Harris Medical Centre

Quality Report

Harris Medical Centre
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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?	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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Harris Medical Centre on 8 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing, effective, caring, responsive and well led services to patients and requiring improvement in its overall safety.

Our key findings were as follows:

- Practice staff understood the importance of identifying and reporting when things had gone wrong, however opportunities for learning from events to prevent them reoccurring was not always maximised.
- Clinical audits were regularly used to ensure the most effective and appropriate care was offered.
- Patients' needs were assessed and care was provided in line with best practice guidance.
- Staff had received training appropriate to their role.
- Patients told us that they were treated with compassion, dignity and respect. They were happy with the care they had received.
- The practice recognised the needs of the population it served and delivered its services accordingly.
- The practice provided a safe environment for the care of its patients; facilities were clean and well maintained. Equipment was looked after appropriately.
- Recruitment procedures did not always follow the practice recruitment policy or required regulation in relation to recruitment of staff

We saw several areas of outstanding practice including:

- The practice's links with other agencies such as the Citizen's Advice Bureau and Salvation Army helped maximise outcomes for vulnerable patients.
- The screening programme for those at risk of Chronic Obstructive Pulmonary Disease (COPD) drew national recognition in the form of a nomination for respiratory

Summary of findings

team of the year at the General Practice Awards 2014. Their approach was adopted throughout the Clinical Commission Group (CCG) area and had resulted in an increase in COPD diagnosis.
- The practice offered a Tier-2 (or targeted) sexual health service. This service was available to all Blackpool residents, even those not registered with the practice

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

.The provider must:

- Ensure recruitment procedures are followed so that all required pre- employment checks are carried out before a new employee commences work.

The provider should:

- Ensure learning identified from significant events and complaints is disseminated to staff appropriately in order to maximise its positive impact on practice.
- Ensure all staff complete fire safety training

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?

Requires improvement

The practice is rated as requires improvement for providing safe services.

Staff recognised the need to raise concerns around safety and demonstrated excellent awareness of safeguarding issues. We saw evidence that significant events and complaints were investigated, with changes to practice implemented as a result to prevent re-occurrence. However, learning points from these investigations were passed on to staff on an ad-hoc basis rather than via formalised methods. There were enough staff to keep people safe. All equipment was regularly maintained to ensure it was safe to use and we saw evidence that the premises was regularly cleaned. Despite there being a detailed recruitment policy in place, two of the personnel files that we checked did not contain evidence that appropriate references had been sought.

Are services effective?

Good

The practice is rated as good for providing effective services.

National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Patients' individual needs were assessed. Care was planned and delivered in line with legislation and the promotion of good health. Staff had received training and support. Effective multidisciplinary working was in place and the practice had good relationships with other support organisations locally in an effort to maximise outcomes for patients. Doctors completed audits regularly in order to ascertain the effectiveness of their clinical practice, and the results of these audits were used to modify and improve the effectiveness of the treatment offered.

Are services caring?

Good

The practice is rated as good for providing caring services.

The patients we spoke with and those offering feedback via our comment cards told us that practice staff treated them with dignity and respect. Patients were very complimentary about the practice. They felt their concerns were listened to and that the clinicians involved them in making choices about their care. The practice proactively signposted patients to other support agencies if it felt it would be of benefit.

Are services responsive to people's needs?

Good

The practice is rated as good for offering responsive services.

Summary of findings

Members of the Patient Participation Group (PPG) told us how suggestions they made were listened to and resulted in changes for the benefit of the patient population. On the basis of patient feedback the practice had shifted the emphasis of appointment availability to provide more same day slots. Practice staff reported this had reduced the level of non-attendance at appointments. Longer appointment slots were available to those suffering from certain long term conditions. The practice offered a Tier 2 (or targeted) sexual health clinic service which was available to all Blackpool residents.

Are services well-led?

Good

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

Staff felt that they were supported in their roles and that they were able to raise any concerns they may have. There was a clear leadership structure in the practice with all staff aware of their roles and responsibilities. There were a set of very detailed policies and procedures to guide staff. A range of different staff meetings were held regularly, but not all were minuted. Management actively sought feedback from patients and changes were implemented in response to their suggestions. There was an active Patient Participation Group.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

All patients over the age of 75 had a named GP. The practice patient population included approximately 120 patients who resided in local residential care homes. Care plans were in place for these patients. The practice pharmacists undertook regular medication reviews as appropriate for older patients who were house bound and GPs liaised with the community matrons, case managers and community healthcare teams when attending palliative care multi-disciplinary team meetings. The percentage of patients aged over 65 who had received a seasonal flu vaccination was 70.34%, which compared with the national average of 73.24%.

