

Care Quality Commission

Inspection Evidence Table

Elizabeth Street Surgery (1-6378033280)

Inspection date: 14 March 2019

Date of data download: 28 February 2019

Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Safe

Rating: Good

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Y
There was active and appropriate engagement in local safeguarding processes.	Y
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence:	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> The principal GP was the safeguarding lead for child and adult safeguarding matters. At our previous inspection in July 2018, we saw there was no named safeguarding lead in practice policies and procedures; this had been rectified for this inspection. Safeguarding registers were maintained for both children and vulnerable adults. All clinical staff were trained to level three in safeguarding apart from one practice nurse and the healthcare assistants who were trained to level two. The practice was aware of new best practice guidance recommending practice nurses were trained to level three for safeguarding and we saw level three training was booked for all clinical staff, the principal GP and managers in June 2019. Staff spoken with were clear on the procedure to follow if they had a safeguarding concern. Policies, procedures and contact information was readily available to the whole staff team on the practice shared drive, in information folders and on laminated sheets on the wall in reception. There was a new process in place to ensure clinicians followed up children, young people, vulnerable patients and patients with a previous diagnosis of sepsis who did not attend appointments both at the practice and for secondary care appointments. Family and household members of vulnerable children were generally highlighted in the patient electronic record system although we saw one example where this had not happened. Following our inspection, staff told us they were working to ensure all potentially vulnerable patients were appropriately identified. Communication with health visitors was good. Our previous inspection in July 2018 had identified there had been no safeguarding meetings at the practice since April 2018 and no general discussion of the registers of vulnerable patients. We saw minutes of meetings that had taken place since August 2018 every two months at which these registers had been discussed. A new practice manager had started at the practice in February 2019 and had introduced a new record of vulnerable patients based on Gold Standard Framework (GSF) principles with links to GSF best practice guidance. We were told this record would be used in future discussions of vulnerable patients. At our inspection in July 2018, we saw not all staff had received appropriate DBS checks. At this inspection, we saw all staff had been DBS-checked to the appropriate level for their role. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff had any necessary medical indemnity insurance.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> At our inspection in July 2018, we saw recruitment files did not contain the necessary information to assure staff were fit for the role in which they were employed; there were missing documents relating to the employment process, references, DBS checks, staff identity and confidential health 	

questionnaires. For this inspection, we checked the file for the latest member of staff employed since July 2018 and saw all relevant and necessary documentation was in place.

- There was a new spreadsheet in place to give managers an overview of clinical staff immunisation status, membership of professional bodies and medical indemnity and we were told how this would be regularly checked to ensure it remained current.

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 04/07/2018	Y
There was a record of equipment calibration. Date of last calibration: 24/08/2018	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 05/09/2018	Y
There was a log of fire drills. Date of last drill: 07/03/2019	Y
There was a record of fire alarm checks. Date of last check: 09/01/2019 (Fire alarm service and check)	Y
There was a record of fire training for staff. Date of last training: Various within the last year.	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 31/07/2018	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Our previous inspection in July 2018 had identified several areas of potential risks to patient safety that had not been reviewed; there were no records of up-to-date fire extinguisher checks, fire drills or safe fire procedures. At this inspection, this had been addressed and records indicated all safety checks had been implemented and addressed.</p> <ul style="list-style-type: none"> • The practice fire policy had been reviewed and three members of staff were named as the fire marshals and had been trained for the role. • There were records of renewed safety checks for gas safety and electrical wiring installation that ensured these were safe and we saw records of legionella testing and mitigating actions to reduce the risk of legionella in the water system. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: February 2019 and 11/03/2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: February 2019	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in 2018, we saw comprehensive health and safety risk assessments had been carried out in 2015, however, these had not been repeated.</p> <p>At this inspection, we saw a range of health and safety risk assessments had been carried out. Staff had conducted a first aid safety audit and premises risk assessments in February 2019 and a car park risk assessment on 11/3/2019. There were also further risk assessment tools in place including for young persons, lone working, handling sharps and handling waste.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met/not met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Date of last infection prevention and control audit: 06/02/2019	
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At the time of our inspection in July 2018, staff were unable to show us evidence of a full infection prevention and control (IPC) audit for the practice since 23/02/2015. Following our inspection, we were sent a copy of a full IPC audit dated 10/05/2018 that had been completed by administration staff. The practice manager at that time told us they were the practice lead for IPC although they had had no training for the role. For this inspection, the IPC policy had been changed to name one of the practice nurses as the lead for IPC and we saw they had received training for this. We saw evidence of an IPC audit carried out on 06/02/2019 where an action plan had been developed. Actions had started to be addressed including the replacement of curtains in clinical rooms and the display of hand hygiene posters. We saw the repair to a wall in one of the clinical rooms was booked to be done two days following our visit. All actions were scheduled to be completed by the end of April 2019. Since the new practice manager had started in February 2019, new hand sanitising dispensers had been fitted in clinical rooms as well as disposable apron dispensers. All sharps bins had also been fitted to fixed wall brackets. 	

