

Dr. P F Tynan and partners

Quality Report

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Date of inspection visit: 23rd October 2014

Date of publication: 05/03/2015

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

Ratings

Overall rating for this service

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

The King Street and University Medical Practice was inspected on the 23rd October 2014. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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.

The practice works over two sites, one in Lancaster city town centre and one on the Lancaster university campus on the outskirts of the city. Patients registered at the practice could use both the King Street and University site as they wished.

The practice is rated good overall but one key question around the safety of the practice requires improvement.

Our key findings were as follows:

- The clinical team each had areas to lead on and took responsibility to ensure practice and protocols were in line with current best practice guidance.
- Patients we spoke with told us they were involved with their own care and were happy with how the practice treated them.
- Risk assessment and risk management plans took into account patient and staff safety.

We saw areas of outstanding practice including:

- The practice has a practice application that can be downloaded to a smart phone. The phone application allows the user to access the practice website to review information, order prescriptions and book appointments.

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

Importantly, the provider must:

Summary of findings

- Have all the evidence they need to ensure all clinical staff are suitably qualified and registered to complete their role.
- Ensure all senior staff are trained in safeguarding at the appropriate level and within given timescales in line with practice policies and good practice guidelines.

In addition the provider should:

- Request a fire service risk assessment of King Street as one has not been completed since 2009. Fire drills and all testing of equipment should be recorded.
- Implement actions on infection control audits in a timely manner.
- Ensure they have one consistent and available complaints procedure

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services. The practice had systems and protocols to identify and respond to risk and potential unsafe practice. Risk management plans identified actions to be taken to reduce risks. However it was not clear when actions had been completed and there was an inconsistent approach to recording unsafe practices. The practice did not keep records on senior clinical staff to ensure they were registered and validated as required to fulfil their role.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. The clinical team each had areas to lead on and took responsibility to ensure practice and protocols were in line with current best practice guidance. Staff attended multi-disciplinary forums to share learning and drive up standards. Data we reviewed confirmed the practice worked to meet the needs of the practice population and changed systems as required to meet patient demand. Patient needs were met by the practice or by referral to specialist services. Practice staff received ongoing training to meet patient needs.

Good



Are services caring?

The practice is rated as good for providing effective services. Patients told us they were happy with the service they received and were involved with their treatment and care and were treated with respect. When the practice assessed patients could no longer give informed consent, they made use of supporting agencies, to assist patients in making decisions that were in their best interest.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. Practice staff understood the needs of the patient group registered with the practice and they delivered enhanced services to fully support those most at risk. The practice developed a new Patient Participation Group (PPG) every year from the student population. The complaint procedure required more clarity.

Good



Are services well-led?

The practice is rated as good for providing well-led services. Performance and improvement plans were developed. Risk assessment and risk management plans took into account patient

Good



Summary of findings

and staff safety. Staff were committed to ensure the practice succeeded in delivering high quality care. The practice had systems in place that supported staff development and promoted an open and fair culture.

Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people. The practice offered services to support this group including flu vaccination clinics and NHS health checks. GPs supported nursing and care homes with care planning and worked with them during admission and discharge between secondary (hospitals) services. Each patient over the age of 75 years and all patients had a named GP.

The practice worked with the local hospice and McMillan nurses to support patients at the end of their life.

Good



People with long term conditions

The practice is rated as good for the population group of people with long term conditions. The practice ran a number of clinics for patients with long term conditions led by the nurse practitioners. Appointment lengths varied dependent on the needs of the patient and included reviews and follow-ups. Nurses combined appointments as required to reduce the number of times patients had to visit the practice. Test results were added to the patient records when monitoring one or more long term conditions.

The practice monitored provision for patients with long term conditions and developed care plans to support patients with monitoring their own condition.

Good



Families, children and young people

The practice is rated as requires improvement for the population group of families, children and young people.

The practice health visitor held child health surveillance clinics monitoring children's health and development up to the age of five. Midwives held a weekly antenatal clinic with access to GPs when required. Family planning and women's health screening clinics were also available. The practice worked with health visitors and midwives to support and safeguard children and young people who may be at risk.

Patients in this group were not represented on the Patient Participation Group (PPG) and feedback from this group was not actively sought.

The practice undertook a number of enhanced services with mothers, children and young people including hepatitis B and pneumonia vaccinations for new born babies.

Good



Summary of findings

There was a range of health promotion and child development leaflets and posters within the waiting rooms.

Working age people (including those recently retired and students)

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

The practice had available information for patients to better manage their own conditions. On line services were available for ordering prescriptions and making appointments up to one month in advance. The practice offered extended practice opening times to meet the needs of this group on a Saturday morning and late one evening.