People with long term conditions

Good

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

The practice had received national recognition in the form of a nomination for Respiratory Team of the Year at the General Practice Awards 2014 for their work in the early diagnosis of Chronic Obstructive Pulmonary Disease (COPD). They used a screening tool (FEV6 monitor) when patients at risk of developing COPD attended for other appointments and referred them on for more detailed investigation as indicated. This process had been adopted by practices throughout the Clinical Commission Group (CCG) and had resulted in increased diagnosis of COPD (11.97% increase in number of patients on COPD registers).

The practice maintained and monitored registers of patients with long term conditions for example cardiovascular disease, diabetes and COPD. These registers enabled the practice to monitor and review patients with long term conditions effectively.

A 'surgery pod' in the waiting area allowed patients suffering hypertension (high blood pressure) to monitor their own blood pressure without the need to wait for an appointment with the nurse. The blood pressure reading could be added electronically to the patient's medical record and a notification sent to the patient's GP if the BP reading was a cause for concern

Families, children and young people

Good

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

Summary of findings

The practice had a consistent uptake of their child immunisation programme, with weekly post-natal checks, child development and vaccination clinics held. The practice offered same day appointments to all children under the age of five. The practice employed a health care assistant who also worked part time as a health visitor. This promoted excellent communication between the two teams. The practice nurse had a weekly session dedicated to reviewing the safeguarding needs of children who were identified as at risk and those who have failed to attend appointments in secondary care. The practice offered a weekly sexual health screening clinic, along with a full contraceptive service. This service was also available for patients who were not registered with the practice.

Working age people (including those recently retired and students)

Good

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

Extended opening hours were not available at this practice. However, patients were able to access appointments on Tuesday and Thursday evening until 8:00pm at Adelaide Street Surgery, with a number of appointments 'ring-fenced' for access by patients with work commitments through the day. Telephone consultations were also available, along with telephone triage by GPs. Appointments could be booked online.

People whose circumstances may make them vulnerable

Good

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

Excellent links with local organisations had been established; a Citizens Advice Bureau clinic was offered at the practice premises and there was an agreement in place with the local Salvation Army hostel to hold correspondence for homeless patients to maximise their ability to access healthcare services. The practice used telephone translation services to support patients who did not speak the same language as the clinician, and double length appointments were booked in such cases.

People experiencing poor mental health (including people with dementia)

Good

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

The practice held regular dementia screening clinics. Patients with known difficulties around mental health were proactively followed up by the GPs if they did not respond to invites for review

Summary of findings

appointments. There was a range of information available for patients and family signposting to community groups and mental health advice services. The practice proactively analysed non-elective admissions data related to mental health issues. Practice staff told us of plans as a result of this to start a dedicated clinic for mental health later this year	

Summary of findings

What people who use the service say

We received 19 CQC comment cards. All comment cards gave positive feedback about the practice. Many complimented the friendly and helpful staff, and commented that facilities were clean and safe. Staff were said to treat patients with dignity and respect, and we were told that GPs explained things to patients in a way that was easy to understand.

Patients we spoke to on the day of inspection confirmed that staff at the practice were very caring and considerate, and treated people with respect. Patients felt that they were involved in the decision making for their care.

One of the three patients we spoke to on the day of inspection reported that appointments did not always run on time, but told us that they never felt rushed when seeing the GPs. Two of the three patients expressed satisfaction with the fact that they could book appointments and order repeat prescriptions online.

Results from the GP Patient Survey published in January 2015 indicated that 69.3% of patients usually waited15 minutes or less after their appointment time, compared to the CCG average of 74.6% and national average of 65.2%. The results also suggested that 86.2% of respondents felt the GP gave them enough time; this compared favourably with the national and CCG averages of 85.3% and 84.9% respectively. Patients felt the GPs involved them in decisions about their care, with 78.2% reporting this (both the national and CCG averages for this were 74.6%).

During the inspection we met with two patients who were also members of the Patient Participation Group (PPG). They told us that the practice actively sought out feedback from their patients. The PPG members felt the practice responded to this feedback and implemented changes to provide a better experience for their patients

Areas for improvement

Action the service MUST take to improve

Ensure recruitment procedures are followed so that all required pre-employment checks are carried out before a new employee commences work

Action the service SHOULD take to improve

- Ensure learning identified from significant events and complaints is disseminated to staff in a timely manner in order to maximise its positive impact on practice.
- Ensure all staff complete fire safety training

Outstanding practice

- The practice's links with other agencies such as the Citizen's Advice Bureau and Salvation Army helped maximise outcomes for vulnerable patients
- The screening programme for those at risk of Chronic Obstructive Pulmonary Disease drew national recognition in the form of a nomination for respiratory team of the year at the General Practice Awards 2014. Their approach was adopted throughout the CCG area and has resulted in an increase in COPD diagnosis.
- The practice offered a Tier-2 (or targeted) sexual health service. This service was available to all Blackpool residents, even those not registered with the practice

Harris Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC lead inspector, with a second inspector also present. The team also included a GP specialist advisor and an Expert by Experience (someone with experience of using GP services).