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At our inspection in July 2018, we saw there were insufficient staff to enable safe systems and processes to be carried out effectively; there were over 500 sets of new patient paper medical records waiting to be summarised onto the electronic patient record system and a backlog of communications coming into the practice that had not been viewed by clinicians or scanned and coded onto patient records. At this inspection, we saw staffing was sufficient to allow all staff to carry out their roles appropriately. There were new rotas in place to allow staff to work effectively. These had been reviewed by the new practice manager and adjusted to give staff better job satisfaction by varying the roles they carried out each day; we were told protected time for training was to be re-instated from April 2019. Staff reported the new rotas had improved their working conditions. Staff had trained in basic life support in July 2018 and we saw further training was booked for all staff and the principal GP in July 2019. The practice had employed a new full-time clinical pharmacist who worked with patients to review medicines and assist other clinical staff in medicine management. At our inspection in July 2018, the practice did not routinely produce and share care plans for vulnerable patients. We saw at this inspection care planning was part of everyday practice for staff and GPs, and clinicians were proactive in identifying vulnerable patients in need of care plans. We saw evidence these plans were shared appropriately with other services. In July 2018, we found the practice business continuity plan was out-of-date and not communicated effectively to staff. At this inspection, the plan had been reviewed and was current, containing up-to-date information. This plan had been shared with staff. 	

- Arrangements to manage patients with rapidly deteriorating health or emergency conditions had been strengthened since our inspection in July 2018. Staff we spoke with and the principal GP were knowledgeable about how to manage and care for these patients. There was a folder on sepsis in all clinical rooms, sepsis posters in reception and in the patient waiting area. The practice had placed alerts on patient records for those patients who had previously been diagnosed with sepsis to highlight those patients to staff if they were showing symptoms of sepsis or did not attend appointments. The new practice manager had produced a newsletter for patients that contained details for patients on the signs and symptoms of sepsis.
- There were resuscitation algorithms in reception for staff to follow if needed and advice for reception staff on the management of suspected patient heart attack and stroke. A new guideline on the first-line management of patients considering suicide had also been developed for reception staff.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • At our inspection in July 2018, we saw medical records for some patient consultations that were not comprehensive and lacked sufficient detail to enable care and treatment to be provided safely. Following our inspection, the practice introduced a regular peer review of consultations to ensure they were to best practice guidelines. We saw records of consultations that evidenced this. • Our previous inspection in 2018 found communications coming into the practice were not handled in a way that kept patients safe; there was a backlog of information not processed by staff or seen by GPs that indicated a high level of risk to patient safety. We saw at this inspection, all communications coming into the practice were seen by GPs and processed on the same day they were received by the practice. • Since our inspection in July 2018, staff had summarised the backlog of new patient medical records and there was dedicated time allocated to allow further new records to be summarised in 	

a timely way. At this inspection, we saw there were only 15 patient records outstanding and these had only been received recently by the practice.

