Kirkham Health Centre

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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Kirkham Health Centre.

We carried out a comprehensive inspection on 2 December 2014. We spoke with patients, members of the patient participation group and staff, including the management team.

The practice was rated as good overall.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Systems were in place to promote identification of safeguarding concerns at the earliest possible opportunity. Lessons were learned and communicated widely to support improvement.
- The practice was proactive in using methods to improve patient outcomes. Best practice guidelines were referenced and used routinely. Patients' needs were assessed and care planned and delivered in line with current legislation.
- The practice was very proactive in identification of patients at increased risk of hospital admission and creation of care plans to minimise that risk.
- Patients were treated with compassion, dignity and respect. They were involved in decision making about the care and treatment they received.
- Patients had good telephone access to the practice and were seen in a timely manner on arrival for appointments. Non urgent appointments could be booked up to six months in advance
- The practice worked collaboratively with a neighbouring practice, the NHS England Local Area Team and Clinical Commissioning Group to discuss local needs and service improvement.

We saw some areas of outstanding practice including:

Summary of findings

- The practice had reviewed patient data to identify those at higher risk of admission to hospital. Care plans had been discussed and agreed with these patients with a view to reducing unplanned admissions. In excess of 2% of the patient population now had care plans in place which exceeded the practice's national target. They were now aiming to achieve 4% by the year end.

In addition the provider should:

- Medicines should be stored in a more appropriate manner.
- The practice should complete an annual infection prevention and control audit.
- Gas or electrical safety checks should be undertaken. certificates in relation to services at the building.
- The practice should carry out an annual fire risk assessment.
- The practice should update the Business Continuity Plan.

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 understood their responsibilities to raise concerns, and report incidents and near misses. Lessons were learnt and communicated widely to support improvement. The practice had systems to manage and review risks to vulnerable children, young people and adults. There were enough staff to keep people safe. However, there were some areas where improvements should be made, for example medicines management.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. NICE guidance is referenced and used routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff received training appropriate to their roles and further training needs were identified and planned through a system of appraisal. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Accessible information was provided to help patients understand the care available to them. We saw that staff treated patients with kindness and respect, ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the NHS England Local Area Team and Clinical Commissioning Group to secure service improvements where these were identified. Patients reported good access to the practice. Urgent appointments and home visits were available when required. The practice was equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded to issues raised in a timely manner.

Summary of findings

Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and regular governance meetings took place. The practice had a number of policies and procedures although some required review. A document control system had recently been introduced with a view to rectifying this. There were systems in place to monitor and improve quality and identify risk. However there were also some areas, such as fire risk assessment, where this was lacking. Staff had received inductions, received regular performance reviews and attended staff meetings. The practice proactively sought patient feedback through surveys and had established a 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. The practice offered proactive personalised care to meet the needs of older people in its population. Patients aged 75 years and over had a named GP and the GPs operated a buddy system ensuring good continuity of care should one be absent. Comprehensive care plans were in place for patients identified as at increased risk of hospital admission. The practice was responsive to the needs of older people, including offering home visits, telephone consultations and memory screening. They were working collaboratively with a neighbouring practice to improve local services with an initial focus upon the elderly.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All nurses were trained in the management of chronic conditions. Patients had structured annual reviews to check their health and medication needs were being met. For those with the most complex needs GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice had plans to work collaboratively with a neighbouring practice to develop and improve community access for those with chronic conditions.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available out of school hours. The practice operated on the principle that children should be seen quickly and this was achieved through triage by the nurse practitioners. Baby change facilities were available and breastfeeding promoted. The practice had a named GP who lead on women's services.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working age people (including those recently retired and students). The needs of this group had been identified and the practice had adjusted the services it offered to ensure these were accessible. Routine appointments could be booked several months in advance enabling patients to plan ahead. Online facilities were soon to be extended to enable patients to book appointments and request repeat prescriptions through the practice website. A full range of health promotion and screening services were offered which reflected the needs of this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of people with learning disabilities and these patients were offered annual health checks and longer appointments. The practice adopted a wide definition of vulnerability so that it included those facing issues such as substance abuse and for whom English was not the first language. Care plans were developed for all vulnerable patients. The practice worked with multidisciplinary teams in the case management of vulnerable people. Staff knew how to recognise the signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Annual physical health checks were offered to people within this population group. The practice worked with multidisciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice was proactive in offering memory checks to its patient population with a view to early identification of dementia. A member of staff had been specifically trained for this role. All staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We received 25 completed CQC comment cards and spoke with three patients visiting the surgery on the day of inspection. We also spoke with three members of the Patient Participation Group. We received feedback from male and female patients across a broad age range.