Background to Harris Medical Centre

Harris Medical Centre is one of two locations operating under the registered provider 'Adelaide Street Family Practice,' the other location being Adelaide Street Surgery. The two locations share a list size of 10,841 patients. Harris Medical Centre occupies a location next to a housing estate on the outskirts of the town, with approximately one third of the practice's patient list living in the vicinity. Patients registered with the practice are able to access services at either location. As such, all data included in this report refers to Adelaide Street Family Practice; the data is aggregated across both locations.

The practice is part of the NHS Blackpool Clinical Commissioning Group (CCG). Services are provided under a Personal Medical Services (PMS) Contract.

Staff employed by the practice include three partner GPs (two male and one female) and four salaried GPs (one female and three male). The GPs are supported by a nurse practitioner and four practice nurses, two pharmacists and three healthcare assistants. Non clinical staff included a practice manager, deputy practice manager, a reception manager, and 18 reception and administration staff. As it is a training practice, one FY2 doctor (a doctor working through postgraduate training programme after completing medical school) was on site on the day of inspection.

Information published by Public Health England rates the level of deprivation within the practice population group as one on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. The practice caters for a population where a higher proportion of patients are unemployed; 21.4%, compared to the national average of 6.2%.

The practice population contains a higher proportion of patients suffering with a long term condition (69.6%) when compared to the national average (54%).

The practice is open between 8:00 and 18:30 on Mondays, Tuesdays, Thursdays and Fridays, and 8:00 until 13:00 on Wednesdays. Patients do have access to extended opening hours at Adelaide Street Surgery until 20:00 on Tuesdays and Thursdays. We were informed that minor surgical procedures were due to be undertaken at Harris Medical Centre in the near future.

When the practice is closed, patients are able to access out of hours services offered locally by the provider Fylde Coast Medical Services (FCMS). Out of hours services are available between 18:30 and 8:00 Monday to Thursday, and from 18:30 on Friday until 8:00 on Monday morning. . Patients are also signposted to access services offered by NHS 111 or the local Walk in Centre on Whitegate Drive if the practice is closed.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. 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 (Regulated Activities) Regulations 2014, and to look at the overall quality of the service to provide a rating for the service under the Care Act 2014.

Please note 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 8 July 2015. During our visit we spoke with a range of staff including three GP partners and a salaried GP, the practice manager, two practice nurses, a health care assistant, a range of administration and reception staff and spoke with patients who used the service. We observed how people were being cared for and we reviewed a range of information provided by the practice leading up to and during the inspection. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice drew on a range of information in order to maintain a safe track record. We reviewed incident reports that showed that they regularly reported and investigated incidents and complaints. The event analysis was written up in detail and conclusions included learning points and recommendations to modify practice so as to mitigate the chances of a repeat occurrence. We saw examples of evidence showing how these recommendations had been implemented in practice. An incident had occurred when a patient had become ill while out of the area. On his return, he contacted the practice to make an appointment with the GP so that the medication he had been given could be reviewed. There was no appointment available on the day so he had to phone back the following day. This had been recognised as a significant event and had been reported and analysed as such. The analysis concluded with additional training being offered to reception staff to ensure they were aware of appropriate cases that should be passed for a GPs attention on the day. Staff were able to tell us about this training and we also saw that the training was supplemented by information posters being displayed behind reception to remind staff of 'red flag' scenarios that need to be brought to a GPs attention immediately.

Staff we spoke with were aware of the need to report significant events and of the procedure by which to do so.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Once written up, significant event documentation was uploaded onto the practice's electronic document management system, making them available for all staff to view. Significant events are discussed at a specific significant event meeting. These meetings were held every six months and were attended by all GPs and clinical staff , reception team leader, practice manager and deputy practice manager.

The nursing staff told us that debriefing regarding significant events occurred verbally on the day of occurrence.

We viewed the write-up for one significant event analysis that highlighted the need to disseminate the learning outcome to staff at the next clinical and operational meetings held by the practice. We were unable to find meeting minutes to confirm that this was done.

National patient safety alerts were disseminated by either the practice manager or one of the pharmacists to relevant staff, as well as being put on the practice's electronic document management system for staff to view. GPs confirmed they received these by email.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We saw that comprehensive safeguarding policies were in place for both children and adults. We looked at training records that showed that all staff had received relevant role specific training on safeguarding. The staff we spoke to were aware of how to recognise signs of abuse in children and adults and of how to report this. The nurse practitioner and practice manager were both able to tell us about a recent example of practice staff appropriately reporting a case of suspected abuse on a child to the local safeguarding team and police. The practice also appropriately notified the CQC of this occurrence at the time.