The practice had developed a Smart Phone Application for patients to download to their phones. This allowed patients to access all services offered by the website from their mobile phones.

The practice were proactive in engaging students at the university to register and to be responsible for their healthcare needs. The practice effectively registered over 2000 students at the start of every student year

GPs attended fresher's week and promoted healthy living and lifestyle choices that included sexual health and binge drinking. Students and all patients had access to Genito-Urinary Medicine (GUM) clinics for sexual health advice and testing. Condoms were available free and discreetly.

The practice provided Meningitis C vaccinations for students There was a range of health promotion and sexual health information within the waiting rooms and across the university.

Outstanding



People whose circumstances may make them vulnerable

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice supported 29 patients who had a learning disability and completed annual health checks to monitor and provide support to the patients and their carers in meeting their needs.

The practice worked with local people and a local support agency to support patients with drug and alcohol addictions. The service provided patients with clear goals so they could clearly measure their own success on the programme.

Good



People experiencing poor mental health (including people with dementia)

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

Good



Summary of findings

The practice worked with 102 patients who were experiencing poor mental health this included patients living with dementia. Access to services could be made via telephone or referral to the acute assessment team based at the university site when patients were in crisis. The GPs worked within shared care principals and local community teams to better meet the needs of patients with poor mental health.

Clinical staff understood the principles of the Mental Capacity Act 2005 and ensured decisions affecting patient welfare were always made in the patient's best interest. GPs completed capacity assessments and worked with local specialist support teams to support patients who may lack capacity.

The practice had leaflets available providing information on how to access support for patients and family members who may lack capacity or were experiencing poor mental health.

Summary of findings

What people who use the service say

We spoke with two patients on the day of the inspection, five patients on the phone following the inspection and reviewed seven completed CQC comment cards. We spoke with patients from different backgrounds and with different health needs. Everyone we spoke with was positive about their experience at the practice.

We were told all staff were friendly and able to meet their needs. All patients were satisfied with how the practice managed their care. One patient was dissatisfied with the length of time a referral had taken but it was within the practice's two week expected timeframe. Patients felt involved with their care and treatment options.

Areas for improvement

Action the service **MUST** take to improve

The practice did not have records to confirm all clinical staff were DBS checked. The practice did not have all the information they needed to have assurances all clinical staff were validated and registered appropriately to undertake their role.

Senior staff were not trained in safeguarding at the appropriate level and within given timescales in line with practice policies and good practice guidelines.

Action the service **SHOULD** take to improve

The last fire service risk assessment had been completed at King Street in 2009. A fire drill and the testing of fire doors were not recorded

There was not a comprehensive and consistent complaints procedure available to staff and patients across the practice. The final results of investigations had not been shared with the patient making the complaint and some investigations remained ongoing long after the complaint had been made.

Infection control audits contained some actions that had rolled over from previous audits including the replacement of the chairs in clinical rooms.

Outstanding practice

The practice has a practice application that can be downloaded to a smart phone. The phone application allows the user to access the practice website to review information, order prescriptions and book appointments.

Dr. P F Tynan and partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector who was accompanied by a GP and a practice manager specialist advisor.

Background to Dr. P F Tynan and partners

The King Street and University Medical Practice is based in the centre of Lancaster. The practice has a second site based within the university grounds. The practice is managed by nine partners and a management team including dedicated management at both practice sites. The clinical team include the partners, two salaried GPs, three nurse practitioners and the support of a health care worker. Of the 11 GPs at the practice five are female. The management team are supported by deputies, a finance manager and a team of secretarial, administration and reception staff.

The King Street site is open Monday to Friday from 8am to 6.30pm. The university site includes extended hours on a Monday evening until 9pm and from 8am to 12pm on a Saturday morning. Treatment advice outside of this time is available from the website and from the national '111' number. Access to appointments is available out of hours from Bay Urgent Care. The practice supports the North Lancashire Clinical Commissioning Group (CCG) out of hours provision outside of working hours.

The practice serves Lancaster City and surrounding areas and Lancaster University with a patient list at the time of the inspection of 20346. The patient population comprises of less than the England average of patients aged 40 years

and over and greater than the England average for patient aged 45 years and under. The practice population has nearly 40% of patients in the 20-24 age range. The practice population area is within the third least deprived population group and includes patients mostly from higher socio/economic backgrounds. The area has a low ethnic minority population but this practice was higher than the local average due to international students at the university. Less than 10% of the practice population were unemployed and just over 30% had a long standing health condition.

The practice has a Personal Medical Services (PMS) contract, this is the contract between general practices and NHS England for delivering primary care services to local communities.