- Our inspection in 2018 showed time constraints had meant staff had not been checking patients referred for urgent two-week-wait appointments had been allocated appointments and attended appropriately. At this inspection, we saw there was a new, safe process in place. There was a spreadsheet that recorded details of referrals, patient appointments and the outcome of these appointments. Patients who were given a diagnosis of cancer were invited into the practice for a care review and those who did not have a cancer diagnosis were invited to the practice for a follow-up appointment if necessary. There were three staff members who were responsible for monitoring patients with these urgent referrals to ensure staff absence was covered.
- We saw patient medical records were complete and contained all information necessary to ensure referrals to other services were comprehensive. Staff told us they were able to manage referrals in a timely way.

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) (NHS Business Service Authority - NHSBSA)	1.12	1.00	0.94	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2017 to 30/09/2018) (NHSBSA)	5.8%	5.9%	8.7%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2018 to 30/09/2018) (NHSBSA)	5.35	5.30	5.64	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2018 to 30/09/2018) (NHSBSA)	2.83	2.72	2.22	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions (PGDs) or Patient Specific Directions (PSDs)).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice held all prescriptions securely and monitored their use although prescriptions were not removed from printers overnight. At these times, doors to the rooms were locked although there was access for cleaners. Staff told us there had been no incidents recorded in relation to this and the risk had not been previously considered. We were told arrangements would be made to remove prescriptions from printers overnight and the practice sent us a copy of a risk assessment that addressed this issue following our inspection. 	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> Our inspection in 2018 identified not all PGDs contained the relevant staff names and/or were appropriately authorised. The practice had reviewed all of the PGDs held for use by clinical staff and had ensured they were current, contained the correct staff names and had been appropriately authorised. A standard PSD form had also been put in place although at the time of our inspection, this was not in use. The new practice clinical pharmacist was responsible for reviewing changes to patient medicines made by other services with the help of GPs who were responsible for the final authorisation of any medicine changes. We saw the practice held all medicines necessary for managing patient emergency situations except for two possible recommended medicines, naloxone (a medicine to treat opioid overdose) and an alternative medicine to benzylpenicillin for patients allergic to penicillin. The practice was aware of the risks of this but had not documented any discussion. Following our inspection, staff sent us evidence of a risk assessment that had been discussed in a practice meeting and confirmed these medicines had been added for use in possible patient emergencies. There were good records held of checks kept on the stocks and expiry dates of emergency medicines and equipment. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	15
Number of events that required action:	15
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in July 2018, we noted there had been no significant incidents recorded since March 2018 although we saw evidence events had occurred. At this inspection, we found three events had been recorded retrospectively for discussion and shared learning. A further 12 events had also been recorded following this by different members of staff. We saw evidence of discussion of incidents in practice meetings and staff we spoke with were aware of significant events.</p> <p>We saw the practice had reviewed and amended the significant event policy and this now followed best practice guidelines. The new practice manager had introduced a summary document so all events could be recorded to identify trends and aid review. Significant events were part of a new standing agenda for practice meetings.</p>	

Example(s) of significant events recorded and actions by the practice.

Event	Specific action taken
A prescription that had been printed remotely by the principal GP for a controlled drug was missing at the surgery. This event had occurred four times.	Each time the prescription was missing, it was reprinted at the practice and IT was contacted for investigation and to correct the error. The new practice manager had noted the common theme with the remote printing of prescriptions for controlled medicines and had carried out a full investigation. It was agreed remote printing of prescriptions would be stopped. Two new folders were introduced in reception, a yellow folder for routine prescriptions and a red folder for controlled medicines which recorded all prescriptions printed and had to be signed off by a GP. For transparency, the practice informed the accountable officer at the central reporting agency and sent the results of the investigation to show all reprinting had been valid and justified.
A patient was prescribed antibiotics from the results of a urine sample that had only been tested with a dipstick. Further testing by microbiology revealed there was no infection present.	Prescribing staff were reminded of best practice guidelines for prescribing antibiotics. The patient was called to the practice for further review.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We saw a log of safety alerts kept by the practice and confirmation recorded that action had been taken. Specific details of actions taken were sometimes lacking. The new practice manager showed us a spreadsheet that would be used in future to record these more fully.</p>	