Most patients spoke very positively about the practice, and the care and treatment they received. Their descriptions of staff included excellent, helpful, kind and friendly. One patient who expressed a negative view told us their experience varied dependent upon the individuals involved. Patients felt they were treated with compassion, dignity and respect. They told us staff listened to them and took time to discuss and explain treatments and options. One patient with experience of bringing a child to the surgery confirmed the GP had spoken with the child in a manner appropriate to their age and understanding and put the child at ease. Patients felt involved in the planning of their care and treatment.

Patients who commented on the ease with which they could get an appointment were generally satisfied. They told us that appointments could be easily arranged by telephone. Patients consistently said they had access to same day appointments where there was an urgent need. Two people commented that they may have to wait two to three weeks if they wished to book a non-urgent consultation with their GP of choice, particularly to see the female GP. One person said they though the practice might be overstretched. Patients said they were seen in a timely manner when they arrived for an appointment. They told us that they felt listened to by staff and did not feel rushed during their consultation.

Several patients commented that the environment was always clean and tidy.

The most up to date results available from the national GP patient survey showed that 78% of those who responded said their overall experience of the surgery was good. 91% said they found it easy to get through to the surgery by telephone and 71% rated their overall experience of making an appointment as good. 77% said reception staff were helpful. 79% said that GPs were good at giving them enough time and listening whilst 89% said the same of nurses. 81% of respondents said the GPs were good at treating them with care and concern, and 90% said the same of nurses.

Areas for improvement

Action the service SHOULD take to improve

- Medicines were not appropriately stored. Checks made to ensure medicines and vaccines were within their expiry date were not recorded. Blank prescription forms were not handled in accordance with national guidance.
- An annual infection prevention and control audit was not undertaken.
- Gas and electrical safety checks were not up to date.
- The practice Business Continuity Plan was not updated.

Outstanding practice

- The practice had reviewed patient data to identify those at higher risk of admission to hospital. Care plans had been discussed and agreed with these patients with a view to reducing unplanned admissions. In excess of 2% of the patient population now had care plans in place which exceeded the practice's national target. They were now aiming to achieve 4% by the year end.

Kirkham Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Kirkham Health Centre

Kirkham Health Centre is one of 21 member practices within the Fylde and Wyre Clinical Commissioning Group. The practice is located in the village of Kirkham and has 8589 registered patients. The nearest hospitals are in Blackpool and Preston, both of which are approximately ten miles away.

Information published by Public Health England rates the level of deprivation within the practice population group as nine on a scale of one to ten. Level one represents the highest level of deprivation and level ten the lowest. The patient population comprises of significantly more over 65s and significantly less under 18s than the national averages.

The practice team comprises of four GPs including one female, two nurse practitioners, three nurses, a healthcare assistant, a phlebotomist, a practice manager and a team of 14 administrative / reception staff. The practice has a Patient Participation Group.

The practice opening hours are Monday to Friday 8.30am to 6.30pm. When the practice is closed an out of hours service is provided by Preston Primary Care Centre.

The practice operates under a contract to provide general medical services (GMS).

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

We carried out comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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?

Detailed findings

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

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

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

We carried out an announced visit on 2 December 2014. During our visit we spoke with GPs, members of the nursing team, the practice manager, reception and administration staff, and patients visiting the surgery. We observed how people were communicated with. We reviewed CQC comment cards where patients and members of the public were invited to share their views and experiences of the service. The CQC comment cards were made available at the surgery prior to inspection.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. We were told of an example where the practice had discovered a patient had been issued with an incorrect medication by a pharmacist. The patient had been contact immediately and given advice. The practice had raised their concerns about the matter with the General Pharmaceutical Council. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where such issues were discussed for the last year. This showed the practice had managed these consistently over time and evidenced a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Records of significant events that had occurred during the last year were made available to us. The records showed events had been thoroughly analysed, actions to prevent recurrence identified, and learning extracted and shared with relevant staff in a timely manner. The practice had a regular programme of meetings which provided a forum for learning to be shared with the wider team.