One of the GPs along with the nurse practitioner were identified as leading on safeguarding issues, with the nurse practitioner running a dedicated weekly safeguarding clinic at the practice. Staff told us that alerts were placed on patient's electronic records so that staff were aware of vulnerable patients. Attendance at Accident and Emergency by such patients was routinely followed up by practice staff. All letters from outpatient clinics for children who did not attend were forwarded on to the nurse practitioner so they were able to follow these up and establish if any further support for the patients was required. Regular external safeguarding meetings were attended by the lead practice staff.

The practice's work around safeguarding had resulted in a recent nomination for the Nursing Standard Public Health Nursing Award, and recognition by the Professional Lead for Public Health at the Royal College of Nursing (RCN). We saw correspondence from the RCN requesting permission for a summary of the practice's safeguarding work to be included on the RCN's website as an example to others.

Requires improvement

Are services safe?

There was a chaperone policy in place and we saw posters advertising this in both the waiting rooms and treatment rooms. A chaperone is a person who acts as support and a safeguard and witness for a patient and health care professional during a medical examination or procedure. Staff with chaperoning responsibilities had received relevant training and had appropriate background checks carried out by the Disclosure and Barring Service.

Medicines management

We checked the medicines stored in the practice. These were stored appropriately and securely. Medicines were kept refrigerated as required and we saw documentation confirming that fridge temperatures were checked regularly to ensure the medicines were safe to use and the cold-chain maintained. The cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines. Staff were aware of appropriate procedures to follow if the cold chain was broken; the practice nurse was able to show us a flow-chart documenting these procedures. All medicines we checked on the day of inspection were found to be in date. The practice nurses had responsibility for checking stocks of medicines and their expiration dates.

The GPs told us that patients' medications were reviewed regularly in line with current guidance by either a GP or one of the practice's pharmacists. One of the practice's prescriptions clerks confirmed to us that blank prescription scripts were monitored and stored securely.

Oxygen was kept on site in case of emergency. This was stored securely and checked regularly.

Cleanliness and infection control

The premises were visibly clean and tidy on the day of inspection. There were cleaning schedules in place in all rooms and associated signature charts to record that cleaning had been carried out; these had been signed appropriately. The practice contracted cleaning duties out to an external company. The practice manager informed us that while cleaning audits had not been carried out regularly up to that point, they were in discussion with the cleaning contractors so that this process could be started. Comments recorded by patients on the CQC comment cards indicated they feel the premises are kept clean, with a number referring to the practice as a hygienic environment.

The practice had a current infection prevention and control (IPC)policy and risk assessment in place, both dated June 2015. Staff told us that everyone working at the practice shared responsibility for maintaining adequate infection prevention and control standards. There was a lead GP named as the IPC lead, along with clinical staff , as part of the IPC team.

We saw that there were adequate hand washing facilities in the treatment rooms, and hand sanitiser dispensers were also located around the premises, including in the waiting area. Posters detailing 'ten steps to effective hand washing' were displayed next to all sinks.

There were appropriately colour coded bins for the safe disposal of used needles in all treatment rooms, and these bins were out of reach of the patients.

We saw a certificate relating to the practice's water system being tested for Legionella in August 2013. The practice was in possession of equipment to ensure the risk of Legionella was monitored.

Equipment

Staff told us that they had sufficient equipment to carry out their jobs. We saw documents such as logs and maintenance certificates evidencing that equipment was calibrated weekly and their service schedules maintained.

The practice planned to conduct minor surgical procedures at the Harris Medical Centre site later in the year. We saw that suitable facilities and equipment were in place for this regulated activity to be carried out.

Contracts were in place for annual testing of fire extinguishers and portable appliance testing (PAT). PAT testing and calibration of electrical equipment had been undertaken in October 2014 and was due to be carried out again in October of this year.

Staffing and recruitment

Staff told us there were enough staff to maintain the smooth running of the practice. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. Rota systems ensured there was a good skill mix on duty at any given time, and non clinical staff operated a 'buddy' system, whereby staff members were trained to carry out work done by their colleagues so that they were able to cover for them should they be off work.

Requires improvement

Are services safe?

The practice had clear lines of accountability for all aspects of care and treatment. Clinical staff had lead roles for which they were appropriately trained. The skill mix of the staff was appropriate; each person knew exactly what their role was and undertook this to a high standard. Staff were skilled and knowledgeable in their field of expertise and were able to demonstrate how they could support each other when the need arose.

