication review of all patients with the condition. Operating in line with national guidelines the practice had been able to reduce their prescribing level to 12.25 which was significantly below the target set by the Clinical Commissioning Group at 21.60. Overall prescribing at the practice was lower than the national average.

There were good systems in place to ensure care and treatment was regularly reviewed to ensure it continued to be effective. All staff had key roles in monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling and medicines management.

The practice maintained lists of patients with particular conditions and vulnerabilities. Care plans were in place for all patients identified as at risk of admission to hospital. They used the electronic systems available to them to diary when patients were due for reviews and ensure they received them in a timely manner, for example, reviews of medicines and management of chronic conditions. The practice had robust systems to follow up and recall patients if they failed to attend appointments, for example, non-attendance at a child vaccination clinic. As soon as they were notified of a birth, the practice contacted new mothers to arrange the baby's vaccinations rather than incur delay in waiting for the NHS to schedule them. The staff were also proactive in acting upon ad hoc opportunities to that arose to follow up on outstanding matters with patients. For example, if a patient who was due for a review called to collect a prescription they would be encouraged to see the GP or nurse whilst they were on site.

The practice offered a range of services to meet the varied needs of the patient population. These included well man and woman checks, health checks for the over 75s, child progress checks and immunisations, hypertension reviews, and clinics for management of chronic conditions such as asthma and diabetes.

Effective staffing

Practice staffing included medical, nursing, managerial and reception staff. The team was small but there was a good mix of skills to ensure there were sufficient staff to meet patients' needs. The practice had training policies for both clinical and non-clinical staff. We reviewed staff training records and saw that staff were up to date with attending mandatory courses such as annual basic life support. The practice manager had additional qualification in medicines management, phlebotomy and as a health care assistant. One of the reception staff had additional qualification in business and administration.

The GP worked part time. Two GPs from a neighbouring practice covered the surgery on a locum basis in their absence. This included a female GP which meant the practice was able to offer consultations with a female GP by appointment if a patient requested one.

Good

Are services effective?

(for example, treatment is effective)

Each member of staff was expected to have an annual appraisal. The practice manager told us these were overdue, the previous appraisals having been completed in the first quarter of 2013. A decision had been taken to delay the 2014 appraisals until a member of staff had returned from maternity leave in August 2014 as there had been additional pressure on the staff team during their absence. The practice manager assured us that arrangements for the 2014 appraisals were planned for the near future. We looked at an example of an appraisal completed in 2013. We saw the process included identification of any learning needs and formulation of action plans to address them. The GP was up to date with their yearly continuing professional development in line with the requirements of the General Medical Council.

If a GP or nurse joined the team on a permanent or locum basis checks were made with the relevant professional body, namely the General Medical Council or Nursing and Midwifery Council, to ensure their registration was valid.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received electronically. Incoming post relating patient care and treatment was provisionally coded on the day of receipt by reception staff and passed the same day to the GP for personal review.

Systems were in place to ensure that other services were promptly notified of matters of mutual interest that impacted on patient care. For example, regular updates were sent to the out of hours service in relation to patients receiving palliative care.

The practice had recently been audited by the NHS area team in relation to vaccinations, immunisations and screening. This had identified the practice had a high uptake amongst their patient population for vaccinations and immunisations, but a low uptake for bowel and breast screening. Bowel and breast screening services were not directly within the practice's control but we saw the practice had identified actions they could take to better promote the service amongst their patient population and encourage increased take up. We noted that the practice had published information about the availability of bowel screening services on its website.

Staff were pro-active in helping patients access health care services not available on site. For example, the practice was currently unable to fit contraceptive coils and patients requiring this service were referred to a local health centre. Staff at the practice offered to contact the health centre and book an appointment for the patient whilst they were in the surgery rather than leave the patient to make the arrangements themselves.

At the time of inspection staff told us the practice had limited contact with the local district nurses as there were few patients to discuss at palliative care meetings. Increasing the level of contact was part of the practice manager's action plan and a meeting had been scheduled for later in November 2014 with a view to achieving this.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider that enabled patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals to secondary care (hospitals). The Choose and Book system enables patients to choose which hospital they will be seen in and book their own outpatient appointments in discussion with their chosen hospital. There was a fast track system for urgent referrals.