We were told national patient safety and medicines alerts were received electronically by the practice manager and cascaded to relevant staff. The practice had recently received a patient safety alert in relation to the Ebola virus advising that if a patient had a high temperature and had recently returned from an infected country physical attendance at the practice should be avoided. The alert had included posters for display in the practice but we noted these were not visible. Reception staff we spoke with had no knowledge of the alert and were not therefore making enquiries of patients. However, nursing staff we spoke with confirmed that as part of the triage system appropriate questions were being asked.

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

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Training records showed all staff had received relevant role specific training on safeguarding and this was up to date. Minutes of primary health care team meetings showed one of the GPs had recently delivered a training session to staff on safeguarding children and young people who self-harm.

There were policies in place in relation to safeguarding both children and vulnerable adults. These were readily accessible and staff knew where to find them. Staff knew how to recognise the signs of abuse. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours. Contact details were easily accessible.

There were dedicated GPs appointed as leads in safeguarding children and vulnerable adults who had completed training to the necessary level to enable them to fulfil this role. All staff we spoke with knew who the leads were.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when the patient attended for appointments, for example, children subject to a child protection plan.

All incoming post to the practice was promptly reviewed by the data team who highlighted areas for GP action and ensured they were brought to the GPs attention in a timely manner. We were told of a recent change to the system so staff now also highlighted and referred to a GP anything they perceived might be an early indication of a safeguarding issue. Staff told us they were well trained and felt confident in this fulfilling this role. We were told the system was working well and given two recent examples of when a GP had made early contact with a health visitor in response to issues highlighted.

A chaperone policy was in place. A notice advising patients they were able to request a chaperone during consultation if they wished was displayed near the nurses rooms.

Are services safe?

However, the nurses' rooms were located at the far end of a corridor and the notices were not immediately visible to patients in the general waiting area. If a chaperone was required the role was fulfilled by clinical staff who had received appropriate training.

Patients' individual records were managed in a way that helped ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of documents from hospitals.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators. Keys for the secure medicines cupboard had been misplaced. Replacement supplies of medicines had been obtained which were being temporarily stored in a lockable filing cabinet within the nursing area. We found the cabinet unlocked. Minutes of practice meeting showed the practice manager had been tasked with arranging more suitable storage for medicines.

We checked the supplies of medication and vaccines held and found them to be within their expiry dates. Nursing staff told us they checked supplies weekly to ensure they were in date and sufficient. There was no system in place to record when checks were completed and by whom in order to provide a clear audit trail.

Staff checked the refrigerators daily to ensure medicines and vaccines stored in them were kept at the required temperatures. These checks were recorded.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

Prescription forms were reviewed and signed by a GP before they were given to the patient. However we found that blank prescription forms were not handled in accordance with national guidance. They were not tracked through the practice. They were stored in cupboard in an upstairs office which was not accessible to the public, however the cupboard was not locked.

Cleanliness and infection control

The practice employed cleaners to attend on a daily basis. We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept.

One of the nurses acted as lead for the practice in relation to infection prevention and control. They had stepped in to take over the role from a colleague who had left in May 2014 but had not received any additional training to support them in this regard. They told us that lead roles amongst the nursing team were due to be reviewed the following week. The lead told us they had not carried out an infection prevention and control audit at the practice during their time in the role. We were unable to establish whether one had been completed by the previous lead. Visiting district nurses used treatment rooms at the practice for their work and as a result an external agency had completed an audit of the nurses' clinical environment in September 2014. The audit had not been commissioned by the practice. Some issues had been identified but we saw the practice had produced an action plan to address them and this had been implemented in a timely manner.

All staff received training about infection control specific to their role as part of their induction but there were no arrangements in place for staff to receive refresher training thereafter. An infection control policy and supporting procedures were available for staff to refer to. This included matters such as glove policy, hand hygiene protocol and dealing with needle stick injuries. The practice had adopted protocols from the former Primary Care Trust and more recently from a local teaching hospital. Those adopted from the Primary Care Trust were in need of review.

Supplies of disposable protective equipment such as gloves and paper coverings for treatment couches were available but staff told us that disposable aprons were not readily available to them. Hand hygiene signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, gel and paper towel dispensers were available in toilets and treatment rooms.