We saw that the practice had a comprehensive induction pack on their network shared drive which was made available to new staff and locum GPs. The pack contained information such as contact details for other staff members, the locations where emergency equipment was stored in the practice, and information around making referrals to secondary care.

We saw evidence that demonstrated professional registration for clinical staff was up to date and valid, for example with the General Medical Council (GMC) and the Nursing Midwifery Council (NMC) where appropriate.

The practice had a comprehensive and appropriate recruitment policy. We reviewed four staff files. We saw evidence that appropriate criminal records checks through the Disclosure and Barring Service (DBS) had been carried out and identification sought as part of recruitment. However, two of the files lacked evidence that references from previous employers had been taken during the recruitment process. In one of the other two files, there was evidence that one reference had been provided prior to employment being commenced, but it was unclear who had provided the reference. References from previous employers form a crucial part of the recruitment process; they corroborate a person's past work experience and ensure staff are suitably qualified and experienced to carry out the role they are being recruited to. Other documentation contained in the files was seen to be appropriate.

Monitoring safety and responding to risk

The practice manager was in the process of compiling an up to date risk register for the practice. All new employees working in the building were given induction information for the building, which covered health and safety and fire safety. The practice regularly had fire equipment tested; the fire alarms were checked on a weekly basis and we saw documentation confirming this. However, one member of staff we spoke to was unable to confirm the fire evacuation procedure. The practice manager confirmed that fire evacuation drills had not been undertaken. We did see that fire action posters were visible in the reception areas with instructions of what to do in the event of a fire, and we saw from practice training records that two members of staff had been trained for the role of fire marshals. The staff training records also showed us that of the 38 employees, 24 had completed fire safety e-learning.

Arrangements to deal with emergencies and major incidents

Staff described how they would alert others to emergencies by use of the panic button on the computer system.

An appropriate business continuity plan was in place. This comprehensive plan covered business continuity, staffing, records/electronic systems, clinical and environmental events. Key contact numbers were included flow chart summaries were displayed for staff to see in the practice. Staff we spoke with were knowledgeable about the business continuity plan and could describe what to do in the event of a disaster or serious event occurring.

Staff had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). This was updated annually. Emergency medicines were available in a secure area of the practice and all staff knew of their location. One of the practice pharmacists took responsibility to check medicines stored were in date. There was a defibrillator kept in the practice and staff were aware of its location.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found clinicians and staff were familiar with the needs of each patient population group and the impact of the socio-economic environment where patients lived. The partner GPs proactively monitored the service they provided against a range of local and national benchmarking tools to measure their effectiveness. National and professional guidance from organisations such as the National Institute for Health and Care Excellence (NICE) was utilised in clinical decision making; for example in their analysis of seven day blood pressure monitoring, the first and last day's readings were discounted as per NICE guidelines.

The practice pharmacists ensured that the GPs were kept up to date with medicine alerts and updates, such as those received from the Medicines and Healthcare Products Regulatory Agency (MHRA).

Management, monitoring and improving outcomes for people

The practice had a clear understanding of the different population groups they provided service for. Care plans were in place for the older population and those with long term conditions. We viewed care plans for patients experiencing poor mental health, as well as palliative care plans.

The practice routinely collected information about patients' care and treatment. It used the Quality and Outcomes Framework (QOF) to assess its performance and undertook clinical audits. QOF is a voluntary national performance standard. QOF data showed the practice achieved 98.7% of the total points available to them and performed above the national average of 94.2% achievement.

The practice has a system in place for completing clinical audit cycles. Examples of clinical audits included the monitoring of coil insertions (a form of contraception) and an audit of the documenting of home visits carried out by the practice. Both of these audits represented full audit cycles, that is, the studies were repeated to monitor changes and maximise learning outcomes. Both resulted in documented learning outcomes and changes to practice. Both showed improvements when they were re-audited. The coil audit demonstrated compliance with Faculty of Sexual and Reproductive Healthcare (FSRH) guidance.

The practice robustly monitored its performance data as compared to their Clinical Commission Group (CCG) peers in order to benchmark themselves and tailor their services to meet the needs of their patient population. For example, it compared its referral rates to secondary care as compared to its local peers. They used an online reporting tool to do this. Such analysis had formed the basis for the practice's decision to start offering alcohol and mental health clinics in the near future.

The practice monitored patients' hospital letters and outcome of A & E attendance in order to identify those at risk of developing long term conditions. They also carried out monthly dementia screening clinics and proactively screened high risk groups for Chronic Obstructive Pulmonary Disease (COPD). The practice used a screening tool when patients attended for other appointments. If concerns were identified additional appointments were made for more detailed investigations into lung and airway function. The practice had been recognised for its work in COPD screening and was a finalist in the 2014 General Practice Awards for Respiratory Team of the year. The screening tool had subsequently been adopted by other practices locally within the CCG. In its first year in use across the CCG, the screening procedure resulted in an 11.97% increase in the size of COPD registers. Early detection of CODP is important if sufferers are to be encouraged to stop smoking.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw staff were up to date with mandatory training such as annual basic life support and safeguarding.

