The Thornton Practice

Quality Report

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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?	Good
Are services responsive to people's needs?	Outstanding
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Thornton Medical Practice.

We undertook a comprehensive inspection on 3 December 2014. We spoke with patients, staff and the practice management team. The inspection took place at the same time as other inspections of GP practices across the Fylde and Wyre Clinical Commissioning Group.

The practice is rated as good.

Our key findings were:

- All staff understand and fulfil their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal incidents were maximised to support improvement.
- The practice was using proactive methods to improve patient outcomes it links with the Clinical Commissioning Group and other local providers to enhance services and share best practice.
- Patients told us they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. Feedback from patients was positive about their care, treatment and communication with the practice staff.
- Complaints were sensitively handled and patients are kept informed of the outcome of their comments and complaints. The appointment system was sensitive to the needs of the population groups the practice served. The practice was actively involved in new initiatives to enhance and support the care they delivered to their patients.
- The practice had a clear vision which had quality and safety as priority.

We saw several areas of outstanding practice including:

- All members of the practice staff had either completed or were working towards becoming Dementia friends.
- All practice patients could be seen by a GP on the same day under their Guaranteed Advanced Access process. This was not always with their named GP but was with one GP within the practice.

Summary of findings

- Patients could directly access, appointments the Help Direct Service from the practice to assist them with their personal needs for example debt management. The service held twice weekly clinics within the practice.
- The practice supported patients to access the electronic Big White Wall Scheme where they could be supported with their mental health and counselling needs at a time to suit their lifestyle. This could be accessed 24 hours a day and patients were signposted to this service appropriately.
- Inter-practice referrals were seen to be effective in addressing patients' needs for specialist advice. Appointments were available under this service within the day or the next 24 hours.
- The practice worked as part of the Rapid Response Team for the area, this ensured patients needing immediate intensive nursing or social support who did not require hospitalisation could be treated in their own home.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. There were systems in place to address incidents, deal with complaints and protect adults, children and other vulnerable people who used the service. Patients we spoke with told us they felt safe. Information from the Clinical Commissioning Group (CCG) and the NHS England Local Area Team (LAT) indicated that the practice had a good track record for maintaining patient safety. Staff took action to learn from incidents and made appropriate safeguarding referrals when necessary. There were appropriate checks to clarify that staff were suitable to work with vulnerable people.

Are services effective?

Good

The practice is rated as good for providing effective services. We found systems were in place to ensure that all clinicians were up-to-date with both National Institute for Health and Care Excellence (NICE) and other locally agreed guidelines. The practice was using innovative and pro-active methods to improve patient outcomes and linked with other local practices to share best practice. Consent to treatment was always obtained where required and this was confirmed when speaking with patients. The practice regularly met with other health professionals and commissioners in the local area. Clinical audits were undertaken on a regular basis and results from those audits were used to improve the quality of services provided.

Are services caring?

Good

The practice was rated is good for providing caring services. 17 CQC comments cards were received and discussion with five patients on the day of the inspection provided positive feedback. However one comment card highlighted the delay to appointment times shown on the waiting room screen was not always accurate. Patients told us staff were extremely friendly and they were always treated with respect, dignity and compassion. Staff we spoke with were aware of the importance of providing patients with privacy and information was available to help patients understand the care available to them. The practice was proactive in offering and supporting patents to ensure they received the care they required by an appropriate means that they felt comfortable with.

Are services responsive to people's needs?

Outstanding

The practice is rated outstanding for providing responsive services. We found the practice had initiated positive service improvements

Summary of findings

for their patients. The practice reviewed the needs of their local population and engaged with the NHS England Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where possible.

Urgent appointments were available the same day. Patients reported good access to appointments on the day however they did stress these were not always with their GP of choice. There was a clear complaints policy and procedure demonstrating that the practice responded quickly to issues raised and brought them to resolution. There was evidence of shared learning from complaints with all staff.

Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice effectively responded to change. There was a clear set of values which were understood by staff and demonstratedt in their behaviours. The team used their clinical audits, information from other sources and staff meetings to assess how well they delivered the service and to make improvements where possible. The practice Quality Improvement Plan had recently been shared across the Local CCG area as an exemplar plan.

There was an open and honest culture and staff knew and understood the lines of escalation to report incidents, concerns, or positive discussions. All staff we spoke with felt valued for the roles and responsibilities they undertook.

Summary of findings

What people who use the service say

We spoke with five patients during the inspection and received 17 completed CQC comments cards.

The patients we spoke with said they were very happy with the service they received. They told us there was sometimes a difficulty getting through to the practice by telephone but were aware the practice was trying to address this. They told us on the day appointments were available if required but this appointment was with the emergency GP for the day and you could not choose who you wanted to see.They also told us they could request an appointment with a GP or nurse of their choice.