We asked the practice if they had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). There was no policy but we were told that a new low risk water and heating system had

been installed in 2009 and a legionella risk assessment completed as part of that process. A further risk assessment had been completed in 2012 with a finding that there had been no changes and it remained a low risk.

Equipment

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us equipment was tested and maintained regularly. We saw equipment maintenance logs and other records that largely confirmed it though we noted that although the defibrillator was regularly tested by staff it had not been serviced. The defibrillator was five years old. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. Further testing was due in December 2014. We saw evidence of calibration of relevant equipment, for example, blood pressure monitors. We noted that the ECG machine was last calibrated in August 2013 and was due further testing.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The policy stated that start dates would be agreed on receipt of satisfactory references. We looked at the records held in relation to three members of staff recruited during the last six months. We saw that they contained evidence that recruitment checks had been undertaken prior to employment, for example, references, qualifications and registration with the appropriate professional body. However, in one case we found that employment had commenced prior to completion of a criminal record check with the Disclosure and Barring Service (DBS). Although the request had been made of the DBS the result had not yet been received and no risk assessment was in place in relation to this. We also noted the practice had not obtained photographic identity for one staff member recently recruited.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of skills available to meet patients' needs. We saw there was a rota system in place for the different staffing groups to ensure there were always enough staff on duty. There were arrangements in place for members of staff to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and always enough to ensure patients were kept safe. In the months prior to inspection the practice had experienced staff shortages in the nursing team but was now back to full strength. Staff we spoke with consistently told us they had pulled together during this time, taking on additional shifts to ensure that any impact on levels of service for patients was minimised. One GP had also retired but the practice had successfully recruited a replacement. All four GPs worked full time.

Monitoring safety and responding to risk

The practice had some systems to assess, manage and monitor risks to patient and staff safety however there were aspects of the service where this was lacking. There were effective systems for reporting, recording and monitoring of significant events and for regular assessment and checks of clinical practice, medications and equipment. However, we found the practice did not complete an annual infection control audit or fire risk assessment. The practice fire alarm system comprised of one central manually operated fire bell. There were no automated alarms, sprinklers or fire doors. The practice manager told us there had been no fire service inspection. There were no current gas or electrical safety certificates in relation to services at the building.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated defibrillator (used to restart a person's heart in an emergency). All staff asked knew the location of this equipment.

Emergency medicines were available and staff knew of their location. These included medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia.

The practice had a disaster recovery plan to deal with a range of emergencies that may impact on the daily operation of the practice. The plan was undated and the practice manager recognised it was in need of updating.

Staff receiving some training on fire safety as part of their induction but there was no programme of annual refresher training thereafter. Exit routes from the building were clearly signed and free from obstruction and an assembly

Are services safe?

point had been identified. Fire extinguishers were located throughout the building and staff had received external training on their use. We saw evidence to show they were regularly checked and in date.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We found from our discussions with GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

Read coding was used for patients. Read coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. These codes improve patient care by ensuring clinicians base their judgements on the best possible information available at any time.

GPs had special areas of interest which they were able to use to the benefit of the practice, for example, sports medicine. Clinical staff were open about asking for and providing colleagues with advice and support. Practice nurses managed clinical areas such as diabetes, COPD and asthma through a programme of clinics. Patients with long term conditions were helped and encouraged to self-manage where possible. Where patients had multiple conditions reviews were completed at the same time and longer appointments scheduled to ensure nurses had plenty of time to do so. Feedback from patients we spoke with and those who completed CQC comment cards confirmed appointments were not rushed.

The practice offered memory screening checks to all patients over 55 years attending for health checks. One of the reception staff had received training to enable them to carry out an initial check. If a patient scored below a certain level they were offered an appointment with a GP for further consideration.

The practice had reviewed patient data to identify those at higher risk of admission to hospital. Care plans had been discussed and agreed with these patients with a view to reducing unplanned admissions. In excess of 2% of the patient population now had care plans in place which exceeded the practice's national target. They were now aiming to achieve 4% by the year end.

Patients told us they received care appropriate to their needs. They told us they felt they were included in planning their care and treatment as much as possible.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was collated and used to support the practice to carry out clinical audits.

The practice showed us examples of clinical audits undertaken in the last year. These included IUCD (coil) fitting and nexplanon removal. Results of audits were analysed and when actions for improvement were identified changes were made to implement them. For example, development of new guidelines for clinicians and reception staff in relation to referrals to coil and nexplanon clinics.