The CQC intelligent monitoring placed the practice in band 4. 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. This provider has been inspected before but had not received a quality rating from CQC and that was why we included them.

Detailed findings

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five key 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?

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
- Mothers, babies, children and young people
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before our inspection we reviewed information we hold about the practice and asked other organisations and key stakeholders to share what they knew about the practice. We analysed information received through our intelligence monitoring system and reviewed policies, procedures and other information the practice provided before the inspection. We carried out an announced inspection on 23rd of October 2014.

During our inspection we spoke with a range of staff including; GPs and nurse practitioners, a health care assistant, the practice manager and reception and administration staff. We did not speak to anyone from the Patient Participation Group (PPG) on the day of the inspection as the group was being reformed for the new university year. The King Street site did not have an active PPG. We spoke with two patients on the day of the inspection and five on the telephone the following day. We reviewed seven CQC comment cards available for patients to complete on the day where patients and members of the public shared their views and experiences of the service. We observed how patients were being cared for at reception and reviewed documentation as required. We looked at the cleanliness and management of the building and verified practice procedures were being followed by the practice staff.

Are services safe?

Our findings

Safe Track Record

Throughout the year issues and concerns were discussed and actions agreed to work towards improvement. Any action taken was shared with the practice staff through email or during team meetings. There were systems in place to monitor areas of risk including health and safety and infection control. Details of significant events, complaints and audits were collated and formally evaluated at the end of each year.

It was not clear from meeting minutes what had been discussed and what had been agreed. We were assured all staff communicated effectively to ensure any actions were taken, however these were not clearly recorded.

Learning and improvement from safety incidents

There was a system in place to ensure significant events were recorded and monitored. Meetings took place as required to discuss significant events to ensure staff understood how they had happened and what action to take to reduce the risk of reoccurrence. Annual education plans were used to reflect on incidents and events from the previous year. Actions were recorded but it was not clear if all actions had been completed. The education plan was used as a reminder to all clinical staff of the actions to be implemented. The nursing team were in the process of developing a similar system for the nursing team.

Reliable safety systems and processes including safeguarding

Each team member took responsibility to share information of concern with the practice. All information of concern around patients was noted and kept together in a file named the hunch file. Items of information held in the file on their own were not enough to form concerns but as information was added from different team members the hunches helped form a picture of concerns that may need to be escalated. Information included may be details of children not attending for routine vaccinations or vulnerable patients attending appointments with someone not known to be a family member or carer. The practice shared information with health visitors as required and at risk children and other patients who may be vulnerable were coded on the patient record system.

The practice safeguarding policy identified the clinical lead for safeguarding and stated all those assessing children have received safeguarding training to level three. However no one at the practice had training above a level two. Most staff had completed level one safeguarding training on line. Safeguarding was discussed at weekly meetings and staff we spoke with were confident to escalate concerns to a GP.

There were posters detailing the safeguarding procedure around the practice, Staff we spoke with knew the procedure. Leaflets were displayed in the waiting room on recognising and reporting safeguarding concerns. Clinical and non-clinical staff had an awareness of the Mental Capacity Act 2005 and we were given examples of when it had been implemented including supporting a patient and their carer with prompts to collect prescriptions

Clinical staff were all trained to undertake chaperone duties if requested. There were posters and information in the waiting room about the role of a chaperone and how patients could request one. When we spoke to patients they were aware the service was offered.

Medicines Management

The practice had a comprehensive policy for managing prescriptions and medicines. Responsibility of implementing the procedures lay with the practice manager. The practice had a pharmacist who held weekly clinics at the practice to support GPs. The pharmacist, GPs and nurse practitioners could prescribe and review patient's medication.

The practice pharmacist regularly attended practice meetings and shared any issues, concerns and alerts around medicines. They were responsible for reviewing and managing medicines alerts and audits on the use of medicines. There was an on-going audit to support GPs with the prescribing of specific medicines.

Routine prescriptions were managed by administrative staff. If a review was required staff would task a specific GP and appointments would be booked if required. Reviews were undertaken dependent on patient need, patient condition or medicines used.

Repeat prescriptions were monitored every three months to ensure they had been collected and were not being duplicated. Any prescriptions the administrative staff were not clear about would be referred to the pharmacist to update, destroy or investigate. Repeat prescriptions could

Are services safe?

be booked online through the website, via telephone and in person. Prescriptions were usually ready within 48 hours. Patients told us their medicines were always ready when they came to collect them. We were told if a prescription was ordered in an emergency the practice would do their best to have it ready on the same day.