Patients did not identify any problems with confidentiality at the reception desk. However, they were aware there was a private room available if they wanted to speak in confidence with a receptionist. Patients told us they were aware of chaperones being available and they said there were notices in consultation rooms telling them how to access this service.

The patients we spoke with told us staff were helpful and treated them with dignity and respect.

We were told that the GPs, nurses and reception staff explained processes and procedures in great detail and were always available for follow up help and advice. They said they were given printed information when this was appropriate.

The practice was currently working to formalise their Patient Participation Group (PPG) membership which at the present time had 45 virtual members but was not actually active within the practice. There were indepth plans for this process which had been agreed with the GPs and would be implemented in the new year.

Outstanding practice

- All members of the practice staff had either completed or were working towards becoming Dementia friends.
- The practice guaranteed patients could be seen on the day by a GP under their Guaranteed Advanced Access process.
- Patients could directly access from the practice, appointments the Help Direct Service to assist them with their personal needs for example debt management. The service held twice weekly clinics within the practice.
- The practice supported patients to access the electronic Big White Wall Scheme where they could be supported with their mental health and counselling needs at a time to suit their lifestyle.
- Inter-practice referrals were seen to be effective in addressing patients' needs for specialist advice for example one GP was the lead for dermatology and rather than refer to the local NHS Trust the patient was referred to this GP for treatment by other GPs in the practice. Appointments were available under this service within the day or the next 24 hours.

The practice worked as part of the Rapid Response Team for the area, this ensured patients needing intensive nursing or social support that did not require hospitalisation could be treated in their own home..

The Thornton Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to The Thornton Practice

The Thornton Practice delivers primary care under a Primary Medical Services Contract between themselves and NHS England. As part of the Fylde and Wyre Clinical Commissioning Group (CCG) they are responsible for a practice population of 9,610 patients. The practice is a training practice offering placement at the present time to two trainee GPs.

The practice population groups are below national averages up to age 65 with the over 65 groups being higher. The largest population group within the practice the 65 plus age group, with over 85 being the smallest group at 2.7%. Both figures are in line with CCG averages.67.1% of patients have a long standing health condition and 0.3% of all patients are resident in nursing homes. 1.4% of all patients are unemployed which is lower than both CCG and national average.

According to statistics available at the tme of the inspection from Public Health England, the practice is at third less deprived percentile for practices in England. Income deprivation affecting older people is in line with the CCG and slightly lower than national average at 16%. Ethnic estimation within the practice is 1.1% non-white ethnic groups with male life expectancy at 78.7 years and female at 82.5 years.

Services available include access to six partner GPs (both male and female), one salaried GP, two Trainee GP's, two practice nurses and one health care assistant (HCA). This clinical team is supported by the practice manager, a part time Clinical Commissioning Group (CCG) pharmacist and administration and reception staff.

Appointments with the team are offered between 8.30am and 6pm Monday to Friday. The practice GPs do not provide an out-of-hours service to their own patients and patients are signposted to the local out-of-hours service Fylde Coast Medical service when the surgery is closed at the weekends.

The nurse and HCA clinics promote healthy living, provide support and care for patients with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD). The doctors are able to carry out minor surgery procedures and provide injections on painful joints.

The premises were purpose built for the service and are shared with another GP practice and the local NHS Trust have a treatment room on the premises.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out the inspection under Section 60 of the Health and Social Care Act as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

Detailed findings

The practice had been inspected before under our previous inspection methodology.

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.

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 that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 3 December 2014. During our visit we spoke with a range of staff including GPs, the practice manager, a health care assistant and members of the administration and reception teams and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members. We reviewed 17 CQC comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

Information from the quality and outcomes framework (QoF), which is a voluntary national performance measurement tool, showed that in 2012-2013 the provider was appropriately identifying and reporting significant events. GPs told us they completed incident reports and carried out significant event analysis as part of their on-going professional development.

The practice had systems in place to monitor patient safety. Minutes of meetings evidenced that significant events and changes to practice were discussed with all practice staff including the nurses and administration staff if that was deemed appropriate. Action was taken to reduce the risk of recurrence in the future. GPs completed evaluations and discussed changes their practice could make to enable better outcomes for their patients.

Administration and reception staff were aware of the significant event analysis policy and knew how to escalate any incidents.

The practice had an accident book and all accidents were fully investigated.

Learning and improvement from safety incidents

The Practice had a system in place for reporting, recording and monitoring significant events. We found that staff were encouraged to report any incidents and they told us they viewed this process in positive way to ensure they provided a high standard of patient care.

Multi-disciplinary practice meetings took place where attendance included clinicians from other disciplines such as Macmillan Nurses and health visitors. Minutes from the meetings identified sharing information and reflective practice to reduce risk and improve services going forward.