The practice had systems in place to review their referral rates to hospitals and other healthcare services. We saw they had identified a relatively high referral rate to the hospital diabetic clinic and as a result introduced a process of peer review at the weekly partners' meetings to ensure consistency of approach. Similarly, the practice was trialling a system whereby all referrals made to a dermatology clinic were subject to peer review by a buddy GP. We were told they hoped to extend this approach to referrals made in other areas.

The practice benefitted from the support of a CCG prescribing pharmacist who was based there twelve hours each week and offered prescribing support. They told us their role included continual review of patient data to look for aspects of medicines management that might be improved upon. Any areas identified were brought to the attention of the GPs so that changes might be made.

The practice used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. They maintained patient registers, for example, patients with learning disabilities, chronic conditions, receiving palliative

Are services effective?

(for example, treatment is effective)

care and eligible for particular immunisations / vaccinations. The data was monitored and reviewed to ensure patients were recalled, reviewed and / or managed as appropriate.

Effective staffing

Patients were complimentary about the staff. We observed staff who appeared comfortable and knowledgeable about the role they undertook.

All new staff completed a formal induction to the practice. We reviewed staff training records and saw that all staff were up to date with mandatory courses such as safeguarding and basic life support. We noted that as part of the induction staff completed training on matters such as infection prevention control and information governance but there were no arrangements for refresher training thereafter. The practice retained attendance sheets as a record of the staff who had attended training events provided. There was no overarching training matrix that would enable them to establish at a glance who had completed specific courses and when any refresher training was due.

A good skill mix was noted amongst GPs. The practice employed two nurse practitioners. Nurse practitioners are able to have more responsibility than practice nurses and see a broader range of patients. All nurses were trained in the management of chronic conditions. One nurse told us they were currently training receiving additional training in gynaecology matters to enable them to assist with procedures such as cervical smears and consequently help increase availability of appointments with the female GP. We were given examples of non-clinical staff being trained to fulfil a number of roles which increased the flexibility of the team. For example, during our inspection we saw both a member of the administrative team and the phlebotomist assisted in providing cover at reception to ensure staffing levels were maintained whilst a member of the reception team was on leave. One of the data processors was also providing temporary cover for an absent medical secretary.

All staff other than the practice manager were supported by an annual appraisal. During these meetings a personal development plan was created and any training needs identified. 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 every five years undertakes a fuller assessment called revalidation. Only when revalidation had been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

Working with colleagues and other services

Practice staff worked closely together to provide an effective service for patients. We were told the practice was working collaboratively with the neighbouring practice with a view to improving local services for the community. The practices met regularly which also provided opportunities for peer review on matters such as clinical practice and prescribing levels. The possibility of shared training for staff was under consideration.

Other multi-disciplinary meetings in which the practice was involved included meetings with district nurses, for example to discuss the needs of patients receiving palliative care. GPs met with health visitors and school nurses every two months to discuss any child protection issues. One of the GPs chaired the Local Medical Committee and represented the practice at monthly clinical forums organised by the Clinical Commissioning Group.

The practice had identified that communication with one local hospital was more effective and timely than another due to the technology available. Minutes showed that the practice manager had been tasked with exploring ways in which this could be improved.

Information sharing

The practice had produced a leaflet for patients containing information about the services it provided. There was also a website where similar information could be found.

The GPs met regularly with the practice nurses and administration staff. Information about risks and significant events was shared openly. A GP attended CCG meetings and shared information arising from them. This kept staff up to date with current information around enhanced services, and requirements in the community.

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals to hospitals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in).

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

Staff understood and were trained in requirements around consent and decision making for patients who attended the practice. The GPs and nurses we spoke with described situations were best interests or mental capacity assessment might be appropriate and were aware of what they would do in any given situation. All staff at the practice had completed training on the Mental Capacity Act 2005 and deprivation of liberty safeguards.

The practice consent policy explained all areas of consent and GPs referred to Gillick competency when assessing young people's ability to understand 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. Patients with learning disabilities and those with dementia were supported to make decisions through use of care plans which they were involved in agreeing.

There was a practice policy for documenting consent for specific interventions, for example immunisation. Templates were available for patients to sign and GPs told us they recorded a patient's consent in the electronic patient notes.