The practice had a fridge within which vaccines were stored. The temperature of the fridge was recorded daily. Vaccines were rotated to ensure they were used before they expired. The fridge had previously failed and vaccines had to be destroyed. A Significant event record was made and improvements to reduce the risk of reoccurrence were considered. The fridge was replaced and systems for monitoring and managing the cold chain for vaccines were re-implemented.

An emergency medicines kit was available to practice staff. The medicines were checked weekly to ensure its contents remained in date.

Cleanliness & Infection Control

A monthly cleaning checklist was completed on the environment. An annual audit was undertaken to ensure equipment and the environment remained within infection control good practice guidelines. The last two audits had identified the need for chairs in consultation rooms to be replaced with chairs that could be wiped clean. Chairs were to be replaced when they became worn or damaged.

Schedules were in place in consultation rooms to ensure rooms were both equipped and cleaned as required. The lead infection control nurse was responsible for ensuring actions were completed and any changes to procedures were shared with practice staff at practice meetings.

There were hand sanitizers throughout the practice for use by staff and patients. There were hand hygiene posters displayed at hand washing sinks to reinforce a good technique. There was infection control mandatory training available to clinical staff; most had completed it in the last 12 months.

Procedures were available for cleaners of the building to follow these included what clean meant within clinical environments. Domestic cleaning schedules were kept and monitored for tasks that required completion including the frequency within which tasks should be completed.

Cleaning equipment was colour coded to reduce the risk of cross infection and the latest Control of Substances Hazardous to health (COSHH) guidance for storing and handling substances and chemicals was followed.

Sharps bins, elbow taps and foot operated clinical waste bins were in use in the consulting and treatment rooms. Spillage kits were available for staff to clean up any spillage including bodily fluids.

There were good supplies of Personal Protective Equipment (PPE). Disposable gloves, aprons and other necessary PPE was available in all treatment rooms. Staff were asked weekly if any stock was required and the Health Care Worker ensured stocks were kept as required.

The practice had last carried out tests for Legionella in October 2014.

Equipment

Emergency equipment was checked to ensure it was always safe to use. The oxygen cylinder, defibrillator and all associated equipment were checked weekly. Nebulisers (used to administer some medicines to improve breathing), scales and other equipment were calibrated to ensure they were accurate. Records were kept of expiry dates and when professional checks were due.

All the equipment held on site had a certificate to evidence it had been checked or calibrated by a suitably qualified professional to ensure it was fit for purpose.

Staffing & Recruitment

The practice had a comprehensive recruitment policy identifying checks to be undertaken to ensure staff were suitable for the role for which they were applying. However the policy was not followed consistently. We looked at six personnel files, across all staff groups except GPs. The practice did not hold any recruitment information or personnel file for the GPs. On the day of the inspection we were unable to ascertain if GPs were appropriately registered, insured and validated to undertake their role. The practice had not routinely kept records of Disclosure and Barring Service (DBS) checks but we did see a number of risk assessments had been undertaken to determine if DBS checks were required for non-clinical staff. We were assured the non-clinical staff did not undertake the role of chaperone with patients during sensitive or personal examinations.

Are services safe?

We saw evidence the practice had taken copies of photographic identification from staff. All staff had practice information technology (IT) security cards which required photographic identification.

The practice worked with trainee doctors and students. Any clinical professional who was training at the practice received support from the permanent clinical team.

Monitoring Safety & Responding to Risk

Clinical meetings took place weekly and monthly. The focus of these meetings changed dependant on practice priorities. Staff met as required to discuss issues of importance and emails were used to ensure key messages were shared amongst all staff.

At the end of every business year the clinical team reflected on analysis and actions undertaken the previous year in response to risks and issues. The meeting was used to update on the completion of actions and share on-going learning.

A generic Health and safety risk assessment had been completed in September 2014 which incorporated building and staff safety. Prevention of accidents was included into risk management plans. The practice regularly monitored

fire equipment and held a weekly fire alarm test. The last fire service risk assessment had been completed at King Street in 2009. A fire drill and the testing of fire doors was not recorded in the evidence reviewed. The practice organised for the testing of permanent electric installations on the day of the inspection.

Many practice staff did not work full time so there was added flexibility within the team to cover sickness and holiday when required

Arrangements to deal with emergencies and major incidents

The practice business continuity plan included risk assessment and management plans for foreseen events including loss of electric, fire and flood. The plan was available to staff on the intranet and on the staff notice board. All staff we spoke with had details of a manager's name and number in case of emergencies. Staff identified the lead fire marshals and understood their role in clearing the building in the event of a fire.

An electronic panic button system was in place. Staff knew how to use the system to alert other staff if required in the event of an emergency.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

A Connecting for Health initiative allowed the practice to view records for patients where other healthcare professionals had contact with that patient. This and access to the urgent care dashboard (used when patients access A&E departments) and shared information with the Out Of Hours (OOH) team allowed the practice to update records, medication and specific care plans as and when required.