Patient records were held electronically on a widely used primary clinical care system. This was used by all staff to coordinate, document and manage patients' care. The software enabled scanned paper communications to be linked to an individual patient's records and saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. Staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in practice. It was clear that the GP was acutely aware of the need for detailed recording of consultations. We saw evidence of best practice reflected in the records of a significant event that had occurred when an unaccompanied minor had attended for consultation and been offered a chaperone.

The practice had a chaperone policy which included guidance and instruction on issues of patient consent and capacity.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

The ethos of the practice was to spend time with patients and encourage them to take ownership of their health rather than prescribing when unnecessary. Patients were assisted to access support services to help them make lifestyle improvements and manage their care and treatment. The GP told us that patients were actively encouraged to lead a full and active life with an emphasis on fresh air and exercise.

The practice had a provision of lifestyle information protocol in place. We saw that this documented the obligation on healthcare professionals to give advice, or know where to find information, on topics such as how to improve diet, reduce weight, reduce stress, improve sexual health and benefit from reduced alcohol consumption. There was a range of information available for patients in the reception area. This included information about specific conditions and general health promotion advice. There were signposts to a variety of support groups in relation to matters such as smoking cessation, teenage cancer and healthy eating. We noted that posters were displayed targeting particular age groups, for example, cervical cancer (HPV) screening for girls aged 12 to 18, bowel cancer tests for those aged 60 to 74.

New patients registering with the practice were asked to complete a health questionnaire. This included questions about medical history, current medication, carers, disability, ethnicity and lifestyle. At the time of registration each new patient was booked a health check appointment with the nurse. These were tailored to meet the needs of the patient, for example, they might include a blood pressure check, weight and lifestyle advice. The GP was informed of any health concerns so they could be promptly followed up.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey in 2013. The data showed the practice was rated amongst the best for the number of patients who would recommend their GP surgery to another, (89% of patients who responded). 100% found receptionists at the surgery helpful. 89% said the GP was good at treating them with care and concern whilst 97% said the same of the nurse. On average 98% of patients had confidence or trust in the last GP or nurse they dealt with.

The practice last completed its own annual patient questionnaire in June 2014. Fifty patients were surveyed. This included questions about treatment by the receptionists, how well the GP had listened, put patients at ease during physical examination, and shown patience in handling questions and worries. The results were overwhelmingly positive with the majority of respondents rating the practice as excellent.

Prior to inspection we asked the practice to make CQC comment cards available in the reception area inviting patients to provide us with feedback about the practice. We received 50 completed comments cards and spoke with four patients attending the practice on the day. They told us they were treated with dignity, empathy, compassion and respect. This was consistent with our observations.

We observed staff working on the reception desk. We noted staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. One of the patients we spoke with confirmed they had been able to speak with reception staff privately in a confidential space when they had sensitive issues to discuss.

Clinicians came through to the waiting area to call patients for their consultation. We observed that in doing so they greeting people in a warm, friendly and polite manner.

Consultations and treatments were carried out in the privacy of a consulting room. We noted that doors were closed during consultation and conversations could not be overheard. Doors were lockable and curtains were provided around consultation couches so that patients' privacy and dignity could be maintained during examinations.

We noted that the practice's chaperone policy included guidance and instruction for staff including cultural, religious, mental health and ethnicity issues. For example, it recognised there may be strong cultural or religious beliefs that restrict being touched by others and clearly stated that patients undergoing examinations should be able to limit the degree of nudity required.

Parents with experience of bringing children to the practice spoke positively of the experience and said staff treated the children in an age appropriate way. They told us the staff tried to engage with the children and put them at ease. The noticeboard displayed a poster advising patients that breastfeeding was welcome in the practice. Baby change facilities were available.

Through conversing with staff we heard of examples of particularly caring practice. For example, when a patient was discharged from hospital the GP would make contact and offer to visit them at home to see how they were. Patients who attended the practice for a fasting blood test were offered hot drinks and biscuits once the test had been completed before they left. We were told of a member of staff delivering a prescription to an elderly patient who lived nearby and found crossing the busy main road to reach the practice a challenge. We heard of sympathy cards being sent to patients who had been recently bereaved.

Care planning and involvement in decisions about care and treatment

In the national patient survey 2013 patients were asked whether GPs and nurses were good at involving them in their care. The results for this practice were positive. Of those patients surveyed 86% rated the GP good in this regard and 84% the nurse. Patients rated the GP (89%) and nurse (97%) as good at explaining tests and treatments to them. The results of the practice's own patient survey were consistent with these findings.

