

# Clifton Medical Practice

## Quality Report

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

### Ratings

#### Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

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 Clifton Medical Practice.

We undertook a comprehensive inspection on 10 December 2014. We spoke with patients, staff and the practice management team. The inspection took place at the same time as other inspections of GP practices across the Fylde and Wyre Clinical Commissioning Group.

The practice is rated as good.

Our key findings were;

- All staff understand and fulfil their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal incidents were maximised to support improvement.
- The practice was using proactive methods to improve patient outcomes, it links with the Clinical Commissioning Group and other local providers to enhance services and share best practice.
- The practice had a clear shared vision across all staff.

- Complaints were sensitively handled and patients are kept informed of the outcome of their comments and complaints
- The practice was actively involved in both local and national initiatives to enhance and support the care they delivered to their patients.
- The appointment system was sensitive to the needs of the population groups the practice served.

We saw areas of outstanding practice including:

- The practice was actively involved in local and national initiatives to enhance the care offered to patients. They were proactive in trialing new ways of working to ensure they continued to meet the needs of the patients registered with the practice.

In addition the provider should:

- Standardise drugs carried in GP bags to ensure all GPs carry the same.
- Ensure all audit cycle processes are fully documented.
- Ensure all post into the practice is seen by the GPs and an audit trail is available of actions identified and completed.

# Summary of findings

**Professor Steve Field (CBE FRCP FFPH FRCGP)**

Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as good for providing safe services.

There were systems in place to address incidents, deal with complaints and protect adults, children and other vulnerable people who used the service. Patients we spoke with told us they felt safe.

Information from the Clinical Commissioning Group (CCG) and the NHS England Local Area Team (LAT) indicated the practice had a good track record for maintaining patient safety. Staff took action to learn from incidents and made appropriate safeguarding referrals when necessary.

There were appropriate checks to ensure staff were suitable to work with vulnerable people.

Good



### Are services effective?

The practice is rated as good for providing effective services.

Systems were in place to ensure all clinicians were up-to-date with both National Institute for Health and Care Excellence (NICE) and other locally agreed guidelines.

The practice was using pro-active methods to improve patient outcomes and linked with other local practices to share best practice.

Consent to treatment was always obtained where required and this was confirmed when speaking with patients.

The practice regularly met with other health professionals and commissioners in the local area. Clinical audits were undertaken on a regular basis and results from those audits were used to improve the quality of services provided.

Good



### Are services caring?

The practice was rated as good for providing caring services.

Patients told us staff were extremely friendly and they were always treated with respect, dignity and compassion.

Staff we spoke with were aware of the importance of providing patients with privacy and information was available to help patients understand the care available to them.

Good



# Summary of findings

The practice was proactive in supporting patients to ensure they received the care they required by an appropriate means that they felt comfortable with.

## Are services responsive to people's needs?

The practice is rated good for providing responsive services.

We found the practice had initiated positive service improvements for their patients.

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

Appointments were available the same day. Patients reported they could access these appointments on the day however they told us they experienced delays on the phone lines first thing in the morning. Patients told us the on the day appointments were not always with their GP of choice. There was a clear complaints policy and procedure demonstrating that the practice responded quickly to issues raised and brought them to resolution. There was evidence of shared learning from complaints with all staff.

Good



## Are services well-led?

The practice is rated as good for providing well-led services.

The practice effectively responded to change. There was a clear set of values which were understood by staff and demonstrated in their behaviours.

The team used their clinical audits, information from surveys, the patient participation group and staff meetings to assess how well they delivered the service and to make improvements where possible.

There was an open and honest culture and staff knew and understood the lines of escalation to report incidents, concerns, or positive discussions.

All staff we spoke with felt valued for the roles and responsibilities they undertook.

Good



# Summary of findings

## What people who use the service say

We spoke with 13 patients during the inspection and received 22 completed CQC comments cards.

The patients we spoke with said they were very happy with the service they received. They told us there was sometimes a difficulty getting through to the practice by telephone but were aware the practice was trying to address this.

They told us on the day appointments were available if required but were with the emergency GP for the day and you could not choose who you wanted to see.