There had been one significant event reported since April 2014. The data showed the date the event was discussed, a full written description of the event, what had gone well, what could have been done differently, a full reflection of the event and what changes had been carried out. The incident had been shared with a number of outside agencies including the Clinical Commissioning Group (CCG). Patient safety had been compromised as part of this incident and the practice had notified all patients effected of the incident by letter and invited them to come in and discuss the incident. Patients who had replied indicated they were satisfied with the actions taken.

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

We saw that practice meetings were minuted such as the partner meetings and monthly staff meetings. Having minutes which outline the content of these discussions and actions improve governance mechanisms and minimise the potential of staff misinformation or error.

Reliable safety systems and processes including safeguarding

Safeguarding policies and procedures for children and vulnerable adults were up to date and staff knew where to locate them. There was also access to local council's policies and procedures and a matrix for escalation with contact names and numbers for each different safeguarding incident.

One partner GP and one nurse were safeguarding leads for the practice and attended safeguarding lead meetings hosted by the Clinical Commissioning Group (CCG) as available. Safeguarding leads had completed adult safeguarding and child safeguarding to level 3 and were updated on a three yearly basis. Other members of the practice team were trained to a level appropriate to their role for safeguarding vulnerable adults and children. All staff had completed mental capacity and deprivation of liberty safeguards training.

Clinical staff undertook chaperoning procedures as per the practice policy. Patients told us they were aware of the availability of chaperones should they request one.

Each consultation and treatment room was fitted with a panic alarm which could be used to raise an audible alert in reception if a member of staff required assistance in an emergency.

Medicines management

We saw medicines management was supported by the local Clinical Commissioning Group (CCG) medicines

management team who worked in the practice on a weekly basis. We saw that audits were carried out by the CCG Medicines Management pharmacist to optimise the prescribing of certain medicines such as antibiotics or medicines for patients with long term conditions.

Emergency medicines for cardiac arrest, anaphylaxis and hypoglycaemia were available within the practice. We checked the emergency drug boxes and saw that medicines were stored appropriately and were in date. We found the practice had a defibrillator available and access to oxygen for use in emergency.

The practice had a protocol for repeat prescribing which was in line with The General Medical Council (GMC) guidelines. This covered how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. There was a system for reviewing patient's repeat medicines to ensure it was still safe and necessary. The practice processed repeat prescriptions within 48 hours. 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.

Medicine reviews were conducted by the GP, CCG pharmacist and the nursing team.

Security measures were in place for prescriptions access in line with suggested best practice within the NHS Protect Security of prescription forms guidance, August 2013.

The practice regularly checked that patients receiving repeat prescriptions had at least an annual medicine review with the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes.

The medicine fridge temperatures were appropriately recorded and monitored and vaccine stocks were well managed. There was a clear cold chain protocol in place that followed NHS England's Protocol for Ordering, Storing and Handling Vaccines March 2014.

Recent medicine alerts which had been discussed at the medicines management meeting included the use of Acyclovir eye ointment. The pharmacist had searched for patients within the practice population on this medication and addressed the alert fully and reported back to the meeting.

We were shown details of how the practice had handled a conflict in medication request from a dentist. The medication requested was not known to the GPs or pharmacist so support was sought from an outside agency as to the validity of prescribing the medicine. It was found the medicine was not indicated for the condition suggested so the medicine was refused, alternatives offered and the patient was referred back to the dentist.

The practice had action plans in place to address areas highlighted in the CCG medicine management data as being outside the medication prescribing limits. These were closely monitored by the CCG.

Cleanliness and infection control

Infection Prevention and Control (IPC) was important within the practice and the IPC policy was very clear. Both clinical and non-clinical staff had specific IPC responsibilities clearly identified within the policy.

The nurse who was overall lead for IPC had attended training. All other staff had completed Blue Stream on-line training.

Pre-employment medical checks and Hepatitis B immunisation checks and updates were carried out every five years for clinical staff.

We observed the premises to be clean and tidy and saw that facilities such as hand gels, paper towels, pedal bins, and hand washing instructions to encourage hygiene were displayed in all the patient toilets and in all the treatment rooms.

The IPC audit carried out in January 2014 had identified areas for improvement and some of these had been actioned such as the use of disposable pillow case covers and curtains. Issues identified such as changes to the flooring in clinical rooms and replacement of chairs to ones with easy wipe surfaces were currently being actioned and quotes for the work were being considered in line with an action plan.

Cleaning of the building was carried out by contract cleaners. Legionella testing was carried out by the building maintenance team.

Equipment

There were contracts in place for annual checks of fire extinguishers, portable appliance testing and calibration of equipment such as spirometers, (used to assess

respiration), which were maintained to International Organisation Standardisation (ISO) guidelines. Portable appliance testing had been carried out on all equipment and dates for next testing were evident.

Emergency drugs were stored appropriately and vaccines were stored in fridges specific for that purpose. A log of maintenance was in place and a record noted when faults were identified and parts required replacement or repair. Staff were aware of the action to take if the temperature was not within the acceptable range.