Health promotion and prevention

All new patients joining the practice were offered a consultation and health check with one of the practice nurses. This included discussions about their environment, family life, carer status, mental health and physical well-being. Checks were made on blood pressure, smoking, diet, alcohol and drug dependency if appropriate. Any health concerns detected were referred to a GP and followed up in a timely manner.

The practice offered NHS health checks to all patients aged 40 to 75 years. A full range of immunisations for children, travel vaccinations and flu vaccinations were available in line with current national guidance. Other services offered to patients included cervical smears and screening for dementia and chlamydia. In the waiting area and on the practice website there was information about the services offered by the practice and health promotion literature. Weighing scales were available for patients to self-check their weight. These were discreetly located to one side of the waiting room.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We received 25 completed patient comment cards. We spoke with three patients visiting the practice on the day of inspection and three members of the Patient Participation Group (PPG) by telephone. Most were very positive about the service they received. Patients told us they were well cared for. They described staff as caring, kind and understanding. Patients said that staff were polite and friendly, they confirmed they were treated with dignity and respect. One person, who expressed negativity about their treatment, told us their experience had varied greatly dependent upon the individuals involved. One patient we spoke with had experience of bringing a young child to the practice. They told us the GP had treated them in a manner appropriate to their age and understanding, putting the child at ease.

We reviewed the most recent data available on patient satisfaction which included information from the results of the national patient survey published in July 2014. This showed that 81% of patients who responded said the last GP they saw or spoke with was good at treating them with care and concern, and 90% said the same of nurses. 85% of respondents rated the last GP they saw or spoke with as good at listening to them and 92% said the same of nurses. 91% of patients who responded had confidence and trust in the GPs and 93% in the nurses.

Consultations and treatments were carried out in the privacy of a consulting room. There were curtains around the treatment couches which could be drawn to maintain patients' privacy and dignity during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

The reception area was extremely busy throughout the day and constantly manned by three members of staff. The reception staff took incoming calls requesting appointments. We observed staff were careful to maintain patient confidentiality when speaking with patients in person or by telephone. Computer screens could not be seen from the waiting area. Notices were prominently displayed requesting patients to wait until a receptionist was free before approaching the desk. There was a separate booth to one end of the desk where patients could speak with reception staff could speak with staff privately if they wished. Seating was located as far away from the reception desk as possible to minimise risk of conversation being overheard. In the national patient survey 64% of respondents had expressed satisfaction with the level of privacy when speaking to receptionists at the surgery.

Notices were displayed indicating that mothers were welcome to breastfeed children and reception staff told us they had a policy of offering a quiet space away from the main waiting area to those wishing to do so.

Care planning and involvement in decisions about care and treatment

Patients told us health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and staff were approachable and easy to talk with. Patients said they had sufficient time during consultations to discuss issues thoroughly and make informed decisions. Longer appointments were available where necessary, for example, for reviews where patients had multiple conditions or learning disabilities. The practice had a nominated learning disability nurse.

The results of the national patients' survey showed that 87% of patients said GPs were good at explaining tests and treatments and 75% said they were good at involving them in decisions about their care. The corresponding figures in relation to nurses were 92% and 79%.

Staff told us translation services could be made available for patients who did not have English as a first language but there was little need for them.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with told us they felt supported by the practice. Of patients who responded to the national patient survey 78% described their overall experience of the surgery as good with 70% indicating that they would recommend the surgery to another.

The practice computer system had a facility that enabled staff to create pop up alerts to highlight where a patient may require additional support or additional sensitivity. For example, patients with learning disabilities or carers, and those who had experienced a recent bereavement. We noted there was list of recent deaths discretely displayed

Are services caring?

behind reception to provide staff with an immediate visual prompt. One patient we spoke with told us their GP had been supportive at the time they had experienced bereavement.

There was a limited amount of written information available to patients in the waiting area, for example, leaflets about whooping cough, shingles and strokes. We saw little information displayed to signpost patients to support groups or organisations although patients we spoke with gave examples of where this had occurred in consultation, for example, smoking cessation support. The range of information available on the practice website was more comprehensive.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The nearest hospital and walk in centre to the practice was located in either Blackpool or Preston, both of which were approximately 10 miles away. We were told that the practice was working collaboratively with the neighbouring practice in the village of Kirkham with a view to improving local services for the community, for example access to same day services.