The practice had a number of enhanced services working with community and population groups where patients may need additional support. Each service, along with each long term condition had a designated named clinical lead. The lead in consultation with partner services and the Clinical Commissioning Group (CCG) developed templates for care plans to be used by health care professionals working with individual patients.

Each area of health had a clinical lead identified. It was the lead's responsibility to ensure the practice delivered services and treatment effectively in line with best practice guidelines. Any updates or changes to policy or protocols were shared via practice meetings, emails and available to all staff electronically on the intranet.

Management, monitoring and improving outcomes for people

Each clinical lead developed practice for their lead area. Time was given to each lead at the practice meetings to update the team on their clinical area. Practice meetings focused on developing how the practice worked with specific patient groups and discussed improvements to the quality of service provision.

The practices completed a voluntary annual QOF (Quality and Outcomes Framework) self-assessment (an annual self-assessment against a national set of targets for quality healthcare provision). The practice was not an outlier for any QOF clinical items.

Clinical staff completed audits on practice held information. We were sent a review of the 12 audits completed in the last 21 months. Four of the audits had completed an audit cycle and clinical or process improvements had been noted when the re-audit had been completed. Two of these identified further actions to be

taken to continue and increase improvement and two noted to carry on with originally identified improvement strategy This included one audit on the use of Hormone Replacement Therapy (HRT) for women aged over 54 years and the continued review on the use of HRT.

Clinical staff were aware of their responsibilities as leads for areas of practice. Practice meetings had agenda items set for feedback on areas such as Long Term Conditions (LTC). Some practice meetings were dedicated to specific conditions and attended by external professionals as required. The practice pharmacist and nurse practitioners attended meetings and held weekly clinics to support patients with specific conditions. Patients were invited in for a review of their condition or medication at the recommended intervals.

Effective staffing

Most staff we spoke with had worked at the practice for a number of years. The most recently employed staff described a comprehensive induction and on-going training. New staff were assigned a named mentor to support them whilst settling into their role. Staff told us the team was supportive and line managers were available when needed.

Revalidation was introduced in 2012 to protect, promote and maintain the health & safety of the public by ensuring proper standards in the practice of medicine. Revalidation requires GPs to provide evidence that they work within robust local systems that support high quality care. Four of the partner GPs had been revalidated in the last 12 months, two were due in the next 12 months and the information was not available for the remaining two. Each GP had received an annual appraisal.

The practice had a whistle blowing policy and staff were aware of how to use the procedure if it was required. All staff knew who to speak with for specific advice.

Training records indicated clinical staff received annual emergency Cardiopulmonary resuscitation (CPR) training and attended other relevant training courses for their role. The practice manager had a comprehensive training matrix for the nurses and non-clinical staff working at the practice. A number of training courses were mandatory and required updating every 12 months or every three years dependent on the staff role. These included CPR, health and safety and fire safety.

Are services effective?

(for example, treatment is effective)

We saw some evidence of annual appraisals but most were due. All staff we spoke with told us support was always available and they could request and agree additional training outside of the appraisal review process. Staff were clear about their accountabilities and their line manager responsibilities. Nurses told us clinical supervision was available as and when they requested it.

Working with colleagues and other services

The practice held multi-disciplinary meetings with other professionals on site as required. More formal meetings included bi monthly palliative care meetings and quarterly health visitors meetings. The practice also met with local community matrons and district nursing teams to support the needs of patients in the community. Clinical staff from the practice also attended local forums to support patient needs.

King street practice worked with a local drug support agency helping patients who misused substances to lead more stable lifestyles. The practice worked with the palliative care team and Out of Hours teams to ensure patients' needs were met at the end of their lives. The practice worked with district nurses to better support people with long term conditions. Through shared care planning patients' needs were met without the need to revisit diagnosis information by different professionals.

The practice was undertaking a patient consultation about the better care together initiative. Patient's views were being sought on how health and social care services could work together to better meet the needs of patients.

Records from any discharge or admissions changes to patient information were managed electronically. Information was sent directly to the named GP who updated patient records and medication if required. GPs would visit nursing and residential homes ensuring summary patient information was taken to the visit. This helped ensure GPs had the most up to date information about specific patients.

The practice staff met regularly to discuss patients' needs both formally through scheduled meetings and informally as required.

Information Sharing

Information was available in the reception about the patient summary care records and who else may access the information within them. Sharing some specific patient

information with other services allowed external services to work with patients as soon as possible. Patients were given details of how to opt out of the service and restrict access to their summary care record if they did not want their information shared.