GPs were up to date with their yearly continuing professional development requirements and had either been revalidated or had a date for revalidation (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Good

Are services effective?

(for example, treatment is effective)

Staff appraisals had been undertaken, with input from a GP, for the nursing staff. Staff were able to identify any areas for development and when we spoke with staff they were very positive about support and opportunities for training and development. The feedback from staff we spoke with was overwhelmingly positive. Staff were enthusiastic about working at Adelaide Street Surgery. They told us patients were central to the services they provided and were clear how their contributions contributed and impacted on the care being provided. They felt the practice placed high emphasis on their professional development. The practice nurses were able to demonstrate that they were trained and updated to fulfil the duties they performed.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. The practice offered Citizens Advice Bureau clinics on the premises so that patients could easily access support from them, and the practice also worked closely with the local Salvation Army in order to support homeless people to access health services.

The practice had coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register and palliative care register. The practice referred patients appropriately to secondary (hospital) care and other services.

Staff regularly attended palliative care and safeguarding multi-disciplinary team meetings.

One of the health care assistants worked part time in her role with the practice, and also part time as a health visitor. This allowed for excellent communication links between the practice and local health visiting team and supported the practice in the care it delivered to families with young children.

Information sharing

We found referrals were made to secondary care (hospital) in a timely way. Staff had all the information the practice needed to deliver care and treatment to patients. We saw that all letters relating to blood results and patient hospital discharge letters were reviewed by the GPs or nurses via the electronic records system. Task allocation to GPs and nurses was utilised effectively to improve workflow and ensure patient information was reviewed in a timely manner.

The practice had effective information sharing protocols in place with both their out of hours provider and Accident and Emergency.

The practice website was used to keep patients up to date with staffing news, surgery closures, services offered, feedback from patients from the Friends and Family test and appointment access information. The practice also had a social media page which was used to disseminate useful information to patients.

Consent to care and treatment

There was a current consent policy in place. Clinical staff demonstrated an understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

We saw records showing clinical staff had received training around the Mental Capacity Act (2005) and they were able to demonstrate appropriate understanding of its implications on practice during discussions with inspectors. Three of the four GPs we spoke to demonstrated an awareness of Deprivation of Liberties Safeguards (DoLS).

We saw that a consent form had been developed by the practice to be used once minor surgical procedures were being undertaken. This was to ensure patient's consent to treatment was recorded appropriately.

Health promotion and prevention

There was a wide range of health promotion and health advice leaflets in both waiting areas. Contacts for various health and social care services in the local community, such as dementia and mental health organisations were available. The practice website also contained links directing people to more in depth health promotion and advice.

While health check screens were not offered as standard to all new patients registering with the practice, they were all sent a screening questionnaire to allow them to flag up any concerns to the GPs.

Good

Are services effective?

(for example, treatment is effective)

The practice nurses held a variety of clinics including a weekly baby clinic. The practice also operated NHS health checks for patients between 40-74 years of age. Two of the nurses were also trained providers of diabetes structured education programmes which empowered patients to take control of the management of their diabetes.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

All patients we spoke to during the inspection told us that they were happy with the care they received. The practice was described by the patients as being very caring. They told us that they were treated with respect and dignity by the practice staff, and that their confidentiality was maintained.

Consultations took place in consulting rooms away from the main patient waiting area. All rooms had an appropriate couch for examinations and curtains to maintain privacy and dignity. We observed staff in the reception area lowering their voices when addressing patients to avoid being overheard, and music was being played in the waiting area to minimise the risk of personal details being inadvertently disclosed to other patients during discussions with receptionists.

The practice offered patients a chaperone prior to any examination or procedure. Information about having a chaperone was seen displayed in the reception area and all treatment and consultation rooms. Staff were appropriately trained.

Patients' responses to the National GP patient survey showed that they felt their GP gave them enough time; 86.2% of respondents felt this was the case, compared to the Clinical Commissioning Group (CCG) average of 84.9%.

Care planning and involvement in decisions about care and treatment

Patients we spoke to told us that both GPs and nurses at the practice were good at involving them in decisions about their care and treatment. We were told that the GPs were good at discussing treatment options with patients. This was reflected in results from the National GP patient survey, where 78.2% of patients felt the GP involved them in care decisions (compared to the CCG average of 74.6%), and 78.3% felt that the nurse involved them in decisions about their treatment (the CCG average was 72.3%). The proportion of patients who felt that their GP was good at explaining tests or treatments was 81.8%, where the average for the CCG was 81.7%.

