Dr. Michael Zaryckyj & Dr. Martin Atherton

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 Dr. Michael Zaryckyj & Dr. Martin Atherton (also known as Park Medical Practice).

We carried out a comprehensive inspection on 30 December 2014. We spoke with patients, a member of the Patient Participation Group (PPG) and staff, including the management team.

Overall the practice is rated as good.

Our key findings were as follows:

- All staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. When things went wrong reviews and investigations were carried out.
- National Institute for Health and Care Excellence (NICE) guidance was used routinely. Patients' needs were assessed and care planned and delivered in line with current legislation.
- Patients were happy with the service provided by the practice. They told us they were treated with compassion, dignity and respect.
- Patients confirmed they were able to contact the practice and speak with a health practitioner in a timely and accessible manner. Patients told us they could always get an appointment when they needed one, including on the same day if it was urgent.
- The practice took time to listen to the views of their patients and ran an active Patient Participation Group. Actions were identified and taken to improve the service.

There were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

Ensure medicines are managed effectively, by means of appropriate arrangements for the recording and safe keeping of medicines.

In addition the provider should:

Summary of findings

- Notify the Care Quality Commission of all relevant incidents as required under the Health and Social Care Act 2008(Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009
- Review systems to ensure training and other personnel information is effectively recorded and managed.
- Ensure patients are aware of the timescales for complaints and the ability to refer complaints to the Parliamentary Health Service Ombudsman if they are unhappy with the outcome of their complaint.

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 as there are areas where it should make improvement. Staff understood their responsibilities to raise concerns and reported incidents appropriately. Investigations were completed and measures were identified to reduce the risk of incidents reoccurring. Staff were knowledgeable about what constituted a safeguarding concern. A GP took the position of safeguarding lead for the practice and staff knew who to contact. Recruitment checks were conducted for clinical and non-clinical staff.

The practice had appropriate stocks of equipment and drugs for use in the event of an emergency. Vaccine fridge stocks were in date and rotated however these were not appropriately stored and managed to ensure they were safe to use.

Are services effective?

Good

The practice is rated as good for providing effective services. Care and treatment was delivered in line with current published best practice. Staff meetings and audits were used to assess how well the service was delivered. Consent to treatment was obtained where required and this was confirmed when speaking with patients. The practice met regularly with other health professionals and commissioners in the local area in order to review areas for improvement and share good practice.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients told us staff were friendly and they were treated with respect, dignity and compassion. Staff we spoke with were aware of the importance of providing patients with privacy. Information was available to help patients understand the care available to them and this was available in an appropriate format .

The practice was proactive in supporting patients to ensure they received the care they required. The results of the 2013 National GP Survey show that 88% of patients said their GP was good or very good at treating them with care and concern and involving them in decisions about their care. We observed a patient centred culture and found strong evidence staff were motivated and inspired to offer kind and compassionate care.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated good for providing responsive services. The practice reviewed the needs of their local population and engaged with the NHS England Area Team and the Clinical Commissioning Group (CCG) to secure service improvements where possible.

Patients reported good access to the practice. Appointments were available the same day.

The practice sought to gain patient feedback and had an active Patient Participation Group (PPG) who provided ideas and suggestions to help improve the service.

We saw evidence that complaints were responded to quickly and that staff were involved in discussions around ways to improve the service. The practice reviewed complaints on an annual basis to identify any recurrent trends.

Are services well-led?

Good

The practice is rated as good for providing well-led services. All staff we spoke with felt valued and told us they were individually supported to progress in their roles. The practice effectively responded to change. There was a clear set of values which were understood by staff and demonstrated in their behaviours. There was an open and honest culture and staff knew and understood the lines of escalation to report incidents, concerns, or positive discussions.

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 was knowledgeable about the number and health needs of older patients using the service. They kept up to date registers of patients' health conditions, carers' information and whether patients were housebound. They used this information to provide services in the most appropriate way and in a timely manner. The practice was responsive to the needs of older people including offering home visits as required and there was a practice plan to reduce avoidable A&E attendance in all groups which included older people.