In addition to taking part in the national patient survey the practice carried out its own patient survey each year. A member of the Patient Participation Group (PPG) told us questions for the survey were agreed with the group and the results shared. We were told the PPG had been established for approximately 12 months and was still in its infancy. After the patient survey the practice had compiled an action plan to address issues raised. One group member told us they thought it was too early to fully determine whether the practice listened to feedback and acted upon it however they were able to give us an example of when this had occurred. As a direct result of patient feedback that the volume of the music played in reception made it difficult for patients to hear when they were called for their appointment the practice had reduced the level.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

The practice had a large car park with designated disabled spaces closest to the entrance door. All treatment and consultation rooms were located on the ground floor. Each room was clearly labelled with the name of the member of staff who occupied it. One end of the reception desk was lowered to enable wheelchair users to access it with ease. The waiting area was spacious and corridors wide. We noted that an audio loop was available for patients who were hard of hearing. Some of the seating in the waiting area had arms on to assist people to rise more easily. Disabled toilet access and baby change facilities were available.

There were posters in the waiting area explaining the availability of the choose and book system. (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). We were told that the practice assisted patients to book these appointments if they wished.

Access to the service

In the national patient survey 91% of respondents said they found it easy to contact the practice by telephone. 82% said they were able to get an appointment to see or speak with someone last time they tried and 88% said they usually waited 15 minutes of less after their appointment time to be seen.

The practice was open from 8.30am until 6.30pm Monday to Friday. When closed an out of hours service was provided by Preston Primary Care. There were five telephone lines into the practice which patients could use to book appointments. The telephone lines opened at 8.00am. At the time of our inspection the provider had not yet developed an on line booking facility for appointments or to request repeat prescriptions.

It is a contractual requirement for GP practices to offer and promote to patients: online booking of appointments, ordering of repeat prescriptions and by 31st of March 2015 access to summary information (as a minimum) in their patient record, subject to the necessary GP systems and software being made available to practices by NHS England. The systems and software to enable this had been installed at the practice relatively recently and they were now working towards achieving this.

Patients were able to book routine appointments up to six months in advance. Same day appointments were available for patients in urgent need. The practice operated a triage system whereby all requests for urgent appointments received at reception were initially referred to the nurse practitioner before being booked in with a GP where necessary. The appointment schedule for each day included a number of dedicated slots to accommodate urgent consultations. There were posters displayed in the waiting area explaining how the triage system operated and what patients could expect. Telephone call backs were available for patients wishing to speak with a GP or nurse practitioner. If a patient was too ill the surgery a home visit by a GP could be arranged.

Are services responsive to people's needs?

(for example, to feedback?)

At the time of our inspection the national flu vaccination campaign was underway. Minutes of meetings showed that, due to the success of the initiative in previous years, the practice had arranged to offer flu vaccination clinics on a Saturday morning. We saw that at one October clinic some 468 vaccinations had been completed.

In response to the national patient survey 67% expressed satisfaction with the practice opening hours. On reviewing the results the practice had found there was actually relatively low patient use of the out of hours service or alternative providers.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy is 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 a summary of the complaints received between November 2013 and November 2014. The summary recorded the nature of the complaint, details of the investigation, the outcome, any learning points identified and actions taken to address them. The summary provided the practice with an overview from which they could identify any emerging themes or trends.

We looked at the records held in relation to two of the complaints that had been received. We saw that these had been dealt with in a timely manner, thoroughly investigated and the patient communicated with throughout the process. Once a complaint had been dealt with the practice send the complainant a follow up form requesting feedback on how the matter had been handled and how well they felt their complaint had been listened to. Systems were in place to ensure that any learning as a result of complaints received was disseminated to staff appropriately.

Are services well-led?

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

Our findings

Vision and strategy

The ethos of the practice was to provide healthcare to a whole population and create a partnership between patients and healthcare professionals which ensured mutual respect, holistic care, continuity of care and continuous learning, development and training.

The stated aims included: ensuring there were high quality, safe and effective services and environment; providing monitored, audited and continually improving healthcare services; and providing accessible healthcare which was proactive to healthcare changes, efficiency and development.