Effective

Rating: Requires improvement

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways were in place to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2018, we found although clinicians had access to best practice guidelines and generally provided care and treatment in line with these, there were no clinical meetings taking place to formally review changes to guidance and ensure all staff were aware of these. We also found patient clinical records sometimes lacked sufficient detail to ensure care was provided effectively.</p> <p>At this inspection, we saw records of staff clinical meetings and discussion of guideline changes to share learning.</p> <p>The practice had developed a QOF desk-aid that reminded clinicians of those actions required for each patient long-term condition during a patient consultation.</p> <p>The practice had employed a full-time clinical pharmacist since our inspection in July 2018 who reviewed patient medicines to ensure care and treatment was provided safely and effectively. They carried out telephone and face-to-face reviews with patients when necessary.</p> <p>Vulnerable patient care plans were reviewed regularly and amended when needed.</p>	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) <small>(NHSBSA)</small>	0.64	0.62	0.81	No statistical variation

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. Care plans were produced for these patients.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks were offered to patients over 75 years of age.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice had developed a software application for patients that enabled them to communicate using their phone to access online patient services and communicate the results of self-monitoring tests, for example, blood pressure readings.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	76.4%	84.3%	78.8%	No statistical variation
Exception rate (number of exceptions).	19.4% (66)	17.8%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure	85.7%	84.8%	77.7%	No statistical variation

reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>				
Exception rate (number of exceptions).	14.1% (48)	12.1%	9.8%	N/A
	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	88.4%	85.8%	80.1%	No statistical variation
Exception rate (number of exceptions).	24.0% (82)	20.3%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) <small>(QOF)</small>	63.0%	77.4%	76.0%	Variation (negative)
Exception rate (number of exceptions).	7.1% (31)	13.7%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	76.8%	91.8%	89.7%	Variation (negative)
Exception rate (number of exceptions).	10.8% (25)	12.8%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	83.1%	85.5%	82.6%	No statistical variation
Exception rate (number of exceptions).	7.9% (57)	5.9%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are	90.0%	89.2%	90.0%	No statistical variation

currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	4.1% (3)	6.7%	6.7%	N/A

Any additional evidence or comments

In November 2018, the practice had started working with specialist services for patients with asthma and those with chronic obstructive pulmonary disease (COPD, a lung disease). A member of each of these services attended the practice separately to run clinics for patients to assist staff with the management of patients with asthma and COPD. We saw unverified data showing improvements in QOF results for patients with these long-term conditions as follows:

- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 to date was 83%.
- The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months to date was 84%.

Families, children and young people

Population group rating: Requires improvement

Findings

- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- Young people could access services for sexual health and contraception.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	55	70	78.6%	Below 80% (Significant variation negative)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)	80	100	80.0%	Below 90% minimum (variation negative)

(01/04/2017 to 31/03/2018) (NHS England)				
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England)	82	100	82.0%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	79	100	79.0%	Below 80% (Significant variation negative)

Any additional evidence or comments

The latest validated childhood immunisation uptake rates were below the World Health Organisation (WHO) targets. These figures related to immunisations given from 01/04/2017 to 31/03/2018 and staff at the practice we spoke with told us they felt figures for childhood immunisations had improved.

There were regular weekly clinics and a clinic on a Monday after 4pm aimed at children needing pre-school booster vaccinations. They had introduced a letter for new mothers congratulating them and giving them an appointment for a baby check and vaccination together with details of the childhood immunisation schedule.

We asked to see up-to-date figures for childhood immunisations. We saw unverified data that indicated:

- The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) was 95.8%.

Figures for children aged two were not available.