The practice had a register of all patients in need of palliative care or support irrespective of age. Palliative Care Nurses were involved in surgery meetings to ensure that care for patients at the end of their lives was co-ordinated.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. There was a high prevalence (59%) of patients with long standing conditions, such as cardiovascular disease and diabetes. Patients had as a minimum an annual review of their condition and their medication needs were checked at this time. When needed, longer appointments and home visits were available.

Patients at risk of being admitted to hospital due to their condition had a care plan in place, this was regularly reviewed by the GP and the multidisciplinary team involved in their care.

Information was available on the practice website and leaflets were also available at the practice to assist patients to manage their conditions.

Health promotion literature was available. The practice also held educational presentations at Patient Participation Group (PPG) meetings in areas such as diabetes and community services.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Children and young people were treated in an age appropriate way and their consent to treatment using appropriate methods was requested.

There was access to on the day appointments where parents had concerns about the health of their child.

Summary of findings

There were comprehensive screening and vaccination programmes which were managed effectively to support patients. Community midwives attended the surgery each per week.

The practice monitored any non-attendance of babies and children at vaccination clinics and worked closely with the health visiting service who were available on site to follow up any concerns. The practice maintained a register to identify children at risk.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people and those recently retired. The practice provided a range of services for patients to consult with GPs and nurses, including on-line booking and telephone consultations. The practice kept their opening hours under review in order to meet the needs of the patient population registered at the practice. Extended opening hours were available on Saturday mornings to meet the needs of the working age population

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. The practice held a register of patients living in vulnerable circumstances for example those with learning disabilities. Patients with learning disabilities were offered annual health checks, longer appointments were available if required and recall letters were in pictorial format to aid understanding. This helped to ensure patients were given time and assistance to be fully involved in making decisions about their health.

The practice worked with multidisciplinary teams in the case management of vulnerable patients. 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.

Patients with conditions which led them to be vulnerable at times of crisis had care plans in place to assist them to be treated in an appropriate setting at a time which addressed their immediate need without the need for assistance from the ambulance service or admissions to A&E.

Staff at the practice knew how to refer people to Help Direct. Help Direct is a support and information service for adults that assists

Summary of findings

people with a wide range of issues. We were told this might include assisting people with learning difficulties, mental health problems and those who had experienced bereavement. Help Direct regularly attended the practice in order to promote their service.

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. The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review.

GPs worked with other services to review and share care with specialist teams. The practice maintained an electronic alert system of patients who experienced mental health problems.

Staff sign-posted patients experiencing poor mental health to various support groups, such as the Big White Wall. The 'Big White Wall' was an online support network to help people to improve their mental wellbeing.

Summary of findings

What people who use the service say

We received nine completed CQC comment cards and spoke with four patients visiting the surgery on the day of the inspection. We received feedback from male and female patients across a broad age range.

The feedback we received was very positive. Comments included that doctors gave patients as much time as they need, the staff were kind and attentive, and the care and treatment had been excellent. Only one negative comment was made which was with regards to an isolated incident.

Patients we spoke with on the day told us they had no complaints and that staff at the practice were caring and considerate to their needs.

The results of the 2013 National GP patient survey showed that 91% of respondents from this practice described the overall experience of their GP surgery as fairly good or very good. 88% of patients said their GP was good or very good at treating them with care and concern and involving them in decisions about their care. 95% of patients said the last time they saw a nurse the nurse was good or very good at treating them with care and concern.

Areas for improvement

Action the service MUST take to improve

- Ensure medicines are managed effectively, by means of appropriate arrangements for the recording and safe storage of medicines.

Action the service SHOULD take to improve

- Notify the Care Quality Commission of all relevant incidents as required under the Health and Social Care Act 2008(Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009
- Review systems to ensure training and other personnel information is effectively recorded and managed.
- Ensure patients are aware of the timescales for complaints and the ability to refer complaints to the Parliamentary Health Service Ombudsman if they are unhappy with the outcome of their complaint.

Dr. Michael Zaryckyj & Dr. Martin Atherton

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Inspector. The team included a GP, a practice manager specialist advisor and a second CQC inspector.