The majority of patients who completed CQC comments cards, or spoke with us on the day of inspection, told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They 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 they wished to receive. One described their relationship with the GP as open and frank. They told us both parties spoke their minds and that was something they valued. Another said the GP always took time to

understand and discuss their issues, and answer any questions they may have. All but three of the CQC comment cards we received were entirely positive about all aspects of the service received at the practice. Of the three responses that contained some negativity two patients said they did not always feel listened to.

Using a coding system on the computer system the practice maintained registers of patients with particular conditions or vulnerabilities, for example, diabetes, mental health issues and chronic obstructive pulmonary disease (lung disease). With the involvement of the patient, care plans had been put in place for anyone at increased risk of admission to hospital. Care plans were in place for patients receiving palliative care and the GP supported patients with discussion about end of life preferences as appropriate. We were told of an example where this had recently occurred when the GP visited a patient at a hospice.

Patient/carer support to cope emotionally with care and treatment

Patient information emphasised the practice strongly believed in a holistic approach to health issues. It stated the GP would try and find the best way of making patients better but they would not always be given medicine as there were other ways of treating them.

Feedback from patients consistently showed they felt well supported by the practice. Responses to the national patient survey showed that patients felt listened to, 94% by the GP and 98% by the nurse respectively. Patients told us they were not rushed during appointments and that staff took time to discuss their concerns with them. One specifically commented that staff took a real interest in their general wellbeing.

There were notices and leaflets in the waiting area that signposted people to a number of support groups and organisations. Examples included support with teenage cancer, Alzheimer's disease and epilepsy.

The GP visited families who had suffered bereavement. Staff described the purpose of the visit as caring, to express sympathy and provide the family with practical information to help them in dealing with their loss.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address them.

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

There was very little staff turnover at the practice which enabled good continuity of care. It had been over six years since any new member of staff had joined the team.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its services. We found the practice had a number of policies in place aimed at tackling inequity and promoting equality, examples included policies regarding equal opportunities and identification of carers. Staff had completed training on subjects such as equality and diversity, and domestic abuse. The computer systems enabled staff to place an alert on the records of patients who had particular difficulties so staff could make adjustments. For example, if a patient had carer support, hearing impairment or learning difficulties.

Translation services were available for patients who did not have English as a first language though staff told us there was little call for them. The practice manager described how they used a live type text service to support a patient who was hard of hearing during consultations. The patient was provided with a mobile phone and the service converted speech to text.

There was level entry to the practice from the street. It was situated on two floors with lift access between them. Reception and the nurses' treatment room were on the ground floor with the GPs consultation room on the first floor. There were adequately spacious waiting areas on each level. We noted there was a power assisted entrance door to the practice and part of the reception desk was at a lower level to facilitate access by wheelchair users. Disabled toilet facilities were available on the ground floor.

The practice manager showed us they were in the process of starting to work towards achieving a Pride in Practice charter mark. Pride in Practice is a benchmarking tool launched by the Lesbian and Gay Foundation which identifies GP surgeries that are fully committed to assuring lesbian, gay and bi-sexual patients (LGB) are treated fairly and able to discuss issues openly with healthcare providers. Surgeries use a toolkit to self-assess their service which aims to help them understand the issues faced by LGB patients and respond to their specific needs.

We noted that information available in the reception area included details of the women's aid helpline. A poster was also displayed to the rear of the toilet door with the telephone number printed on tear off slips enabling patients to take the details discreetly if they wished.

Access to the service

The practice was open Monday to Friday from 8.00am until 6.30pm, except on Wednesday when the hours were 8.30am until 3.00pm. The GP held a morning surgery between 9.00am and 10.30am, and an afternoon surgery between 4.00pm and 5.30pm. No appointment was necessary during these times, patients were simply able to drop in and be seen. Later consultations were available by appointment and the GP carried out home visits where patients were too ill to attend the practice. The nurse held surgeries between 9.00am and 5.00pm by appointment.

Responses to the national and practice patient survey showed that patients were highly satisfied with the drop in system. This was consistent with the responses we received on CQC comment cards. In the national survey 100% of patients who responded said their last appointment was convenient, 99% rated their overall experience of making an appointment as good. The practice was rated as amongst the best in the national survey in this regard. Patients reported they were seen in a timely manner under the drop in system and our observations on the day confirmed this. Results of the practice survey showed approximately 80% of patients who had responded waited a maximum of 10 minutes to be seen. The remainder had waited no more than 20 minutes.