Through connecting for better health some health information was available to other health care professionals. This allowed records to be updated by professionals treating patients and for all those involved in someone's care to have influence over the best care and treatment for individual patients.

Consent to care and treatment

The consent policy considered when it would be appropriate to act on a patient's implied, written or verbal consent to treatment, immunisation or investigation. Practice staff told us consent would always be recorded in a patient's records. Specific forms were used for certain consents including consent for minor operations.

The policy explained the Gillick competencies and how they were to be used when asking younger patients to give their consent. Individual patient understanding of diagnosis, treatment, risks and issues and consequences would be considered before a child may be considered to consent to their own treatment. Procedures were also available for patients to agree to students sitting in on consultations.

Clinical staff told us how each patient would be assessed to give consent each time consent was required. When it was assessed a patient may not have the capacity to make a decision clinical staff would ascertain if patients had someone with lasting power of attorney who could support them to make decisions. When this was not the case the practice had used the services of capacity advocacy services to ensure decisions were made in a patient's best interests in line with the Mental Capacity Act 2005.

Health Promotion & Prevention

The practice had different waiting rooms in different parts of the building at King Street. Each waiting room had posters and leaflets to support healthy living and patients with specific conditions and needs. Leaflet displays were accessible and posters were clearly displayed and visible to their target audience.

Are services effective?

(for example, treatment is effective)

There was information for patients around managing their own conditions and support offered for changing lifestyle choices including smoking cessation. There were chlamydia testing kits available in the public toilets as well as condoms patients could take away with them.

Posters identified the availability of the flu vaccine and encouraged eligible patients to make appointments.

Clinics held at the practice were clearly advertised including visiting clinics such as help direct.

New patients were screened to help identify any immediate health care or social care needs and included details of lifestyle choices that could be detrimental to patients' health including smoking and drinking.

Various local support groups advertised in the practice and included support for carers and patients who may find themselves sleeping rough.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We spoke with two patients on the day of the inspection, five patients on the phone following the inspection and reviewed seven completed CQC comment cards. All but one comment we received was very positive about practice staff with the majority identifying them as helpful and polite. One concern was identified with the timeliness of a referral but when we discussed this we found the practice was within their two week procedure for the referral to be received.

Consultation rooms were private and patients could be offered a private space other than reception to discuss any sensitive information. A poster was available advertising this space so patients could request it if they so wished.

The practice had a patient's charter outlining what both staff and patients should expect from a visit to the practice. Expectations included fair and appropriate access to treatment and mutual respect. Patients we spoke to on the day of the inspection had nothing but praise for how they were treated. We saw a number of staff and patient interactions on the day and found the staff to be pleasant at all times.

Posters advertising chaperones were visible throughout the practice and patients we spoke with were aware of the service.

We saw from staff training records that all non-clinical staff had attended training in equality and diversity and information governance. Initial training had been undertaken and was refreshed at given points in time. This training helped support staff when dealing with patients face to face and when managing patient information.

Care planning and involvement in decisions about care and treatment

Patients told us practice staff took the time to understand their needs. We were told their opinion was sought and considered when agreeing treatment options and

medication. Patients told us they never felt rushed during appointments and had the opportunity to ask any questions they needed to help them understand their condition or ailment.

We spoke with one person who was a carer for patients and others who had taken family members into appointments for support. Everyone we spoke with told us the practice involved carers and family members in an appropriate way and ensured they could continue to support the patient in the community.

Patient/carers support to cope emotionally with care and treatment

The waiting room had leaflets available to support patients at times of bereavement. Staff we spoke with showed an understanding and empathy when discussing bereavement and were confident in how to deal with patients who faced this type of loss.

The practice took practical steps to manage relationships with bereaved relatives after a patient had died. This included the practice informing various teams and removing reviews and follow up appointments from the system. GPs visited bereaved families shortly after the death of a patient and noted on bereaved patient records they may be in need of support following bereavement. The practice sent sympathy cards and showed support to patients faced with a loss of a loved one.

Support group information for health conditions was available in reception and the practice referred to Help Direct for more practical support with general living including housing and benefits.

The practice had a carer's notice board offering support and advice. A carer's register was kept both for patients who were carers and for patients who were cared for. A carer's passport was completed with patients and their carers identifying routines and support networks. The passport was used to support and inform healthcare professionals what and who was important in a patient's life.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had undertaken bespoke training on the needs of specific patient groups including carers and patients with addictions. The practice delivered a number of specific enhanced services to support the needs of the local population. This included supporting patients in avoiding unplanned admissions and offering extended opening times at the university to support working patients.