Background to Dr. Michael Zaryckyj & Dr. Martin Atherton

Dr. Michael Zaryckyj & Dr. Martin Atherton provides a service to 6237 patients and is part of the Fylde and Wyre Clinical Commissioning group.

The largest percentage practice population are patients aged over 65 years, accounting for 26.3% of practice patients. 61.7% of patients have health related problems in daily life, compared to the national average of 48.8%.

According to statistics available at the time of the inspection from Public Health England, the practice is in the seventh least deprived percentile for practices in England, on a scale of one to ten.

The practice is open Monday to Friday between the hours of 8am and 6pm. The practice also operates extended opening hours which are available on Saturday mornings between 8.45am and 11.45am.

When the practice is closed patients are requested to contact 999 for emergencies or telephone 111 for the Out of Hours (OOH) service provided by Fylde Coast Medical Services. This information is available on the practice answerphone and practice website.

The practice has five GP's (two male and three female), two practice nurses, two health care assistants and a pharmacist. The practice also has a practice manager and staff are all supported by administration, reception and secretarial staff.

The practice is a training practice and regularly has medical students.

The premises were purpose built for the service and are shared with one other GP practice and the local NHS Trust who provide community services.

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 a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal

Detailed findings

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?

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 a member of the Patient Participation Group (PPG). The information reviewed did not highlight any risks across the five domain areas.

We carried out an announced visit on 30 December 2014. During our visit we spoke with GPs, members of the nursing team, the Clinical Commissioning Group (CCG) pharmacist, the practice manager, reception and administration staff. We observed how staff communicated with patients. We reviewed CQC comment cards where patients and members of the public were invited to share their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. These included complaints, findings from clinical audits, significant events and feedback from patients. Staff were clear about their responsibilities in reporting any safety incidents.

We reviewed a range of information we hold about the practice and asked other organisations such as NHS England and the Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice.

The quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2012-2013 the provider was appropriately identifying and reporting incidents.

There were mechanisms in place for the prompt management of safety alerts. The CCG pharmacy manager identified drug alerts requiring further action and shared these with the relevant staff.

Staff informed us that on one occasion police were called to the practice. Any incident reported to or investigated by police (which occurs whilst services are being provided in the carrying on of a regulated activity) should be notified to CQC.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. The practice had an open, honest and transparent culture and staff were encouraged and supported to report any incidents.

The significant events we reviewed showed that that learning was identified and improvements were made and sustained. We could see that staff and patients were involved in these improvements.

Bimonthly meetings were used to discuss and communicate learning and improvement from complaints and incidents. Staff confirmed they were kept up to date with such information.

We saw the practice had a system for managing safety alerts from external agencies. For example those from the Medicines and Healthcare products Regulatory Agency (MHRA). These were reviewed by the GPs and the practice manager and action was taken as required

Staff told us that any changes to national guidelines, practitioner's guidance and any medicines alerts were discussed in clinical staff meetings. This information sharing meant the GPs and nurses were confident the treatment approaches adopted followed best practice.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. All staff at the practice, including the receptionists, were proactive when following up information received about their patients, specifically those who were vulnerable to risk of harm.

Staff had a good awareness of how to recognise signs of abuse in vulnerable adults and children. All staff had completed adult safeguarding and child safeguarding to a level appropriate to their role, with the lead GP being trained to level 3.

Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies both in and out of hours. We saw evidence that where concerns were raised that the appropriate referrals had been made.

Safeguarding policies and procedures for children and vulnerable adults were up to date and staff knew where to locate them. There was also access to local authority contact names and numbers in each consultation room and behind reception.

The practice held a register of patients living in vulnerable circumstances including those with learning disabilities.

Staff we spoke with understood what was meant by the term Whistleblowing and the practice had a policy in place. This meant there were processes in place to assist staff to expose poor care or bad practice.

Details about chaperone facilities were seen in consulting rooms. This service was provided by clinical staff.

Medicines management

Requires improvement

Are services safe?