Patients did not identify any problems with confidentiality at the reception desk there was a sign which directed patients to wait a short distance from the desk whilst other patients were being spoken to. However, they were aware there was a private room available if they wanted to speak in confidence with a receptionist.

Patients we spoke with told us they were aware of chaperones being available.

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

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

The practice had an active patient participation group (PPG) who met bi-monthly, We spoke with two members of the PPG who told us they were actively recruiting patients from younger age groups to compliment the group. They told us there was a quarterly practice newsletter produced by the practice manager which was available in the waiting area. They told us they felt they had a voice in the practice but they were still in their infancy as they had only been together as a group for six months.

## Areas for improvement

### Action the service SHOULD take to improve

Standardise drugs carried in GP bags.

Ensure all audit cycle processes are fully documented.

Ensure all post into the practice is seen by the GPs and an audit trail is available of actions identified and completed.

## Outstanding practice

The practice was actively involved in local and national initiatives to enhance the care offered to patients. They were proactive in trialling new ways of working to ensure they continued to meet the needs of the patients registered with the practice. For example enhanced care for vulnerable house bound patients within the area and

participation in an elderly re-enablement project for vulnerable patients living in care and nursing homes. This included educating staff, care planning for residents and putting comprehensive systems in place for end of life care.

# Clifton Medical Practice

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and an expert by experience.

## Background to Clifton Medical Practice

The Clifton Medical Practice delivers primary care under a General Medical Services Contract with NHS England. As part of the Fylde and Wyre Clinical Commissioning Group (CCG) they are responsible for a practice population of 5480 patients.

The practice population groups are below national averages up to age 65 with the over 65 groups being higher. The largest population group within the practice the 65 plus age group, with under 4 years being the smallest group at 3.5%. Both figures are in line with CCG averages. 65.9% of patients have a long standing health condition and 1.8% of all patients are resident in nursing homes. 5.6% of all patients are unemployed which is higher than the CCG average but in line with the national average.

According to statistics available at the time of the inspection from Public Health England, the practice is in the fourth less deprived percentile for practices in England. Income deprivation affecting older people is lower than both the CCG and national average at 12%. Ethnic estimation within the practice is 1.6% non-white ethnic groups with male life expectancy at 78.0 years and female at 82.7 years.

Services available include access to three partner GPs (male and female), one type 2 salaried GP (this is a GP who

has been a locum GP within the practice for more than 12 months), three practice nurses and two health care assistant (HCA). This clinical team is supported by the practice manager, a part time Clinical Commissioning Group (CCG) pharmacist and administration and reception staff. All staff work part time with the exception of the practice manager and two partner GP's.

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

The nurse and HCA clinics promote healthy living, provide support and care for patients with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD).

The doctors are able to carry out minor surgery procedures and provide injections on painful joints.

The premises were purpose built for the service and are shared with another GP practice and the local NHS Trust who have community services on the premises.

## Why we carried out this inspection

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

# Detailed findings

The practice had not been inspected before.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

## How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 0 December 2014. During our visit we spoke with a range of staff including GP's, the practice manager, nurses and administration staff. We also spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members. We reviewed Care Quality Commission comment cards where patients and members of the public shared their views and experiences of the service.

# Are services safe?

## Our findings

### Safe track record

There were clear lines of leadership and accountability in respect of how significant incidents were investigated and managed.

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 and other health and social care professionals. 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.

We reviewed practice records and for example saw the practice's training policy had been regularly reviewed. We saw all staff had been trained to at least a minimum level of basic life support.

There were mechanisms in place for the prompt management of safety alerts. The CCG pharmacy manager identified drug alerts requiring further action and sent these through to the relevant professional to action. We tracked two recent alerts that had been received and found they had been accurately actioned.

We saw that any complaints once investigated were analysed, summarised and reviewed to identify trends or recurrent risks. All actions from complaints were shared with staff and the PPG as appropriate.

Appropriate arrangements were in place for the maintenance of the building. Fire alarms and extinguishers were placed throughout the building. The fire exits were well signposted and free from hazards to prevent escape in an emergency. Fire alarms were tested weekly and the fire systems had been fully serviced. Fire training was up to date.

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

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. It was clear the practice had an open culture and that staff were encouraged and supported to report any incidents.