Patients expressed the same high levels of satisfaction with the practice opening hours and the ease with which they could contact the practice by telephone, for example, to speak with a GP or request a repeat prescription.

Good

Are services responsive to people's needs?

(for example, to feedback?)

When the practice was closed the care and treatment needs of patients were met by an out of hours provider, East Lancashire Medical Services. Contact information for this service was well publicised.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person for handling all complaints in the practice.

We saw that information was available to help patients understand the complaints system, for example, notices in the waiting area and details on the website. Three of the four patients we spoke with on the day of inspection were aware of the complaints procedure but had not had reason to use it. The fourth was unaware of the procedure but told us if they had any concerns they would speak with reception staff.

We looked at the complaints received in the last 12 months. We found they had been dealt with in a timely manner and satisfactorily managed. The practice reviewed complaints on an annual basis as a team to detect themes or trends. None were evident from the two complaints that had been received. We saw that when actions that would reduce the risk of further occurrence were identified they were implemented.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision. Delivery of high quality care and promotion of good outcomes for patients was paramount. The practice belief was; to cure sometimes, to relieve often and to care for always. They strongly believed in a holistic approach to health issues. The values were well published, for example, on the website and in practice literature.

It was clear from speaking with staff they were fully committed to the vision and values.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. These were readily accessible to staff. Systems were in place to annually review policies to ensure they remained up to date. After each review staff were required to sign a control sheet to confirm they had read and understood the content. We sampled a number of policies and found them to be up to date. The practice manager told us the infection prevention and control policy was in need of review and this work had been scheduled on their action plan.

The practice held monthly meetings which all staff attended. We looked minutes of recent meetings and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data showed the practice to be a high achiever in comparison with national averages. QOF data was regularly reviewed to ensure achievements were maintained or improved upon.

The practice had completed a number of clinical audits, including prescribing of opiates. We found that audits cycles were complete and any actions identified as a result implemented

Leadership, openness and transparency

The leadership culture of the practice was open and transparent. The GP led the practice but all members of staff took an active role in delivery of the service. The staff team was small and management were visible and approachable. The practice had a committed team of long serving staff who shared a common vision where patients and pro-active delivery of care were the priority. Staff told us they worked very well together and the team appeared to be a cohesive and mutually supportive unit. Staff were clear about their own roles and responsibilities and felt valued.

There were a number of policies and procedures in place to provide guidance and instruction to staff. These included matters such as equality and diversity, recruitment, training, whistleblowing, disciplinary and grievance. A staff handbook also provided guidance on practice procedures and expectations.

Practice seeks and acts on feedback from its patients, the public and staff

The practice conducted an annual survey of patient feedback which included the opportunity for patients to comment on any aspect of the service they felt could be improved or was particularly good. There was also a suggestion box located in the reception area and a facility on the website for submission of comments or suggestions. We saw evidence that feedback was analysed and discussed at practice meetings to see if there were any common themes where improvements could be made. We viewed the feedback from the last survey and saw it was extremely positive. No common themes suggesting change were identified and the practice had concluded there was no need to do so. The vast majority of patients had not identified any areas that could be improved. One patient had said that to change anything would jeopardise the professional service already delivered.

The practice had a patient participation group which met annually. Minutes of the meeting were recorded so they could subsequently be reviewed by the practice team with a view to implementing any changes identified. The practice manager told us no suggestions had been made.

Management lead through learning and improvement

The Clinical Commissioning Group funded a package of online training for staff. The practice closed for half a day periodically to enable staff to pursue this.

There were good development opportunities within the practice. For example, the practice manager told us they had been strongly encouraged to expand their role. They had completed qualifications in medicines management, phlebotomy and as a health care assistant. One of the reception staff had completed qualification in business and administration. The nurse told us they were supported to

Are services well-led?

Good

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

maintain their clinical professional development. They had expressed an interest in pursuing additional training in a number of specialist areas and were in the process of sourcing appropriate training courses. They also attended monthly nurse forums with peers across the Clinical Commissioning Group.

The GP had been revalidated in 2014. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council.

The practice completed reviews of significant events and other incidents. Such matters were discussed at regular monthly staff meetings.