We saw medicines management was supported by the local Clinical Commissioning Group (CCG) medicines management team. Audits were carried out by the CCG pharmacist to optimise the prescribing of certain medicines.

The practice processed repeat prescriptions within 48 hours. Patients confirmed requests for repeat prescriptions were dealt with in a timely way. The practice checked that patients receiving repeat prescriptions had at least an annual medicine review with the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes. Patients who had not collected prescriptions were reviewed in an ad hoc manner. There was not a system in place to review this or to support or guide staff in this process.

Emergency medicines were available within the practice. We checked the emergency medication and saw that these were stored appropriately and were in date. The practice had recently implemented a new system to ensure that these were appropriately stocked and in date.

GPs had access to 'grab bags' which held emergency medication for home visits. We found the medication to be in date and the stocks were well managed and recorded.

The practice held two fridges used for the storage of vaccines. We found the vaccines stocked to be in date and appropriately rotated. Practice nurses were responsible for the re-ordering of stock, however administrative staff were responsible for monitoring fridge temperatures. When we looked at the records we found that the temperature of both fridges had been recorded as above the maximum on a number of occasions.

Staff confirmed that no action had been taken. Therefore checks to establish whether the vaccines stored in the fridge's were safe to use had not been made. Administrative staff had not been trained to understand the importance of maintaining vaccines at a cold temperature (known as the cold chain) and so not aware of the required action to be taken should temperatures fall outside the appropriate range.

Cleanliness and infection control

We observed the premises to be clean and tidy. Arrangements were in place with an external contractor for the cleaning of the practice. Comprehensive schedules were in place and cleaning records were kept. Patients told us they were happy with the cleanliness of the practice.

The practice had recently completed an infection control audit and identified actions to keep people safe, for example wipe able chairs and foot pedal bins. We were told this would be revisited on a monthly basis to ensure actions were met or ongoing and improvements were made.

An infection control policy and supporting procedures were available for staff to refer to which enabled them to plan and implement infection control measures.

Hand washing instructions were displayed in staff and patient toilets. Hand washing basins with soap, gel and hand towel dispensers were available in treatment rooms.

The practice had systems in place for the segregation of clinical and non-clinical waste. There were sharps bins in the treatment room. We saw that these were not always signed and dated as per The Health and Safety (Sharps instrument in Healthcare) Regulations 2013. An external contractor attended the practice on a weekly basis to collect clinical waste and remove it off site for safe disposal.

Legionella testing was part of the routine annual service carried out by the building management team.

All staff received induction training about infection control and annual updates thereafter. Staff were also required to provide evidence of their immunisation against Hepatitis B.

Equipment

There was a contract in place between the practice and the building management company. The building management company had the responsibility for some equipment checks, for example the fire extinguishers. Evidence was kept at the practice to confirm annual safety checks had been completed.

There was a contract in place to check that medical equipment was calibrated to ensure it was in working order. The practice also had contracts in place for portable appliance checks to be completed on an annual basis.

Requires improvement

Are services safe?

The practice had a defibrillator which ensured they could respond appropriately to a patient experiencing a cardiac arrest. Staff told us they had been trained to use this equipment.

Emergency equipment including oxygen was readily available for use in the event of an emergency. Staff told us a visual check was conducted on a weekly basis. We were told this check would now be recorded.

Staffing and recruitment

The practice recruitment procedure identified which checks were required prior to the employment of a member of staff. Appropriate pre-employment checks were completed for a successful applicant before they could start work in the service.

All the GPs had disclosure and barring service (DBS) checks undertaken annually by the NHS England as part of their appraisal and revalidation process. The nurses also had DBS checks undertaken and copies of this were kept in the staff files.

There was an established team at the practice, with many staff being employed there for a number of years. We saw the file for a new member of administrative staff and found references, proof of ID and DBS check obtained. The practice manager confirmed that all non clinical staff would be checked by the DBS in the next 12 months.

The practice manager assured us she routinely checked the professional registration status of GPs and practice nurses with the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) each year to make sure they were still deemed fit to practice We were assured that yearly checks of professional registration were conducted however no central record of this was kept

We saw evidence of forward planning. The practice had identified future concerns relating to staffing, such as retirement of staff, and had plans in place to recruit accordingly.