We saw that patient records documented patient involvement when care plans were drawn up. The examples we saw related to care plans around poor mental health and palliative care.

Patient/carer support to cope emotionally with care and treatment

There were health promotion and prevention advice leaflets available in the waiting room for the practice including information on identifying the signs of asthma and local weight management programmes. There were also leaflets and posters to raise awareness of local dementia services, respite care and peer support groups for people suffering alcohol addiction.

The practice notice board contained details for carers on support groups and events to assist them in their caring role.

The practice told us that they contacted family members after there had been bereavement by sending them a sympathy card. The sympathy card contained details signposting family members to support groups they may find useful to access. Patients we spoke to confirmed that this was done.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice used the coding of health conditions in patients' electronic records and disease registers to plan and manage services. The practice identified patients who needed on-going support with their health. The practice kept up to date disease registers for patients with long term conditions such as diabetes, asthma and chronic heart disease, which were used to arrange annual health reviews. The practice also kept registers of vulnerable patients such as those with mental health needs and learning disabilities and used these to plan annual health checks. Alerts identified on the practice system when recalls were due. There were identified staff members who took responsibility for monitoring these alerts, who followed, predefined procedures to recall the patients for review.

Practice staff pro-actively followed up information received about vulnerable patients, including notifications of failures to attend secondary care appointments.

The practice provided a number of enhanced services which included dementia assessments, influenza and pneumococcal vaccinations, rotavirus and shingles immunisation and extended opening hours.

The practice offered a Tier-2 (or targeted) sexual health service. This service was available to all Blackpool residents, even those not registered with the practice. The service offered screening and treatment for sexually transmitted diseases and was offered on a confidential basis if patients did not wish to disclose their names or personal details.

The practice had also linked up with the Citizens Advice Bureau and offered clinics enabling patients to access advice. This aimed to reduce areas of stress and anxiety and promote improved opportunities for mental wellbeing. They had an agreement in place with the local Salvation Army hostel to facilitate the practice being able to contact homeless people on their patient list. The hostel would pass on correspondence to patients. This maximised their opportunities to access healthcare services. The practice also signposted patients who were recovering from drug and alcohol addictions to several other agencies to support their rehabilitation, for example 'Delphi' and 'Jobs, Friends & Houses.'

The practice benchmarked their referral data to secondary care against local practices in the Clinical Commissioning Group (CCG) using an online tool. This information was used to plan and tailor services offered to meet the needs of their patient population.

We spoke to members of the Patient Participation Group (PPG) who told us that they feel the practice listened to them and acted on suggestions they made. It was a recommendation made by the PPG group that resulted in the practice sending out bereavement cards to relatives of patients who had died.

Tackling inequity and promoting equality

The practice facilities enabled appropriate access to those patients in wheelchairs; there was a ramp allowing access to the front door.

The practice provided services to patients from a range of different ethnic and cultural backgrounds.

The practice website contained links to information leaflets explaining the roles and functions of GPs in the English healthcare system. These leaflets had been translated into a number of different languages, for example Polish, Croatian, Punjabi, Albanian, Mandarin and Cantonese.

Translation services were used for patients whose first language was not English. The practice would use either an interpreter face to face or the telephone interpreting service. Double appointments were booked in these instances to ensure that there is sufficient time to adequately explain treatment.

Access to the service

Patients had access to appointments at Adelaide Street Surgery, where the practice operated extended opening hours, with evening surgeries on Tuesdays and Thursdays when the practice was open until 8:00pm. The practice offered a mixture of same day appointments and some that could be booked in advance. It also had telephone appointment slots. A number of the evening appointment slots were ring-fenced for those patients who worked.

Appointment and repeat prescription requests could be booked online via the practice website. The pharmacists offered home visits to those patients who were house bound or residing in care homes in order for medication reviews to be carried out.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice sent out text message reminders of appointments to patients' mobile telephones in an effort to minimise failures to attend and minimise appointments being wasted.

A 'surgery pod' was available in the waiting area. This allowed patients to take their own blood pressure readings as well as accessing new patient questionnaires and health services via touch screen prompts. Patients had the option to submit their results electronically directly into their medical records, with the GP alerted should there be any results that needed to be followed up. This service could be used without the need to book an appointment.

National GP Patient Survey results published in 2015 indicated that 95.5% of the 120 patients who responded found their last appointment was at a convenient time. This compared favourably with the CCG average of 94.6%. The proportion of patients who found the practice easy to contact by phone was 72.3%, which is below the CCG average of 77.1% but slightly above national figures of 71.8%.