Significant events that we reviewed showed the date the event was discussed; a description of the event, what had gone well, what could have been done differently, a full reflection of the event and what changes had been carried out. We saw evidence that changes in practice had been applied. For example protocols had been changed to ensure the situation did not arise again.

Monthly practice staff meetings and weekly clinical meetings were used to discuss and communicate learning and improvement from complaints and incidents. Minutes from these meetings were shared by email with all staff and paper copies retained within the practice.

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 practice manager and action was taken as required.

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

### Reliable safety systems and processes including safeguarding

All the staff at the practice, including the receptionists, were proactive when following up information received about their patients, specifically those who were vulnerable. Staff had an awareness of how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies both in and out of hours.

# Are services safe?

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

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.

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

The safeguarding records and register at the practice were updated as a minimum on a monthly basis following discussion and meeting with the GP and other professionals involved in the care. The practice was able to inform us of the number of children and vulnerable adults currently on their register and where they were in the process.

Staff were trained to undertake chaperoning procedures as per the practice policy. Details about chaperone facilities were seen in the waiting room. Patients told us they were aware of the availability of chaperones.

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

## Medicines management

Systems were in place for the management of medicines.

We saw medicines management was supported by the local Clinical Commissioning Group (CCG) medicines management team who visited the practice on a weekly basis.

We saw that audits were carried out by the CCG medicines management pharmacist to optimise the prescribing of certain medicines such as antibiotics or medicines for patients with long term conditions.

Emergency medicines for cardiac arrest, anaphylaxis and hypoglycaemia were available within the practice. We checked the emergency drug boxes and saw that medicines were stored appropriately and were in date.

We saw other medicines stored within the practice were in date and robust systems to check expiry dates were implemented. There were procedures to ensure expired and unwanted medicines were disposed of in line with waste regulations.

GPs told us they each had their own preference for medicines they held in their doctors bags. We discussed with the lead GP and the practice manager the need to standardise the medicines carried to ensure they all had the same appropriate medicines to deal with any emergency they may find whilst out on their visits.

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

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

The practice had a protocol for repeat prescribing which was in line with the General Medical Council (GMC) guidelines. This covered how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. The practice processed repeat prescriptions within 24-48 hours. Patients confirmed requests for repeat prescriptions were dealt with in a timely way. Systems were in place for reviewing and re-authorising repeat prescriptions, providing assurance that they always reflected the patients' current clinical needs.

Security measures were in place for prescriptions access in line with suggested best practice within the NHS Protect Security of prescription forms guidance, August 2013. . We were told hand written prescriptions were rarely used other than on home visits where the number from the form was recorded and entered in to the patients electronic records on return to the practice.

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.

Recent medicine alerts had been discussed at the practice meetings. The pharmacist had searched for patients within the practice population on this medication, addressed the alert fully and reported back to the meeting.

# Are services safe?

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

## Cleanliness and infection control

Infection Prevention and Control (IPC) was monitored within the practice and the IPC policy was available to all staff. This gave full information about aspects of infection control such as the handling of specimens, hand washing, and the action to be taken following exposure to blood or bodily fluids. There was an identified IPC lead who ensured all aspects of the policy were implemented fully. The lead had attended appropriate training to carry out her role.

Infection control training was provided for all staff as part of their induction, and we saw evidence the training was updated annually. The staff we spoke with confirmed they had received training and said any updated guidance relating to the prevention and control of infection was communicated to them by the infection control lead.

Occupational health checks at pre-employment medical and Hepatitis B immunisation checks and updates were carried out every five years. The practice was informed of the results and a copy was kept on staff personnel files.

We observed the premises to be clean and tidy and saw facilities such as hand gels, paper towels, pedal bins, and hand washing instructions to encourage hygiene were displayed in all the patient toilets. We saw there were hand washing facilities in each surgery and treatment room and instructions about hand hygiene were displayed. Protective equipment such as gloves, aprons and masks were readily available.

Curtains around examination couches were reusable; the practice showed us the planned schedule for cleaning. Examination couches were washable and were all in good condition. Each clinical room had a sharps disposal bin. There was a record of when each bin started to be used.