The computers in the reception and clinical rooms had a panic button system where staff could call for assistance if required.

Staffing and recruitment

The provider recruitment policy was in place and up to date. Appropriate pre-employment checks were completed for a successful applicant before they could start work in the service.

All the GPs and trainee GPs had disclosure and barring service (DBS) checks undertaken annually by NHS England as part of their appraisal and revalidation process. The nurse's reception and administrative staff also had criminal records bureau (CRB) checks undertaken by the practice.

The staff at the practice had all been employed for several years and there was little or no staff turnover. The staff were also multi skilled which enabled them to cover each other in the event of planned and unplanned absence.

The practice GPs covered each other's absence as much as possible and a locum agency was not used

Monitoring safety and responding to risk

There were systems in place to identify and report risks within the practice. These included regular assessments and checks of clinical practice, medications, equipment and the environment. We saw evidence that these checks were being carried out weekly, monthly and annually where applicable.

We saw that staff had specific areas of responsibility but no one person was responsible in entirety. This in itself reduced the risk of error.

Staff reported that they would always speak to the practice manager if an accident occurred. They knew where to record the information and to share what could be done with other staff to reduce the risk of it happening again.

All events and incidents were discussed at staff meetings and staff told us that reflection and learning was seen as a normal part of the day.

The practice had a system in place for reporting, recording and monitoring significant events. There were procedures in place to assess, manage and monitor risks to patient and staff safety.

The building management company were responsible for aspects of environmental safety. There was a system in place to inform the building management company of any concerns they had.

The practice ensured the appropriate checks and risk assessments had been carried out. These included regular assessments and checks of clinical practice, medications, equipment and the environment. We saw evidence that these checks were being carried out as required.

The practice management team had procedures in place to manage expected absences, such as annual leave, and unexpected absences, such as staff sickness. Annual leave for staff was managed to ensure there were sufficient reception and clinical staff on duty each day

There was an incident and accident book and staff knew where this was located. Staff reported that they would always speak to the practice manager if an accident occurred. They knew where to record the information and confirmed this was shared with other staff to reduce the risk of it happening again. All events and incidents were discussed at staff meetings.

There were checks in place to ensure vaccines were in date and ready for use.

Arrangements to deal with emergencies and major incidents

The practice had a robust business continuity plan available to all staff for use in case of loss of essential services and actions to take to maintain a service to patients.

An automatic external defibrillator (AED) was available in the practice. The practice carried out regular checks on the AED, so they could be satisfied it was available and ready for use. Staff had received training in cardiopulmonary resuscitation (CPR) and use of the AED. Oxygen was available within the building for use with the AED.

Good

Are services safe?

We spoke with staff who had been trained and knew what to do in the event of an emergency such as sudden illness or fire. We saw emergency equipment and emergency drugs which were available and up to date and staff knew where these could be located. There were panic buttons in all consulting rooms and according to a member of staff they were able to respond to emergencies immediately because of their close proximity.

During the inspection we observed staff appropriately deal with a patient who required transfer to the local NHS Trust after collapsing in the on-site pharmacy.

The practice manager was responsible for managing expected and unexpected absences which could cause disruption to the running of the practice. Staff were multi-skilled and were able to quickly cover each other's roles in the event of emergency absence. Most of the staff at the practice had been employed for many years and knew the patients well. Staff we spoke to told us they were able to identify if patients were unwell, agitated or distressed and could take them to a private room if necessary whilst they waited for assistance.

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 and monitored their long term conditions.

There were systems in place to ensure referrals to secondary care (hospitals) were made in line with national standards. Referrals were managed primarily by using the 'choose and book' system, or where urgent, a 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. Where patients had problems with literacy the practice staff actively assisted them with the referral system.

Requests for home visits were referred to the GP on call for the day. They were triaged by the GP then visited if necessary. By having a daily GP on call system all patients were treated in a timely
manner.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. GPs in the surgery undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. They also regularly carry out clinical audits on their results and use that in their learning. Examples of clinical audits on joint injections and audit of patients on Metoclopramide (used to treat nausea and vomiting) once new guidance was issued for use of the drug. An audit on infection control identified areas for improvement which led to the practice producing an action plan which contained changes currently being addressed.

We saw evaluations of medication for people with long term conditions where treatment was changed if required so that the best outcomes could be achieved. Patients told us they were always consulted if the GP wished to change their medication and they were given enough information to enable them to make an informed decision. They told us they trusted the doctor and had never questioned any changes but felt they could if they wished.

The practice reviewed patients under a locally enhanced service to minimise admissions to hospital. 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 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 resulted in the practice ringing the parents to check why they had not attended and offer further appointments.

Regular clinical meetings took place with multi-disciplinary attendance to share information and provide reflection and learning to the benefit of the patients. We saw evidence of collaborative working with district nurses and other practices which resulted in a positive outcome for the patient concerned.