Monitoring safety and responding to risk

The practice team had agreed the requirements for safe staffing levels at the practice. Staff worked regular sessions and set days each week to maintain the service provided.

Reception and administrative staff, in the event of staff sickness or leave, supported each other to provide cover amongst the remainder of the staff. The staff were multi skilled which enabled them to cover each other in the event of planned and unplanned absence.

Arrangements to deal with emergencies and major incidents

The practice had a business continuity plan which had recently been put in place. We were told this required improvement and staff awareness needed to be raised. The plan gave staff guidance on how to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included fire, flood, and loss of electricity supply and telephone system. The document also contained relevant contact details for staff to refer to.

Records showed that most staff were up to date with fire training and they confirmed they practised regular fire drills.

Emergency equipment was readily available and included a defibrillator and oxygen. Checks were undertaken to ensure they were ready for use and in date.

Each room had access to a panic alarm which could be used to raise an alert to all other members of staff if assistance was required.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We found from our discussions with the clinical staff that they completed thorough assessments of patients' needs and these were reviewed as appropriate. New patient health checks were offered and regular health checks and screenings were on-going in line with national guidance.

There were systems in place to ensure referrals to secondary care (hospitals) were made in line with national standards. Referrals were managed primarily by using the 'choose and book' system.

Patients we spoke with said they were happy with the care and treatment they received at the practice. They told us they were involved in decisions about their care and that staff explained options and involved them in the process.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included an Atrial Fibrillation audit in response to NICE guidance and an audit regarding the prescribing of the medication Tramadol. We saw evidence that these audit cycles were completed in full and that these were reviewed to ensure actions taken were having the desired impact to improve outcomes for patients.

Patients we spoke with who had long term health complaints confirmed they received regular health reviews and were called by the practice to arrange these. We saw evidence of these systems in the practice.

Care plans were in place for patients with complex or multiple health conditions. This enabled the practice to effectively monitor patients at regular intervals. We found these care plans to be effective and inclusive of the patient and other people and professionals involved in their care. Care plans were not restricted to those groups of patients identified as required by the CCG. Where clinicians believed a care plan would help improve the outcomes for a patient these were implemented to a high level. It was clear that consideration had been taken to identify and implement strategies which would assist the individual attain an improved level of health and wellbeing.

Electronic record systems alerted staff when patients were due for reviews. This ensured patients received their review in a timely manner, for example, reviews of medicines and management of chronic conditions. The practice had systems in place to follow up and recall patients if they failed to attend appointments, for example, non-attendance at a child vaccination clinic.

The practice reviewed patients under a locally enhanced service to minimise admissions to hospital. The practice maintained lists of patients with particular conditions and vulnerabilities. Care plans were in place for all patients identified as at risk of admission to hospital.

One of the GP partners undertook minor surgical procedures within the practice in line with their registration and NICE guidance. A micro suction clinic was held at the practice. This was available to patients from other practices which meant they did not have to attend hospital for this service.

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

The practice used the information they collected for the Quality Outcome Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. QOF data was subject to on-going monitoring to ensure the needs of patients were identified and met in a timely manner. For example, to ensure that those with long term conditions, learning disabilities or mental health issues attended for regular review.

Effective staffing

The practice team included medical, nursing, managerial and reception staff. We reviewed a sample of staff training records and saw staff were mainly up to date with attending mandatory courses such as basic life support, however the systems to record and monitor staff training required strengthening. Systems to identify when training required to be updated was not robust.

Good

Are services effective?

(for example, treatment is effective)

Each member of staff was expected to have an annual appraisal. The practice manager told us and staff we spoke with confirmed these were on-going. Before our inspection this had been identified by the practice as an area for improvement. Staff confirmed that this was on the agenda to ensure appraisals were conducted in a timely way and that performance and development was well managed.

We saw evidence of on-going monitoring of performance; GPs reviewed each other's notes and educational and patient safety meetings were held within the practice.