Cleaners were employed by the building management company. There was a cleaning schedule in place to make sure each area was thoroughly cleaned on a regular basis. There was also a record that each task had been carried out. The practice was cleaned in line with infection control guidelines, with the cleaners routinely attending every day.

An IPC audit carried out by an independent IPC company had identified areas for improvement and these were ongoing with the practice being at the stage of requesting quotes for the recommended remedial work.

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

## 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, such as for fire extinguishers had been completed. Portable electrical appliances and equipment calibration had been carried out by the practice.

Vaccines were kept in a locked fridge. The fridge temperature was monitored twice daily. Staff were aware of the action to take if the temperature was not within the acceptable range.

A machine for patient use for blood pressure taking was available in a discreet area of the waiting room. Instructions for use were displayed, along with guidance for patients to seek advice from staff if they had any queries or concerns about the results.

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

## Staffing and recruitment

The practice recruitment policy was up to date. 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 the numbers were kept in the staff files.

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

# Are services safe?

The practice GPs covered each other's absence as much as possible which meant there was rarely a need to use a locum agency.

The practice routinely checked the professional registration status of GPs and practice nurses against the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) each year to make sure they were still deemed fit to practice.

## **Monitoring safety and responding to risk**

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

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

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

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

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

The practice management team had procedures in place to manage expected absences, such as annual leave, and unexpected absences, such as staff sickness.

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

The practice had identified a fire marshal and first aider.

Fire extinguishers and alarms were checked and maintained by an external company.

## **Arrangements to deal with emergencies and major incidents**

The practice had a current and comprehensive business continuity plan in place. This gave staff detailed guidance on how to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

When we spoke with staff they were fully aware of the plan, each member of staff had a personal copy of it.

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

We found the practice had a defibrillator available and access to oxygen for use in emergency.

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

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

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

We were told from regular review of treatments and prescribing, the practice was able to review medications and stabilise patients using current guidance and recommendations. Sharing information with the staff team.

We found from our discussions with the clinical staff that they completed thorough assessments of patients' needs and these were reviewed as appropriate. For example, the nurse actively screened patients for diabetes and monitored their long term conditions.

There were systems in place to ensure referrals to secondary care (hospitals) were made in line with national standards. Referrals were managed primarily by using the 'choose and book' system, or where urgent, a fast track system. Staff followed up on each referral to ensure that it had been received, was progressed in a timely manner, and the result received back at the practice.

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

Patients we spoke with said they received care appropriate to their needs. They told us they were involved in decisions about their care as much as possible. New patient health checks were carried out by the practice nurses or health care assistants and regular health checks and screenings were ongoing in line with national guidance.

### Management, monitoring and improving outcomes for people

Care plans were in place for patients with complex or multiple health conditions. This enabled the practice to effectively monitor patients at regular intervals. Electronic systems had alerts when patients were due for reviews and ensured they received them 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.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included minor surgery outcomes and review of referral documents for cancer diagnosis to secondary care. The staff were appropriately trained and kept up to date.

One of the GP partners undertook minor surgical procedures within the practice in line with their registration and NICE guidance.

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

### Effective staffing

Practice staffing included medical, nursing, managerial and reception staff. The practice had training policies for both clinical and non-clinical staff. We reviewed staff training records and saw staff were up to date with attending mandatory courses such as basic life support.

The GPs covered each other for 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.

Each member of staff was expected to have an annual appraisal. The practice manager told us and staff we spoke with confirmed these were ongoing. We saw the process included identification of any learning needs and formulation of action plans to address them.

The GPs were up to date with their yearly continuing professional development in line with the requirements of the General Medical Council. Doctors were revalidated and nurse professional registrations were up to date and checked on an annual basis.

# Are services effective?

## (for example, treatment is effective)

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

All patients we spoke with were complimentary about the staff. We observed staff communicating with patients and they appeared caring and knowledgeable about the role they undertook.

### **Working with colleagues and other services**

The practice worked effectively with other health and social care services.

We were provided with examples of joint working with district nurses, health visitors and palliative care nurses.