Effective staffing

Practice staffing included medical, nursing, and managerial and reception staff. 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 basic life support.

The GPs covered each other for leave and sickness. We saw there was a rolling rota for GPs which identified their work pattern and clinic times. This ensured there were sufficient emergency appointments available for patients to book on the day and ensuring that pre booked appointments were available. Staff worked in a flexible manner and assessed and changed the appointments available on a regular basis to ensure they were meeting the needs of the patients.

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 some of these were overdue but had been added to the diary for completion. We saw the process included identification of any learning needs and formulation of action plans to address them.

The GPs were up to date with their yearly continuing professional development in line with the requirements of the General Medical Council.

Most of the staff were long serving but we saw new staff had had an induction which covered the practice ethos, introduction to policies and procedures, medical etiquette and duty of care.

Doctors were revalidated and nurse professional registrations were up to date and checked on an annual basis.

All patients we spoke with were complimentary about the staff. We observed staff who appeared extremely competent and knowledgeable about the role they undertook.

Working with colleagues and other services

All the practice staff worked closely together to provide an effective service for its patients. They also worked collaboratively with community services who shared the building and professionals from other disciplines to ensure all round care for patients. Minutes of meetings evidenced that district and palliative nurses and community matrons attended the GP quality team meeting to discuss the palliative patients registered with the practice. The detail evidenced good information sharing and integrated care for those patients at the end of their lives.

Systems ensured all hospital letters and discharge documents were directly scanned onto the electronic system on arrival in the practice, these were also given in paper form to the GP for review. All amendments were made electronically by the GP.

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 hour's service in relation to patients receiving palliative care.

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

The practice was currently working with other practices of part of a rapid response team, this ensured patients who required emergency intensive nursing or social care support in their own homes could access this support and avert unnecessary admission to hospital. The practice was also working with the Clinical Commissioning Group to devise an intravenous therapy protocol to work within the rapid response process to assist patients to remain in their own home for treatments that were not immediately life threatening.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's 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.

GPs met regularly with the practice and palliative care nurses and administration staff. Information about risks and significant events was shared openly and honestly at practice meetings. One of the lead GP's worked within the CCG for part of his working week and shared new and good practice with the practice staff. This kept all staff up to date with current information around local enhanced services, requirements in the community and local families or children at risk.

Patients were discussed between the practice clinicians and also with other health and social care professionals who were invited to attend practice meetings. Information sharing also took place within multi-disciplinary team meetings, palliative/supportive care meetings.

Good

Are services effective?

(for example, treatment is effective)

All staff completed mandatory training which included; Information Governance (IG) and confidentiality training. We saw that the practice staff completed on line IG training which included; records management and the NHS Code of Practice, access to health records.

Access to patient information was dealt with in accordance with NHS guidelines. The practice follows the guidelines of Caldecott principles, the Data Protection Act (1998) and Freedom of Information Act (2000). This supported staff to ensure that only appropriate and secure information sharing took place when appropriate to do so and that information would not be given to any other bodies without first gaining the patient's consent. The practice had a named Caldecott Guardian. A Caldecott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing.

There was a practice website with information for patients including signposting, services available and latest news. Information leaflets were available within the practice waiting room and at the request of any of the clinicians if a patient required more private information. We saw there was a plan to produce in the New Year a monthly patient newsletter.

Consent to care and treatment

Staff understood and were trained in requirements around consent and decision making for people who attended the practice. The GPs and the nurses we spoke with described situations where best interests or mental capacity assessment might be appropriate and were aware of what they would do in any given situation.

GPs and clinicians were Mental Capacity Act trained and we saw evidence that patients were supported in their best interests, with the involvement of other clinicians, families and/or carers where necessary.

The practice policy explained all areas of consent and GPs referred to Gillick competency when assessing young people's ability to understand or consent to treatment. This meant that their rights and wishes were considered at the same time as making sure the treatment they received was safe and appropriate. Some trainee GP consultations were recorded to allow the GP mentor to discuss with the trainee at a later date. All patients were notified of this and asked for their consent when they made the initial appointment and then were reminded and asked to sign a written consent form when they attended the practice. These consent forms were scanned onto the patient record for future reference.

Patients with learning disabilities were offered longer appointments to allow time for the GP or nurse to ensure the patients fully understood the treatment they were about to undergo.

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

Health promotion and prevention

The practice encouraged patients 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. GPs we spoke with told us that patients were actively encouraged to participate in life, for example, through exercise. Membership of a health club was available on prescription from the practice to encourage patients to be more active.

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

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

Each GP took the lead for an area of patient need for example chronic disease management and ensured all relevant guidance and protocols were up to date.

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

We saw that there was a range of health promotion information on display in the waiting areas and leaflets

Good

Are services effective?

(for example, treatment is effective)

explaining different conditions were also freely available in the treatment rooms of the practice. This meant that preventative work could be completed with these patients to assist them to improve their health and wellbeing.