Working age people (including those recently retired and students)

Population group rating: requires improvement

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified	61.7%	69.8%	71.7%	No statistical variation

period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)				
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	56.1%	62.2%	70.0%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	47.7%	52.8%	54.5%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	13.3%	74.8%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	48.3%	47.7%	51.9%	No statistical variation

Any additional evidence or comments

- The practice had arranged for the newest practice nurse to undertake cytology training so both nurses at the practice were qualified to do cytology screening. This nurse had recently trained and was about to start a period of observed practice before being signed off to be fully qualified. In the months prior to our inspection, the practice had employed locum nurses to carry out additional cytology screening. We saw unverified data from the practice that indicated cytology screening had improved over the last three months.
- The practice had worked with staff from the bowel cancer screening team during May and June 2018 to help improve their screening rates. Latest figures for this were not available.
- The practice percentage of patients with a recent diagnosis of cancer who had a patient review recorded as occurring within 6 months of the date of diagnosis was only 13% and was significantly below local and national averages. Following our inspection, we were sent evidence to show a new system had been introduced to manage the care of patients diagnosed with cancer to ensure they were offered a review within six months of diagnosis.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

**People experiencing poor mental health
(including people with dementia)**

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. Receptionists had a protocol in place to help them to deal with patients considering suicide.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	86.0%	93.2%	89.5%	No statistical variation
Exception rate (number of exceptions).	31.3% (26)	19.6%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	94.3%	93.3%	90.0%	No statistical variation
Exception rate (number of exceptions).	15.7% (13)	17.0%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	72.2%	85.7%	83.0%	No statistical variation
Exception rate (number of exceptions).	18.2% (4)	9.5%	6.6%	N/A

Any additional evidence or comments

The exception reporting figure for care planning for patients with poor mental health was high. We

reviewed records for a sample of these patients and found care plans were in place and had been produced by secondary care services. Patients with these care plans in place had been excepted by the practice rather than included.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	511.7	522.7	537.5
Overall QOF exception reporting (all domains)	9.6%	8.0%	5.8%

Any additional evidence or comments

The practice exception reporting figures were higher than CCG and national averages. We reviewed figures for other practices in central Blackpool with a similar patient population and found rates of exception reporting were high. Staff told us the patient population was very transient and they made every effort to engage with patients and ensure patient contact details were up-to-date.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

- Since our previous inspection in July 2018, we saw evidence of quality improvement work done to review the content of clinician consultations entered on the practice electronic patient record system. This monitoring ensured best practice guidelines were followed.
- The clinical pharmacist who commenced working at the practice in August 2018, had implemented an audit of clinical prescribing practice. We saw evidence of an audit that demonstrated reduced prescribing of antibiotics for children aged up to five years old as recommended by best practice guidelines.
- There was regular audit of the prescribing of non-medical prescribers in the practice which was reviewed by the principal GP.
- Patient access to appointments was regularly reviewed and capacity adjusted to ensure good appointment availability.
- There had been two audits of minor surgery carried out in the practice to ensure outcomes were as expected and patient consent for procedures had been obtained.
- Staff told us they planned to use NICE best practice guidelines to produce a programme of clinical audit including the identification and management of patients who were pre-diabetic, reviews of patients who were diagnosed with diabetes during pregnancy and the management of patients with gout.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Staff we spoke with told us they could do training within their usual role. Staff rotas were to be introduced at the beginning of April 2019 to give formal, protected time for training. • Since our inspection in July 2018, a staff training matrix had been developed to give a management overview of training. Information from individual staff files and staff online training had been pulled together to give an overall view of training. • Staff appraisal had been carried out and only one staff member remained to be appraised (that staff member had been off work long-term sick for some time and had only just returned to the practice). All staff had completed a training needs analysis and assessments for the use of visual display units (VDUs). 	

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams	Y

and organisations, were involved in assessing, planning and delivering care and treatment.	
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Following our inspection in July 2018, the practice had re-started meetings with staff from other health and social care services and we saw these meetings took place every two months. Minutes for these meetings were comprehensive and the principal GP attended and made notes on patient electronic records contemporaneously. Attendance at these meetings were good and included members of community services, social care, health visitors and members of the local hospice service. The meetings discussed vulnerable adults and children and reviewed patients who had recently died. Care plans for patients were updated and shared with other services when needed. 	

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice involved patients in monitoring and managing their own health, for example using the electronic health application developed by the practice. Patients were encouraged to self-monitor at home and report findings via the application to inform their care and treatment. 	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma,	92.9%	96.2%	95.1%	No statistical variation

schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	2.9% (41)	1.6%	0.8%	N/A

Any additional evidence or comments

The practice exception reporting figures for recording smoking status were higher than CCG and national averages. Clinicians had been reminded of the need to record all relevant data for patients when a review was conducted. A reminder for clinicians had been produced and was on every clinician's desk.

Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Clinical staff told us how they would seek and record consent appropriately. Staff were trained and had a good understanding of consent issues. We saw two audits of minor surgery, one of which audited consent had been suitably obtained and recorded. 	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: We heard staff greeting patients in reception in a friendly and polite manner. During our inspection, we observed a staff member dealing with an upset patient with empathy and understanding. They were supported with this by the practice manager.	

CQC comments cards	
Total comments cards received.	3
Number of CQC comments received which were positive about the service.	3
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Patient interviews	We spoke with four patients at this inspection. They told us they found staff caring and helpful. They said clinicians were good at explaining care and treatment options and they felt respected by clinicians. One patient told us they had been in the waiting area when the practice manager arrived and was pleased to hear them greet all the waiting patients.
Comments cards	Although we only received three comments cards, all three praised the staff and GPs at the practice. They spoke of helpful and cheerful staff and a professional and caring service.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5048	390	100	25.6%	1.98%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)	87.1%	88.3%	89.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018)	82.9%	86.6%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	96.4%	95.2%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	85.0%	84.8%	83.8%	No statistical variation

Any additional evidence or comments

The practice had reviewed the results of the national patient survey and had documented discussion of these in practice meeting minutes. Discussion showed acknowledgement of the high levels of achievement shown by the survey for areas of clinical care.

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Y

Any additional evidence

Staff told us the practice had last carried out a patient survey in 2017. There was a list of actions identified following the survey. These included future planned improvements to the telephone system and further staff training to actively signpost and manage patient requests for appointments. At the time of our inspection in July 2018 these had yet to be addressed. However, at this inspection we saw the new practice manager, following discussion with clinical staff, had produced a flowchart and matrix to guide reception staff as to how to book patient appointments with the most suitable clinician. There was also a guide as to other services available to patients outside the practice.

The number of telephone lines into the practice had been reduced from eight to two to match the number of staff available to answer the phones.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff used an easy-read questionnaire to be completed prior to appointments for health reviews for patients with learning difficulties.</p> <p>Health information leaflets were available in the practice waiting area and information on local support services was displayed in the waiting area and on the practice website.</p>	

Source	Feedback
Interviews with patients.	The four patients we spoke with told us they felt involved in any decision made by clinicians. They said treatment was explained including any possible side effects of medicines. They all said they trusted clinicians.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)	88.1%	92.9%	93.5%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first	Y

language.	
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in 2018, we found the patient waiting area to be disorganised and a folder of information left for patients that had been intended for staff. At this inspection, the waiting area was tidy and organised. Notice boards had been tidied and information displayed was useful and current.</p>	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 116 patients as carers (2.3% of the practice patient list).
How the practice supported carers.	All carers on the practice register had alerts added to their electronic health record so flexible appointments could be offered if needed. All carers were offered an annual health review and flu vaccination.
How the practice supported recently bereaved patients.	The practice contacted families who were bereaved by telephone and/or with a visit if it was appropriate. They signposted patients to bereavement support services.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The reception desk was screened with glass with a window for patients to speak to staff; this helped to muffle conversation. Staff knew that if a patient needed to speak privately they could use a separate area and this was advertised to patients at reception.</p>	

Responsive

Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The principal GP had worked with the appropriate organisations and stakeholders to develop a new computer software application that allowed patients to access the national patient access service to book and cancel appointments, order repeat medications and view medical records, as well as report self-monitoring results such as blood pressure readings. This application had been further developed to give patients access to the principal GP through "GP Connect". This allowed patients to select a telephone appointment with the GP and give the reason for the appointment. Patients could then describe symptoms and upload a photograph or a short video to aid the consultation. All necessary safeguards were in place and once viewed, these images were then deleted. Patients were also able to send update messages or cancel the appointment if necessary. This service was in development at the time of our inspection and was limited to a small number of appointments. The practice proactively identified vulnerable patients and produced care plans, for example for palliative care patients, which were shared with other services. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 8pm
Tuesday to Friday	8am to 6.30pm
Appointments available:	
Monday	8am to 11.50am and 3pm to 7.50pm
Tuesday, Thursday and Friday	8am to 11.50am and 3pm to 5.50pm
Wednesday	Walk-in clinic 8am to 10.30am and booked