Blood test results, X ray results, discharge summaries and letters received from the local hospital were managed in a timely manner. However these communications were triaged by a clinical administrator and only referred to the GP if deemed necessary. The practice need to ensure all incoming communications are seen and actioned by a GP before being added to the patients electronic record. We were assured that only GPs were responsible for the amendments to any medications in patient records following hospital admissions. Information from the out of hour's service or when patients attended A&E were received the following day and need to be addressed in the same way. The practice was currently waiting for an electronic document management system to be installed to allow them instant access to records for their patients held with other healthcare establishments such as the local NHS Hospital.

The practice had regular clinical meetings and the relevant health professional was invited to discuss and manage future care of patients. Palliative care meetings took place monthly to co-ordinate the care of patients coming to the end of their life.

Systems were in place to ensure that other services were promptly notified of matters of mutual interest that impacted on patient care. For example, regular updates were sent to the out of hour's service in relation to patients receiving palliative care.

The practice worked with other agencies such as Help Direct who held bi-weekly clinics at the practice. Help Direct is a support and information service for adults that

seeks to assist people with a wide range of issues. This might include assisting people with learning difficulties, mental health problems and those who had experienced bereavement.

The practice had a close working relationship with Fylde and Wyre Clinical Commissioning Group and worked collaboratively on a large number of both national and local initiatives. The practice had been involved in piloting processes and sharing outcomes from the pilots with other practices in the area. Examples included the project for extensivist Care which used a risk profiling tool to ensure timely management of multiple complex chronic conditions. Also the CCG project looking at Episodic Care for patients who attended the practice infrequently to ensure their continuing needs were being met.

Patients we spoke with said that if they needed to be referred to other health providers this was discussed fully with them and they were provided with enough information to make an informed choice. CQC comments cards also confirmed patients felt they had been referred for hospital appointments within an appropriate timescale.

### **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. We saw there was a plan to produce a monthly patient newsletter in the new year.

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 enables patients to choose which hospital they will be seen in and book their own outpatient appointments in discussion with their chosen hospital. There was a fast track system for urgent referrals.

# Are services effective?

## (for example, treatment is effective)

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

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, palliative/supportive care meetings.

The out of hour's services and other community health staff were alerted to any possible emergencies that could occur out of surgery hours, when a patient's condition had deteriorated.

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

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

### **Consent to care and treatment**

The practice had a consent policy. Consent to care and treatment was obtained in line with the ethos of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. Clinical staff told us they had received training in regards to consent but had not

received formal training for the Mental Capacity Act 2005; however they assured us they had read the available documentation within the file to ensure they were fully orientated with the requirements of the act.

Staff had a good understanding of what was required to determine a patient's best interests and how these were taken into account, if a patient did not have capacity to make a decision. Clinical staff demonstrated an understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity and understanding to consent to medical examination and treatment).

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

### **Health promotion and prevention**

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

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

We saw that staff in-depth knowledge of their patients' needs led to targeted services being in place such as childhood immunisation schedules being followed.

At the time of inspection the practice was promoting flu vaccination. Data supplied by the practice suggested 85% of eligible patients had taken the opportunity to have a flu vaccination with 85% also taking up the offer of pneumovax vaccination. 52% of patients in the relevant age group for shingles vaccination had also accessed this service.

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.

In the reception area we saw a display of information dedicated to carers which provided signposting to support

# Are services effective?

(for example, treatment is effective)

on a wide variety of issues. Carers could be referred to the Carers Point! A local organisation who supported carers in their own homes or met them in a mutually agreed place to offer support and respite.

The practice was participating in a national initiative seeking to develop caring neighbourhood communities.

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We spoke with 13 patients whilst in the practice and received 22 completed CQC comment cards.

Comments we received were 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, particularly during physical examinations. 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 informed us they were aware there was a room available if patients or family members requested a private discussion.

We found there was a strong culture of patient centred care and ensuring a holistic approach to care was delivered by all staff. It was clear staff were motivated to provide the best possible care.

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

We were told by a member of the patient participation group (PPG) the practice listened to their comments at the meetings and even though they were a new group they felt they could influence changes in the practice in the future. From recent PPG minutes we could see one member of the PPG had made a suggestion that the practice was currently evaluating regarding communication with patients and using alternate means of ensuring patients were aware of changes.