The GPs covered each other for annual leave and sickness. Staff worked in a flexible manner and assessed and changed the appointments available on a regular basis to ensure they were meeting the needs of the patients.

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

Working with colleagues and other services

The practice worked with other agencies to support continuity of care for patients. Information received from other agencies, such as accident and emergency and out of hours service, was read and actioned by the GP and scanned onto patient records in a timely manner.

The practice worked with the local community nursing team, midwives and health visitors. Clinicians appropriately referred patients to community teams which were often based within the same building. For example pregnant women were seen by the community midwives for their ante-natal appointments.

Information sharing

There was a practice website with information for patients including signposting, services available and latest news. Information leaflets were available within the practice waiting room.

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

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider that enabled patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals to secondary care (hospitals). The 'Choose and Book' system enabled patients to choose which hospital they preferred and book their own outpatient appointments at their chosen hospital.

In appropriate situations patients were discussed between the practice clinicians and also with other health and social care professionals who were invited to attend practice meetings. Information sharing also took place within multi-disciplinary team meetings, for example in palliative care meetings.

Consent to care and treatment

The practice had a comprehensive policy on consent and decision making for patients who attended the practice. The policy explained all areas of consent and GPs referred to Gillick competency when assessing younger patients' ability to understand or consent to treatment. This meant that their rights and wishes were considered at the same time as making sure the treatment they received was safe and appropriate.

Templates had been produced for completion in circumstances where written consent from the patient was required, for example, immunisations. We were told that where patients gave verbal consent to care and treatment it was recorded in their notes.

Patients with learning disabilities and dementia were supported to make decisions through the use of care plans which they were involved in agreeing. The GPs and nurses we spoke with described situations where best interests or mental capacity assessment might be appropriate and were aware of what they would do in any given situation.

Staff were knowledgeable in the Mental Capacity Act 2005 and we saw that training was undertaken.

Health promotion and prevention

The practice supported patients to manage their health and wellbeing. Vaccination programs, long term health reviews and health promotion information were provided to patients.

Patients were assisted to access support services to help them make lifestyle improvements and manage their care and treatment.

Good

Are services effective?

(for example, treatment is effective)

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

We saw that there was a range of health promotion information on display in the waiting areas and leaflets explaining different conditions were also freely available in the treatment rooms of the practice. Local voluntary services were advertised on both the notice boards and TV screen which included befriending service.

Staff at the practice knew how to refer people to Help Direct. Help Direct is a support and information service for adults that assists people with a wide range of issues. We were told this might include assisting people with learning difficulties, mental health problems and those who had experienced bereavement. Help Direct regularly attended the practice in order to promote their service.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the results of the most 2013 National GP Survey. This showed that 88% of patients seeing a GP and 95% of patients seeing a nurse said the GP or nurse was good or very good at treating them with care and concern. We spoke with four patients whilst in the practice and received nine completed CQC comment cards. Comments we received were mainly very positive about how staff treated patients.

Patients told us they felt listened to and were treated respectfully by staff. Patients said their privacy and dignity was maintained.

All patient appointments were conducted in the privacy of a consultation or treatment room. There were privacy curtains for use during physical and intimate examinations and a chaperone service was available. Staff and patients informed us they were aware there was an interview room available if patients or family members requested a private discussion.

The patient electronic recording system included flags on patient records to alert staff to patient needs that might require particular sensitivity. For example, where a patient had a learning disability.

We were told by a member of the patient participation group (PPG) that the practice listened to their comments at the meetings and they felt they could influence changes in the practice in the future. We saw evidence that suggestions had been listened to and actioned.

Care planning and involvement in decisions about care and treatment

Patients we spoke with and CQC comments cards we received confirmed that patients felt involved in decisions about their care and treatment. Patients told us diagnosis and treatment options were clearly explained and they did not feel rushed in their appointment. Comments from patients included that they felt listened to and treated with respect, and options were always discussed.

Care plans were in place for patients receiving palliative care and the GP supported patients with discussion about end of life preferences as appropriate. These care plans were kept up to date and shared with relevant healthcare professionals such as the out of hours (OOH) service. We saw evidence that staff were proactive in identifying patients who would benefit from a care plan and that these were put in place with the input of the person involved.