In the reception area we saw a display of information dedicated to carers which provided signposting to support on a wide variety of issues. The practice was participating in a national initiative seeking to develop caring communities.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients we spoke with told us they felt very well cared for and that staff were considerate, friendly and genuinely concerned and attentive to their needs. Privacy during consultations was maintained; curtains were used when patients required examinations and window blinds were closed. Conversations could not be heard through closed doors.

Patients spoke highly of the practice, the reception staff and the doctors. One patient went out of their way to tell us about the wonderful care they had received at the practice that day and every time they visited.

We observed reception staff to be respectful and patient. There was friendly interaction between the reception staff and patients of all ages.

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 17 completed comments cards and spoke with five 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.

Patient experience feedback showed a high degree of satisfaction with the service provided and the attitude towards them by the staff who delivered it. One patient described the practice as the friendly doctor and most patients we spoke with told us that all their families, children and grandchildren, used the same practice.

Clinicians came through to the waiting area to call patients for their consultation. We observed that in doing so they greeted people in a warm, friendly and polite manner. Patients told us they were very happy with this process and commented that some other practices had your name flash up on a screen and you could miss this and this then delayed the patients waiting to see the doctor.

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

Care planning and involvement in decisions about care and treatment

Patients we spoke with and CQC comments cards we received confirmed that they felt involved in decisions about their care and treatment. Patients told us diagnosis and treatment options were clearly explained and they did not feel rushed and felt able to come away from an appointment to think about matters before deciding what they would like to do. Another said the GP always took time to understand and discuss their issues, and answer any questions they may have. All but one of the CQC comments cards we received were positive about all aspects of the service received at the practice.

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 learning disabilities. 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 on palliative care and the GP supported patients with discussion about end of life preferences as appropriate.

All the staff we spoke to were effective in communication and all knew how to access and use Language Line if required. Language Line is a worldwide telephone interpretation service. Literature was available in different languages as and when required.

We looked at the consent policy and talked to clinical and administration staff about consent. We saw the policy provided clear guidance about when, how and why patient consent should be requested. There was reference to children under the age of 16, patients with limited capacity and chaperoning requirements. All staff had completed Mental Capacity Act 2005 training appropriate to their roles.

Patient/carer support to cope emotionally with care and treatment

The practice had systems in place that reflected best practice for patients nearing the end of their life and demonstrated an ethos of caring and striving to achieve dignified death for patients. We were told that in appropriate cases GPs had conversations around end of life planning such as advance care plans, preferred care priorities and resuscitation with patients. This was to ensure patients wishes were managed in a sensitive and appropriate way.

Good

Are services caring?

Multi-disciplinary supportive care meetings were held on a monthly basis to discuss the needs of those approaching end of life. Systems were in place to prioritise support according to estimated prognosis. Patient preferences were shared electronically with appropriate healthcare partners to ensure they were met, for example, with the out of hour's services.

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

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs.
All the patients we spoke with confirmed they would be offered a same day appointment if there was an urgent need, however this would be with the GP on call. This was part of the practices Advanced Access Appointment system.

At the time of inspection the practice was promoting flu immunisation. They had carried out a number of Saturday clinics to help to assist patients to attend who worked during the week.

The practice had tried extended hours for their appointments but had found patients who attended these appointments were not the targeted patient groups (working age patients) so these were no longer available. We were informed that this was something the partners at the practice regularly reviewed to ensure they could meet the needs of their registered patients.

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

Extra diabetic clinics had been added to the practice timetable as the practice found that diabetic patients were being slotted into regular clinics and may not be getting the best from their appointments. These specific clinics were now run by the nurse and the GP lead for diabetes and following the clinic they meet to reflect and discuss the patients seen and any changes to the treatment that may be needed. The clinics allowed time for patients to have full assessments of their need and have their monitoring carried out in a timely manner.

The practice was currently working on a neighbourhood project looking at residential care homes and the management of chronic disease in the homes. This was a project to maintain delivery of care for these patients in the homes and to try to keep patients out of hospital. This was especially targeting education for staff on what the GP could appropriately deal with in the home to reduce the need of emergency admission to A&E.

The practice did not have an active patient participation group. The group was virtual and had 45 members. The practice manager told us the group was set to formally meet in the New Year and then to become active with a GP and practice staff assisting in the running of the group.

We received 17 completed Care Quality Commission comment cards and spoke with five patients. All were very complimentary about the care provided by the clinical staff and noted the overall friendliness and attitude of all staff. They all found the GPs and nurses to be competent and knowledgeable about their treatment needs. They felt that the service was exceptionally good and that their views were valued by the staff. The only negative comment we received was regarding the delay in appointment time suggested in the waiting area not being accurate.

The practice was pro-active in contacting patients who failed to attend vaccination and screening programmes and worked to support patients who were unable to attend the practice. For example, patients who were housebound were identified and visited at home to receive their influenza vaccinations.