Listening and learning from concerns and complaints

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

We saw documentation demonstrating that complaints were recorded appropriately and dealt with in the required time scales. We saw that the practice had responded to complaints and modified its procedures to avoid similar instances from happening again.

The practice held an annual meeting to discuss complaints received. The staff we spoke to were unsure about how feedback arising from specific complaints was routinely disseminated to the workforce. They were, however, able to describe verbal feedback that had been given to them on an ad-hoc basis.

None of the patients we spoke to had felt the need to raise any complaints with the practice.

We saw that information was available to help patients understand the complaints system in the form of a summary leaflet available on the practice web site.

Modifications to the practice had been made on the basis of concerns raised by its patients. For example, music being played in waiting areas in order to minimise other patients overhearing when someone checks in at reception. The practice had also marked out a 'privacy zone' around the reception desk to prompt patients to give people enough space then liaising with receptionists. The 'surgery pod' with blood pressure monitoring equipment had been installed as a result of patients suffering hypertension raising concern over the time they had to wait for a nurse's appointment.

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 demonstrated a clear vision and strategy for the future to improve services for patients. Plans were underway to construct new premises for the practice and expand the services offered. Working with a neighbouring practice it was hoped these new premises would become a Neighbourhood Hub for the Intensivist team (an Intensivist care model aims to provide coordinated and proactive care for patients offered through a single point of access). We saw an executive summary document outlining the plans that had been submitted to local councillors in order to garner support for their proposal. The staff we spoke to on the day of inspection were able to articulate this vision to us.

The practice had plans in place to start offering minor surgical procedures as well as offering dedicated mental health clinics.

Governance arrangements

There was a system in place for assessing and monitoring the quality of service provision. This included delegated lead roles and duties for clinical and non-clinical staff for areas such as complaints management and significant events.

Staff we spoke with were able to tell us who the leads were for clinical and non-clinical areas and said they would speak with either the GPs or lead receptionist to raise any queries.

The practice had policies and procedures in place to give staff guidance. These were dated appropriately and specified appropriate dates for regular review.

Clinical audits were undertaken by the GPs throughout the year to audit their performance and change practice as required for the benefit of patients they supported. For example, we saw that audits examining the coding of home visits in patient records and examining outcomes following the insertion of coils had been completed and evaluated.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed the practice performed above the England average in 2013/14.

Leadership, openness and transparency

Staff told us that they felt supported in their roles. They said there was a friendly, open culture in the practice and that staff worked well as a team.

Staff had specific roles within the practice for example for safeguarding. We saw that the practice had a Whistleblowing policy in place.

We saw that various staff, team and operational meetings were held on a regular basis and staff told us that these meetings were rotated to fall on different days of the week so that they were not consistently falling on days that some people did not work. However, not all of these meetings were minuted. Feedback from complaints and significant events were discussed at specific meetings that occurred infrequently. We did not see minutes of meetings with all staff in attendance where learning outcomes from these events were disseminated to staff.

The practice website contained links directing people to the GP patient survey results for the practice.

The practice manager demonstrated a good awareness of when to appropriately notify the CQC of an event and had recently done so, following a safeguarding concern.

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

The practice proactively sought to obtain feedback from its patients; sending text message reminders to prompt patients to complete questionnaires and surveys. Patients were able to complete the NHS Friends and Family test via the practice website.

The staff we spoke to told us that they felt they were able to raise concerns and make suggestions. This could be done either during one of the structured meetings or informally. They felt that the practice took on board any suggestions that they made. The practice had an active patient participation group which met on a regular basis and the members of the group we spoke with reiterated this sentiment. They gave examples of changes put in place as a result of suggestions the group had made, for example sending out bereavement cards.

There was also a 'virtual' patient participation group of approximately 50 members who were registered and engage with the practice electronically by completing surveys online.

Management lead through learning and improvement

Are services well-led?

Good

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

Most staff were up to date with annual appraisals, which included looking at their performance and development needs. Staff told us appraisals were useful and provided an opportunity to share their views and opinions about the practice.

The practice was seen to support the continuing development of its staff. One member of staff we spoke to initially started work in the practice as a receptionist and told us how the practice supported her through training to become a health care assistant.

Staff undertook a wide range of training relevant to their roles and responsibilities. Records of some staff training were available in the form of certificates in the staff files we reviewed. A complete central record of training was available for all practice staff.

Staff told us that peer support in the practice was actively encourage, with opportunities given to share examples of good practice with colleagues.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered provider must ensure recruitment procedures are followed and all information specified in Schedule 3 is available in respect of staff employed to ensure staff are safely and effectively recruited and employed.** Regulation 19 (1)(2)(3) Schedule 3