### Care planning and involvement in decisions about care and treatment

Patients we spoke with and CQC comments cards we received confirmed that they felt involved in decisions about their care and treatment. Patients told us diagnosis and treatment options were clearly explained and they did not feel rushed and felt able to come away from an appointment to think about matters before deciding what they would like to do. Another said the GP always took time

to understand and discuss their issues, and answer any questions they may have. All but one of the CQC comments cards we received were positive about all aspects of the service received at the practice.

Care plans were in place for patients on 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 (OOHs) service.

Using a coding system on the computer system the practice maintained registers of patients with particular conditions or vulnerabilities, for example, diabetes, mental health issues and learning disabilities. With the involvement of the patient, care plans had been put in place for anyone at increased risk of admission to hospital.

All the staff we spoke with were effective in communication and all knew how to access an interpreter if required. Literature could be accessed in different languages as and when required.

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

The 2014 GP patient survey reported that 81% of respondents said the last GP they saw or spoke to at the practice was good at involving them in decisions about their care. 61% of respondents said the 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 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.

## Are services caring?

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

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

The practice had a display of information dedicated to carers which provided signposting to support on a wide variety of issues. Carers could be referred to the Carers Point! a local organisation that supported carers in their own homes or met them in a mutually agreed place to offer support and respite.

The 2014 GP patient survey reported that 91% of respondents said the last GP they saw or spoke to at the practice was good at listening to them. 72% said the last nurse they saw or spoke to at the practice was good at listening to them.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

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.

The NHS Local Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and had identified service improvement plans. This included improving access to the service for patients for appointments. On- line and telephone booking had also been introduced.

The practice had also implemented a new patient participation group (PPG). A member of the PPG acknowledged the practice was proactively trying to gain feedback from patients and 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.

The practice was actively involved in local and national initiatives to enhance the care offered to patients. They were proactive in trialling new ways of working to ensure they continued to meet the needs of the patients registered with the practice. For example an elderly re-enablement project for vulnerable patients living in care and nursing homes. This included educating staff, care planning for residents and putting comprehensive systems in place for end of life care.

The practice was currently working as part of the neighbourhood scheme to offer health reviews and specialist assistance for example geriatrician assessment to house bound patients. The practice offered specific support services to carers, this was via Carers Point!.

Clinical staff also conducted home visits to patients whose illness or disability meant they could not attend an appointment at the practice

### Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its services. We found the practice had a number of policies in place aimed at tackling inequity and promoting equality, examples included policies regarding equal opportunities and identification of carers. The

computer systems enabled staff to place an alert on the records of patients who had particular difficulties so staff could make adjustments. For example, if a patient had carer support, hearing impairment or learning difficulties.

There was level entry to the practice from the street. Reception and the nurses' treatment room and the GP consultation rooms were on the ground floor. There were adequately spacious waiting areas. We noted there was a power assisted entrance door to the practice and part of the reception desk was at a lower level to facilitate access by wheelchair users. Disabled toilet facilities were available on the ground floor.

Public Health England's data found the practice's average male life expectancy was 78.0 and female life expectancy 82.7 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 provide health promotion information and advice on matters such as chronic disease management, immunisation and vaccination, smoking cessation and diabetes.

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

The practice had systems in place to ensure people experiencing poor mental health (MH) had received an annual physical health check. The practice could refer patients for support and counselling to the local Mental Health Centre where after appropriate assessment, the patients could then attend the practice to meet with their counsellor on a regular basis. This supported patients to maintain their confidentiality as other patients would not be aware they were attending for counselling as it was their general GP practice.

The practice also encouraged patients experiencing MH issues to use the Big White Wall Scheme available locally which allowed them to access support when they needed it most regardless of time of day.

### Access to the service

The practice was purpose built and was visibly clean and well maintained. There was a car park with dedicated disabled bays closest to the door. There was level entry to

# Are services responsive to people's needs?

## (for example, to feedback?)

the building. All consultation and treatment rooms were on the ground floor. A disabled toilet and baby change facility were available. Corridors and doorways were wide enough to accommodate wheelchair access.

The practice was open Monday to Friday from 8.30am until 6.00pm. The practice offered emergency on the day appointments every day with pre bookable appointments also available. The nurse held surgeries between 9.00am and 6.00pm by appointment. 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 website.