The practice staff had started to complete the Demenita friends training all other staff members were actively completing this training. The practice had chosen to complete this training after identifying problems their patients were experiencing once they had been given a diagnosis of dementia. A Dementia Friend learns more about what it's like to live with dementia and then turns that understanding into action to assist the person with the diagnosis. For example extended appointment times,helping the practice environment to become more dementia friendly and signposting patients to appropriate support and information.

All the practice staff pro-actively followed up information received about vulnerable patients.

The practice responded to feedback, if any, on other sites such as NHS choices.

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.

There was level entry to the practice from the street. Reception and the nurses' treatment room and the GP consultation rooms were on the ground floor. There were adequately spacious waiting areas. 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.

Public Health England's data found that the practice's average male life expectancy of 78.7 and female life expectancy 82.5, compared to England's national average is 78.9 for males and 82.9 for females. Clinical staff held a number of regular clinics at the practice to review for example chronic disease management, immunisation and vaccination, smoking cessation and diabetes to provide health promotion information and advice.

The premises were shared with another practice and community services. Initially it was unclear to us where patients should sit because the waiting room was also shared. None of the patients spoken with found this to be an issue and the staff said that new patients were clearly instructed about the layout. There had been instances where patients had waited in the wrong place but GPs had come to reception to call patients so they had not missed their appointment.

Staff reported that there was little diversity within their patient population. However they were knowledgeable about language issues, they also described awareness of culture and ethnicity and understood how to be respectful of patients' views and wishes.

Access to the service

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

The practice was open Monday to Friday from 8.30am until 6.30pm. The practice offered emergency on the day appointments every day with GPs with pre bookable appointments also available. The nurse held surgeries between 9.00am and 6.00pm by appointment. Home visits and on the day appointments were available every day. All surgery opening times were detailed in the practice leaflet which was available in the waiting room for patients and website.

Responses to the national and practice patient survey showed that patients were satisfied with the practice. This was consistent with the responses we received on CQC comment cards. In the national survey 91% of patients who responded said their last appointment was convenient, 87% said they could get an appointment when required. 84% of respondents said the GP was good at listening and giving them time to discuss their needs. Patients reported they were seen in a timely manner and our observations on the day in general confirmed this. We observed a slight delay due to a patient collapsing in the pharmacy who was registered with the practice so one of the GPs went to attend to her. This delay was relayed to waiting patients and they were offered alternative appointments if they did not wish to wait.

Information about access to appointments was available via the practice information leaflet and on the practice web site. The practice operated a choice of same day appointments and those which could be booked in advance.

From the CQC comment cards completed and speaking with patients we were told that it was sometimes difficult to get through by telephone to make an appointment but patients told us they were aware the practice was addressing this with a new system in the near future.

GP appointments were provided in 12 minute slots. Where patients required longer appointments these could be booked by prior arrangement. Staff confirmed that longer appointment times were always allocated for patients with multiple long term conditions or for patients with learning difficulties to ensure time was appropriately spent with patients. Patients with mental health needs were where possible added to the end of clinics to allow them time to discuss their condition with the GP.

When the practice was closed the care and treatment needs of patients were met by an out of hour's provider (Fylde Coast Medical Services). Contact information for this service was well publicised.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

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

We reviewed how the practice managed complaints within the last 12 months. Four complaints had been made by patients or their family. We found the practice handled and responded to complaints well. Complainants always received acknowledgement of the complaint and complaints were investigated and documented in a timely manner as required. Investigations addressed the original issues raised and action was taken to rectify problems.

Patients' comments made on the NHS Choices website were monitored and answered where appropriate. These were discussed at practice meetings and where changes could be made to improve the service these were put in place.

All the staff we spoke with were aware of the system in place to deal with complaints. They told us feedback was welcomed by the practice and seen as a way to improve the service.

We saw that information was available to help patients understand the complaints system in the form of a summary leaflet and on the practice web site. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had needed to make a complaint about the practice.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

Discussions with staff and evidence we reviewed identified that the management team had a clear vision and purpose. The GPs we spoke with demonstrated an understanding of their area of responsibility and they took an active role in ensuring that a high level of service was provided on a daily basis. There was an evident team working ethos that demonstrated all staff worked to a common goal and had all had input.

All the staff we spoke with said they felt they were valued and their views about how to develop the service were acted upon. The staff told us they were dedicated to providing a service with patient's needs at the heart of everything they did.

The practice leaflet and website stated that the practice were interested in the views of their patients and carers and these views were fed into the practice so that they could consider how the service could be improved.

GPs and the practice manager attended neighbourhood and Clinical Commissioning Group (CCG) meetings to identify needs within the community and tailored their services accordingly.