A coding system on the computer system in the practice maintained registers of patients with particular conditions or vulnerabilities, for example, diabetes, mental health issues and learning disabilities.

All the staff we spoke with were effective in communication and all knew how to access an interpreter if required.

The 2013 GP patient survey reported that 90% of respondents said the last GP and last nurse they saw or spoke to at the practice was good at involving them in decisions about their care.

Patient/carer support to cope emotionally with care and treatment

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

Multi-disciplinary supportive care meetings were held to discuss the needs of those approaching end of life. Patient preferences were shared electronically with appropriate healthcare partners to ensure they were met, for example, with the out of hour's services.

The practice had a display of information including how patients could access emotional support, including counselling. The practice held record of carers and there was some information available for carers on how they could access support.

The practice had access to mental health team who were available on-site each week. 'Big white Wall' (an online support network to improve mental wellbeing) was promoted and sign posted to by staff where appropriate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice liaised regularly with the NHS Area Team and Clinical Commissioning Group (CCG) to discuss local needs and identify service improvement plans. This included improving access to the service for patients for appointments. On- line booking had also been introduced. The practice was actively involved in local and national initiatives to enhance the care offered to patients.

The practice had also implemented a Patient Participation Group (PPG). We spoke to one members of the PPG who told us the practice gained feedback from patients and was trying to encourage more patients to join the group in order to determine how to improve and meet the needs of the population it served. Regular patient surveys were used to identify areas for improvement. We saw evidence of action taken as result and review of this.

Regular reviews of long term conditions such as chronic heart disease, diabetes and chronic obstructive pulmonary disease were undertaken, with alerts identified on the practice system for when recalls were due. Clinical staff also conducted home visits to patients whose illness or disability meant they could not attend an appointment at the practice.

Patients we spoke with and the CQC comment cards we received confirmed patients were happy with the practice appointment system. Patients told us they could get an appointment the same day if they needed one. We also saw the online access for appointments was being promoted around the practice.

It was clear that staff knew the patients well. We were told that longer appointments would be offered if, for example, a patient was anxious or had a learning disability.

Tackling inequity and promoting equality

The new patient list at the practice was open and staff were able to offer appointments to patients including to those with no fixed abode.

The computer systems enabled staff to place an alert on the records of patients who had particular difficulties so staff could make adjustments. For example, if a patient had carer support or learning difficulties. Staff told us they would offer longer appointments to patients when needed.

Public Health England data found the practice's average male life expectancy was 77.9 and female life expectancy 82.6 years, compared to England's national average of 78.9 for males and 82.9 for females. Clinical staff held a number of regular clinics at the practice to provide health promotion information and advice on matters such as chronic disease management, immunisation and vaccination and diabetes.

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

Access to the service

The practice was purpose built and was visibly clean and well maintained. There was a car park with dedicated disabled bays closest to the door. Reception and the nurses' treatment room and the GP consultation rooms were on the ground floor. There were adequately spacious waiting areas and corridors and doorways were wide enough to accommodate wheelchairs. Disabled toilet and baby changing facilities were available on the ground floor.

The practice was open Monday to Friday from 8am until 6pm, with extended hours available from 08.45 – 11.45am on a Saturday. The practice offered emergency on the day appointments every day with pre bookable appointments also available. Home visits were available every day. All surgery opening times were detailed in the practice leaflet which was available in the waiting room for patients and on the website.

Responses to the national and practice patient survey showed that patients were satisfied with the practice. This was consistent with the responses we received on CQC comment cards. In the 2013 national GP survey 79.2% of patients who responded said they were very or fairly satisfied with their GP opening hours, 79.1% were satisfied with phone access. Overall 79.8% said they would recommend the practice.

GP appointments were provided in 10 minute slots. Where patients required longer appointments these could be booked.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns.