Responses to the national and practice patient survey showed that patients were satisfied with the practice. This was consistent with the responses we received on CQC comment cards. In the national survey 88% of patients who responded said their last appointment was convenient, 88% said they could get an appointment when required. 91% of respondents said the GP was good at listening and giving them time to discuss their needs. Patients reported they were seen in a timely manner and our observations on the day in general confirmed this.

Information about access to appointments was available via the practice information leaflet and on the practice web site.

From the CQC comment cards completed and speaking with patients we were told that it was sometimes difficult to get through by telephone to make an appointment but patients told us they were aware the practice was trying to address this.

GP appointments were provided in 10 minute slots. Where patients required longer appointments these could be booked by prior arrangement. Staff confirmed that longer appointment times were always allocated for patients with multiple long term conditions or at the request of the GP.

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

### **Listening and learning from concerns and complaints**

The practice had 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 is a designated responsible person who handled all complaints in the practice.

We reviewed how the practice managed complaints within the last 12 months. Seven complaints had been made by patients or their family. We found the practice handled and responded to complaints well. Complainants always received acknowledgement of the complaint and complaints were investigated and documented in a timely manner as required. Investigations addressed the original issues raised and action was taken to rectify problems. These were discussed at practice meetings and where changes could be made to improve the service these were put in place.

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

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

Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had needed to make a complaint about the practice.

# Are services well-led?

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

## Our findings

### Vision and strategy

There was an established leadership structure with clear allocation of responsibilities amongst the partner GPs and the practice staff. We saw evidence that showed the GPs and practice manager 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.

Discussions with staff and evidence we reviewed identified that the management team had a clear vision and purpose. The GPs we spoke with demonstrated an understanding of their area of responsibility and they took an active role in ensuring that a high level of service was provided on a daily basis. There was 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 friendly, caring good quality service that was accessible to all patients.

All the staff we spoke with said they felt they were valued and their views about how to develop the service were acted upon.

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

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

### Governance arrangements

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

The practice manager took an active role in overseeing the systems in place to ensure they were consistent and effective. The practice manager was also responsible for ensuring policies and procedures were kept up to date and that staff received training appropriate to their role.

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. However staff were not able to fully articulate what governance meant to the practice. The practice needs to ensure all staff have a clear understanding of what governance means in a holistic manner. Staff we spoke with were only aware of the aspects of governance they influenced for example infection prevention and control.

The practice manager took an active role in overseeing the systems in place to ensure they were consistent and effective. There was evidence that feedback from patients was discussed with all staff and learning was applied.

### Leadership, openness and transparency

All staff were observed to follow the vision and values of the practice which were very clear. There was an open and honest culture and clinical, administrative and reception staff all encompassed the concepts of compassion, dignity, respect and equality. We observed a friendly relationship with the reception staff and patients. Patients spoke very fondly of the reception team.

Staff understood their roles and were clear about the boundaries of their abilities.

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

The practice manager undertook appraisals for the reception and administration team and a named GP 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. The practice manager had her appraisal carried out by the GP.

The GP's 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.

# Are services well-led?

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

The culture at the practice was open and fair. We saw from minutes that staff practice meetings were held monthly. Staff told us they felt comfortable raising any issues or concerns and that they had the opportunity to discuss at these meetings.

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

The practice conducted an annual survey of patient feedback which included the opportunity for patients to comment on any aspect of the service they felt could be improved or was particularly good. We saw evidence feedback was analysed and discussed at practice meetings to see if there were any common themes where improvements could be made. Patients had complained about the road surface outside the practice being unsuitable for patients with limited mobility or the elderly and the practice had worked with the local council to ensure a timely repair of this road surface to reduce the risk of accidents for patients attending the practice.

The practice had a newly reformed patient participation group which had 10 members. The group was due to meet bi-monthly. Work was currently underway to produce a monthly newsletter for patients which highlighted news and information on the practice.

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

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

## **Management lead through learning and improvement**

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. E-Learning was carried out.

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 had a designated GP who carried out their appraisals. The nursing team met regularly for clinical supervision however this was not recorded. Nurses we spoke with told us they would discuss particular cases and reflect on them to enhance their care and management of patients but also to share good practice.

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

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

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