Governance arrangements

We saw systems in place for monitoring all aspects of the service such as complaints, incidents, safeguarding, risk management, clinical audit and infection control. Each topic had a practice lead and reception and administration staff were included in areas of responsibility such as monitoring appointments and introducing systems to improve the smooth running of the practice.

All staff we spoke with were aware of each other's responsibilities and who to approach to feedback or request information. The practice manager took an active role for overseeing the systems in place to ensure they were consistent and effective. The GP partners were also pro-active in that process.

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically. All the policies we looked at had been reviewed and were up to date. The systems and feedback from staff showed us that strong governance structures were in place. The practice manager was also responsible for ensuring that policies and procedures were kept up to date and that staff received training appropriate to their role. There was evidence that feedback from patients was discussed with all staff and learning was applied.

We saw the minutes of recent clinical meetings. The meetings followed a regular agenda and patient feedback, clinical cases and safeguarding were always discussed. The practice regularly submitted governance and performance data to the CCG.

It was evident that staff were able to raise concerns in a constructive and fair manner. Staff were able to describe how they would raise any concerns and explained how feedback and action was disseminated to staff.

The practice participated in the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing well against national standards. We saw that QOF data was regularly discussed at practice meetings and plans were produced to maintain or improve outcomes.

Leadership, openness and transparency

All staff were observed to follow the vision and values of the practice which were very clear. There was an open and honest culture and clinical, administrative and reception staff all encompassed the key concepts of compassion, dignity, respect and equality. They welcomed input from patients of the practice and acted upon feedback. Staff understood their roles and were clear about the boundaries of their abilities. . A staff handbook also provided guidance on practice procedures and expectations.

Staff felt supported in their roles and were able to speak with the practice manager at any given time. They also said they would be happy to speak to any of the GPs if they felt they had any worries. Staff felt valued and were rewarded for the good work they provided.

The practice manager undertook appraisals for the reception, administration and nursing staff on an annual basis. This gave staff an opportunity to discuss their objectives, any improvements that could be made and training that they needed or wanted to undertake. The practice manager had their annual appraisal carried out by the lead GP.

Are services well-led?

Outstanding ☆

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

Clinicians received appraisal through the revalidation process. Revalidation is whereby licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

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. This survey was prepared and ready to be sent out to patients. 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.

The practice had a virtual patient participation group which had 45 members. The group was due to meet face to face in January 2015. Following this meeting the group would set the regularity of meetings and the agenda to be discussed. Work was currently underway to produce a monthly newsletter for patients which highlighted news and information on the practice.

Staff we spoke with told us they were asked for their opinion on matters concerning the practice and they told us they would feel comfortable making any suggestions to improve the service. Staff said the management team constantly looked for areas where they could improve and there was an ethos of improving outcomes for patients and staff within the practice.

Staff were aware there was a whistleblowing policy. They knew who they should approach if they had any concerns and knew the contact details of senior managers within the company who they could contact if required.

Management lead through learning and improvement

We saw a clear understanding of the need to ensure that staff had access to learning and improvement opportunities. Newly employed staff had a period of induction. Learning objectives for existing staff were discussed during appraisal and mandatory training was role relevant. E-Learning was carried out.

Each GP had one hour protected time per week to allow them to meet with staff and discuss any issues that were raised. Staff told us this had been good for them to discuss patients and situations that had occurred.

GPs were supported to obtain the evidence and information required for their professional revalidation. This was where doctors demonstrate to their regulatory body, The General Medical Council (GMC), that they were up to date and fit to practice.

Nurses were also registered with the Nursing and Midwifery Council, and as part of this annual registration were required to update and maintain clinical skills and knowledge. The nursing team had a designated GP lead who could be called upon for support and supervision with their clinical role.

The quality improvement plan designed by the practice had been shared as an exemplary plan across the CCG. The practice was actively involved in the CCG long term strategy plan.

The GPs were involved in local clinical meetings. Similarly the practice nurses and practice manager regularly attended their professional forum groups established by the CCG to provide training and support and share good practice.

The GPs discussed the challenges for services whilst experiencing funding changes however the practice aimed to be innovative and participate in future locality developments, working closely with other practices and the CCG. The GPs were involved in local neighbourhood initiatives and were leading on some of these.

The practice completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice learned from and took action, which improved outcomes for patients.

The lead GP had been the first member of staff to complete the Dementia friends training all other staff members were actively completing this training. The practice had chosen to complete this training after identifying problems their patients were experiencing once they had been given a diagnosis of dementia. A Dementia Friend learns more about what it's like to live with dementia and then turns that understanding into action to assist the person with the

Are services well-led?

Outstanding ☆

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

diagnosis. For example extended appointment times, helping the practice environment to become more dementia friendly and signposting patients to appropriate support and information.

The practice had recently had discussions with Health Education North West to become a training practice for practice nurses.

This section is primarily information for the provider

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.

This section is primarily information for the provider

Enforcement 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.