We reviewed how the practice managed complaints within the last 12 months. Ten complaints had been made by patients or their family and we saw these were dealt with in a timely manner. Investigations addressed the original issues raised and action was taken to rectify problems. Staff told us these were discussed at practice meetings and where changes could be made to improve the service these were put in place.

There was a designated responsible person who handled complaints in the practice. However the procedure in place did not highlight timescales when complainants could expect a response nor make reference to the Parliamentary Health Service Ombudsman who the complainant could refer to if they were unhappy with their response.

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

We saw the practice regularly reviewed the NHS Choices website for patient comments. Where negative feedback was received we saw the practice manager encouraged the patient to contact the practice and actively promoted their right to complain.

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.

We saw evidence that GPs met with the Clinical Commissioning Group (CCG) on a regular basis to discuss current performance issues and how to adapt the service to meet the demands of local people.

The staff we spoke with were clear on their role and responsibilities within the practice. There was an established leadership structure with clear allocation of responsibilities amongst the partner GPs and the practice staff.

Discussions with staff and evidence we reviewed identified that the management team had a clear vision and purpose. We found there was a clear vision throughout the practice to offer high quality care. The practice was considering ways to maintain this quality despite increasing demand.

There was a clear team working ethos that demonstrated all staff worked to a common goal and had contributed. Most staff had been working at the practice for a number of years and had been part of the development of the service. All staff were clear on their roles and responsibilities and each strived to offer a service that was accessible to all patients. One patient told us they always received good service and the staff were attentive and treated them with respect.

Staff told us they felt valued and that their views about how to develop the service were acted upon.

Governance arrangements

We saw systems in place for monitoring service provision such as complaints, incidents, safeguarding, risk management, clinical audit and infection control.

The practice manager was responsible for ensuring policies and procedures were kept up to date. We found some policy guidance was not completely relevant to the practice and the system for updating and reviewing policies needed to be more robust.

All staff we spoke with were aware of each other's responsibilities and who to approach to feedback or request information. Those systems and feedback from staff showed us that strong governance structures were in place

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for the practice showed it was performing in line with national standards.

Leadership, openness and transparency

We saw there was a clear leadership structure in place. Staff told us they felt valued, well supported and knew who to approach in the practice if they had any concerns.

Staff told us they had the opportunity to ask questions during staff meetings or to approach the practice manager at any time.

The practice manager undertook appraisals for the reception and administration team and GPs undertook nursing staff appraisals on an annual basis. This gave staff an opportunity to discuss their objectives, any improvements that could be made and training that they needed or wanted to undertake. We were told the practice was currently looking at ways to further improve this process.

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

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

The practice had a patient participation group. We spoke to a member of the group who commended the practice for their ability to listen to suggestions to improve the service. The members told us action had been taken to improve the service. This included identifying staff special interests, an improved online access and staff uniforms.

Staff told us patient feedback was discussed at practice meetings to see if there were any common themes where improvements could be made. Some staff were also involved in the PPG meetings held at the practice.

Staff were aware there was a whistleblowing policy. They knew who they should approach if they had any concerns. This meant there were processes in place to assist staff to expose poor care or bad practice. Staff we spoke to were also aware they could also contact CQC.

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)

We saw a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Newly employed staff had a period of induction. Learning objectives for existing staff were discussed during appraisal and mandatory training was role relevant. There was no clear system to monitor on-going staff training. The practice manager told us this would be looked into as part of the planned improvement in appraisals.

GPs were supported to obtain the evidence and information required for their professional revalidation.

Nurses were also registered with the Nursing and Midwifery Council, and as part of this annual registration were required to update and maintain clinical skills and knowledge. The nursing team met regularly for clinical supervision however this was not recorded. Their appraisal was carried out by a practice GP.

The practice had an on-going quality improvement plan with the CCG. They were actively involved in the CCG long term strategy plan and also local and national initiatives to improve patient care.

The GPs discussed the challenges for services however the practice aimed to be innovative and participate in future local developments, working closely with other practices and the CCG.

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

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Regulation 13 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Management of Medicines** **The provider must review how medicines are managed within the practice. Vaccines were not subject to appropriate arrangements for storage and recording of these medicines.**