Each enhanced service was led by a clinician. The lead attended forums to improve their understanding and learning in specific areas. Learning and improvements were shared with the team through practice meetings. Specific services used care plans and monitoring templates to improve patient care. Care plans were completed in a holistic way ensuring that all healthcare professionals involved with someone's care had access to the information and could update the information as required. This ensured the plans remained current documents changing as the patients' needs changed.

The practice used the choose and book system to make referrals to secondary (hospital) services. This ensured the patient had influence over where their care and health care needs were met. The practice had a comprehensive system for making referrals and we saw a number of referral forms for specialist services. Patients we spoke with told us they had confidence in the clinical staff and their diagnosis of conditions and ailments.

The practice saw patients in clinics for reviews and check-ups specific to conditions and needs of the patients. The practice had recently brought forward reviews of some patients to allow for the university intake at the start of the student year. The practice would combine reviews where tests were required for more than one condition. For example a patient would only be called in for one appointment to check their blood pressure and the result would be recorded against more than one review if required.

The practice held registers of patients with differing needs and conditions. The current patient registers for patients experiencing poor mental health was 102 and the practice was supporting 29 patients with learning disabilities. Keeping registers of this type helped the practice judge

where more support was needed. The practice had both male and female GPs with all patients having a named GP. Patients told us they could see a GP of choice if booked in advance.

The King Street site did not have a Patient Participation Group (PPG). The university site had an annual PPG set up at the start of the student year in September. The King Street site had a patient suggestion box and access to the online questionnaire. Nearly a fifth of the patient population were not represented on the PPG. We looked at the results of the 2014 survey and found most of the specific actions were related to the university campus. One action identified displaying posters clearly identifying the complaints procedure. We noted at the Kings Street site a complaint procedure was on display but it was not clearly labelled as the complaints procedure.

Tackling inequity and promoting equality

The practice had completed an annual Disability Discrimination Act (DDA) risk assessment. Actions identified on the assessment had been completed including developing a street level extension to the rear of the building ensuring patients with mobility issues or those using a wheelchair, or pushing a pram could access the building with ease. There was an intercom and CCTV for patients to check in with reception as they entered. The door could be opened via a waist height disabled access button. All doorways to treatment and consultation rooms were of adequate width for patients using a wheelchair. The practice had disabled parking available and access to disabled facilities.

Practice staff told us they knew the patient list well and patients requiring longer appointments could be accommodated. All reception staff had received training in using an interpreter and using the hearing loop system installed to the phone system. We saw leaflets and information in different languages around the reception areas and the website had access to information for patients in a number of different languages and prints.

Access to the service

We were told patients could always get an appointment on the day if it was needed in an emergency. Reception staff would offer patients telephone consultations if these were appropriate and GPs had time each morning for three telephone consultations. Any additional Telephone

Are services responsive to people's needs?

(for example, to feedback?)

consultations or urgent same day appointments requested but not booked were recorded within the home visits book and GPs discussed and allocated them at the end of morning surgery.

The practice had a comprehensive practice information leaflet. The leaflet identified all of the practice staff and identified how to book specific types of appointment including urgent and routine. Routine appointments could be booked up to a month in advance; urgent appointments were available on the day. All the urgent appointments were assessed within two hours by the acute team who assessed the necessity and speed of an appointment. Telephone consultations and home visits were available to patients who were unable to get to the practice. Each routine appointment was 10 minutes long, longer appointments could be booked if required.

Listening and learning from concerns & complaints

The practice leaflet identified how patients could give compliments, constructive criticism and make a complaint.

Information was available on a poster in the waiting rooms throughout the practice. It was unclear if patients could complain verbally as posters and leaflets stated they had to be made in writing.

The practice had a designated person responsible for dealing with complaints. Complaints were responded to as they were received. Complaints were reviewed at the end of the business year to ascertain if anything could be learnt from them or any more general improvements could be made to systems or practice. We noted from the list of complaints and action taken a number of complaints investigations were on-going following a response being made to the patient. An annual synopsis was completed of all complaints for the Clinical Commissioning Group (CCG) detailing numbers and types of complaint.

Patients we spoke with told us they had not needed to make a complaint but were confident they could raise concerns with the reception and they would be managed appropriately.

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 were proactive at looking ahead and identifying possible risks. The practice had developed plans on how they were going to move forward including steps towards a potential federation model across Lancaster and Morecambe. A federation model includes the development of a business core where universal policies and procedures are developed and managed yet individual practices keep their autonomy and locally manage what is important to their practice population.