Governance arrangements

The practice had systems in place to monitor the quality of treatment and services. These included consideration of aspects such as patient experience, access to the practice, prevalence of conditions, quality, use of alternative services, prevention and prescribing.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. They also participated in the Practice Quality and Improvement Programme (PQIP). Using monitoring data provided by the Clinical Commissioning Group, their own referral and prescribing data, QOF data and feedback from patient surveys they had identified areas where they felt improvement could be made and implemented plans to achieve them. For example, under the domain of prevention the practice had recognised their performance in key areas such as diabetic care had been poorer than projected. Plans to address the shortfall included additional training for staff. Under the domain of prevalence the practice had identified lower levels of COPD prevalence in the patient population than anticipated. They had liaised with the CCG and arranged use of a toolkit to interrogate their clinical system to establish and address the reasons for this.

Systems were in place for monitoring aspects of the service such as complaints, incidents, safeguarding and clinical audit. A number of policies and procedures were available to provide guidance and instruction to staff but some of these had not been reviewed for several years to ensure they remained up to date, for example, in relation to some aspects of infection control. We saw that a document control system had recently been introduced with a view to rectifying this but the system had not yet been fully implemented. We were told this was work in progress.

Six months prior to inspection a new comprehensive computer system had been installed at the practice. This had presented challenges in terms of facilitating training for all staff and maintaining the smooth operation of the day to day running of the practice whilst the system embedded. We were told that the practice had identified some areas where further staff training was required to ensure best use of the capabilities of the system and they were making arrangements to address this.

Leadership, openness and transparency

The practice had faced significant challenges over the past year. One longstanding GP partner had retired and a new partner had joined the team. Due to unforeseen circumstances there had been a number of changes within the nursing team. For a period of several months, despite attempts to recruit, the team had been understaffed and working under considerable pressure. Staff told us how the nursing team had pulled together during this difficult period, covering additional shifts to try to ensure the level of service for patients was maintained. Additional nursing staff had now been recruited and the team was back to full strength.

It was clear that the practice was embracing change. Staff spoke positively and enthusiastically about the future of the practice. Staff told us there was an open culture and they had opportunity and were happy to raise issues at team meetings. The GPs had recently reconsidered their respective areas of responsibility and there were named leads for matters such as safeguarding, oversight of the Quality and Outcomes Framework and liaison with the Clinical Commissioning Group. A meeting was scheduled for the week following inspection at which lead responsibilities for members of the nursing team were to be decided.

The practice had a whistleblowing policy. Whistleblowing is defined as the disclosure by an employee of confidential information, which relates to some danger, fraud or other illegal or unethical conduct connected with the workplace be it of the employer or a fellow employee.

Are services well-led?

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

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

The practice gathered feedback from patients through patient surveys, family and friends questionnaires and complaints received.

A Patient Participation Group (PPG) had been established for approximately one year and was still in its infancy. We were told the PPG met every three months but meetings were during the day and those who attended were largely older retired people. One attender told us they were exploring ways to increase younger representation including creation of a virtual group enabling patients to participate through email. They commented they felt it was still early days to determine how influential the group would be, however they provided an example of where the practice had acted upon feedback to reduce the volume of the music played in reception. We saw information about the group was displayed in the waiting area and on the practice website with a view to increasing membership.

The practice gathered feedback from staff through appraisal and staff meetings. Staff we spoke with told us they felt able to make suggestions and contribute ideas. One member of the nursing team provided an example of when the practice had responded to feedback and changed procedure. They had suggested that rather than book standard appointments for patients requiring travel vaccinations they should be asked to complete a questionnaire regarding their travel plans in advance enabling staff to tailor appointment length to meet individual need.

Management lead through learning and improvement

We saw an understanding of, and commitment to, the needs of staff and ensuring they had access to learning and improvement opportunities.

Newly employed staff had a period of documented induction. Learning objectives for existing staff were discussed during appraisal and mandatory training was role relevant. However, we found the practice manager had not had the opportunity of an annual appraisal for several years. Nurses and GPs kept their continuing development up to date and attended training courses pertinent to their roles and responsibilities. Nursing staff had protected learning time. One of the GPs held a nurse training meeting every fortnight which included opportunity for clinical peer review. Nursing staff spoke positively about the training opportunities and supervision available to them. We found there were opportunities for non-clinical staff to develop their roles and acquire new skills. For example, one of the reception staff had trained as a phlebotomist.

The practice completed reviews of significant events and other incidents and shared learning with staff through their programme of regular meetings to ensure they improved outcomes for patients.