Governance Arrangements

Different practice staff took the lead for different administrative and clinical areas. Leads took responsibility to update procedures and policy as best practice guidance changed. Procedures were available in a hard copy and on a shared network drive (intranet). Staff were given hand-outs of relevant protocols annually to refresh their learning. The practice did not have a process in place to ascertain if staff read and understood the procedures.

Practice management and senior staff were available on site daily. We were assured by practice staff there was always someone to ask a question of, if they ever were in doubt.

At the end of every year the practice reviewed the previous year's education plan. The education plan included details of events, issues, meetings of significance, audits and identified lessons learnt. The education plan we received did not reflect the other information we received around significant events, audits and complaints. We could not see a rationale as to why some items were included and some were excluded.

The practice was proactive in addressing and questioning some of the wider issues and concerns around General Medical Practice. The lead GP had engaged with senior leaders and asked a number of appropriate questions. The GP was soon to present his questions to NHS England and would feed back to the CCG going forward.

Leadership, openness and transparency

The practice manager from the university site had been overseeing and spending time at both locations The

practice were to assess the necessity to fill the role in the director's absence allowing both sites to benefit from a full time manager. Staff we spoke with were clear as to who their line manager was and who to go to for support.

We spoke with seven GPs, three other members of the clinical team and six members of the management and clerical team. All staff we spoke with were proud of how the team worked together. Each clinical staff member felt the practice utilised them for their strengths and got the best from each team member.

Staff we spoke with described the team as happy and supportive, with staff helping each other as and when required. Staff felt the training they received was good and described a positive work environment. Staff told us meetings had been less frequent recently but were confident to raise concerns as they arose.

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

The practice had a virtual Patient Participation Group (PPG) made up of students using the university site. The group was reformed each year from the new intake of students. The PPG was not representative of the whole practice population as patients from the Kings Street site were not actively involved with the group. The PPG's main aim was to develop the annual patient survey. Questions were developed based on what was important to the patients and included access, helpfulness and awareness of services. Surveys were distributed by hand to patients as they attended for appointments over a two week period. The university site received 300 completed surveys. A questionnaire was also available on the practice website for all patients to complete.

We were unable to meet any members of the PPG as the group was being reformed in line with the start of the university year. The PPG was representative of the student population using the university site. PPG members were recruited from advertising in a variety of places that included the student union, porter's lodges at each college entrance and the practice website.

We looked at the results from the last survey and identified the actions the practice took to address any areas identified for improvement. We saw the practice website

Are services well-led?

Good 

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

had been updated to include clearer links for patients to book appointments or order medicines. This was in a response to the last survey where only 17% of those who responded were aware of the internet booking system.

The practice held clinical and non-clinical meetings. We read minutes of some of these meetings and could see how staff had agreed change to support better ways of working. This included reception staff sending a screen message to a supervisor when they felt overloaded. The supervisor would provide support but was also using the information to determine if a further reception staff member was required.

The practice had a staff handbook which included a whistle blowing policy. Staff we spoke with were confident in escalating any concerns if required.

Management lead through learning & improvement

Regular meetings were held to discuss performance and improvements. The annual education plan included external speakers and feedback from audits. Meetings were scheduled a year in advance and the specifics would be agreed when appropriate. This ensured the practice were flexible and able to focus agendas on areas of importance at any given time. Lead clinicians updated on changes made to protocols following audits and agreed improvement agendas for their implementation. Any training needs identified from changes was agreed and delivered. This included sharing knowledge to improve audit outcomes if required.

The local Clinical Commissioning Group (CCG) took responsibility for external peer review. GPs who attended the meetings told us case studies were shared and performance against enhanced services and contractual obligations were discussed. The CCG and representative GPs agreed solutions for group wide performance improvements.

The practice was a training practice and had regular trainees at different stages of their learning. As a training practice staff were supported through mentorship and guided learning. Trainees we spoke with said they were well supported to develop.

Staff were supported to be included in practice developments. We were told staff were asked prior to meetings if they wanted to add anything to the agenda. The nursing team were developing their own education plan, identifying key themes and training they wanted to look into in the next 12 months.

Significant events including accidents, incidents and complaints were discussed and improvements agreed and shared within the team. Practice staff all told us they wanted the practice to succeed. Regular training was delivered by different methods that included e-learning and internal and external speakers on practice related topics. The practice reviewed the previous 12 months performance and reinforced improvement action. Plans were developed with a continued focus on practice developments and improvements.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The provider had not kept records to ensure all staff are suitable for employment by way of a DBS check when required. The provider had not taken the necessary steps or kept records to ensure all staff are registered with the relevant professional regulator or professional body where necessary and are allowed to work for that body. The provider had not taken the necessary steps to ensure all staff have the necessary qualifications, skills and experiences necessary for the work to be performed.