	appointments 3pm to 5.50pm
Extended hours opening:	
Weekdays	6.30pm to 8pm offered by the local extended access service at a central Blackpool location.
Weekends	Some booked appointments offered by the local extended access service at a central Blackpool location.
Local walk-in service	Offered at Blackpool, Freckleton and Fleetwood.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5048	390	100	25.6%	1.98%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	96.7%	93.4%	94.8%	No statistical variation

Older people

Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice nurses accommodated home visits for annual flu vaccinations.

People with long-term conditions

Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Good

Findings

- Additional nurse appointments were available after 4pm on a Monday for school age children so that they did not need to miss school.
- Staff ran a baby clinic on Monday evenings aimed at children who needed pre-school booster injections.
- The baby clinics were changed from being offered on the first floor of the practice to being run on the ground floor.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 8pm on a Monday. Emergency and pre-bookable appointments were also available to all patients at additional locations within the area every day, as the practice was a member of a local collaboration of GP practices.
- The practice participated in the local provision of appointments for patients with clinicians every weekday from 8am to 8pm. Appointments were available at the practice until 8pm on Mondays. When the practice was closed appointments were provided at other local sites. A walk-in centre was located close to the practice.
- Telephone appointments were available and some appointments with the principal GP through a computer software application, GP Connect.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice was working with a local service for young, homeless patients to arrange for those patients to have easy, on-the-day access to a GP at the practice.
- Staff had invited a self-help service for patients with chronic pain, Smile Blackpool, into the practice

to discuss how they could work together to offer a one-stop shop for those patients.

- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. Longer appointments were offered where necessary.

People experiencing poor mental health (including people with dementia)

Population group rating: **Good**

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff used a flowchart guide to manage patients telephoning the practice who were considering suicide. This protocol was written to try to keep patients safe until help could be given.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

People were able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
Explanation of any answers and additional evidence: Staff recorded all requests for patient home visits with as much detail as possible so the GP could assess the level of need before the visit. Staff were aware of patient symptoms that required immediate attention and would interrupt the GP if necessary to pass on information.	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	63.2%	N/A	70.3%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	60.1%	67.4%	68.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	64.1%	66.8%	65.9%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	67.2%	72.3%	74.4%	No statistical variation

Source	Feedback
Patient interviews	The four patients we spoke with told us they always got an appointment with a clinician when they needed one. They said they were happy to see any of the clinical staff if it was appropriate for their needs. They said they rarely had to wait to see a GP and usually got an appointment on the day they called.
Comments cards	Two of the three comments cards we received said appointments were timely and the service was prompt.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	8
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>Explanation of any answers and additional evidence:</p> <p>During our inspection in July 2018, we noted the practice complaints policy was not comprehensive and there was a lack of recording of complaints after April 2018. Documentation of complaints was also poor with details of practice responses sometimes missing.</p> <p>At this inspection, we saw the complaints policy had been reviewed and updated and documentation of</p>	

complaints had improved. A new spreadsheet had been set up to enable better management of complaints and there was provision for verbal complaints to be recorded to better identify any trends.

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient's relative complained of a late diagnosis following several visits to the practice and the hospital.	The circumstances of the patient's care were reviewed and all attendances at the practice were examined in detail. The case was used as reflective learning by the GP and a full explanation and apology sent to the patient relative.

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: At our inspection in July 2018, we noted a lack of leadership and management of risks. There was inadequate non-clinical staffing and this had not been addressed. At this inspection, we saw this had changed in all respects. <ul style="list-style-type: none">• A business plan had been developed to set out practice objectives and share the practice vision for the future and how it would be achieved.• Leaders demonstrated a good knowledge of challenges to the practice and how risks to service delivery could be managed.• The practice had an agreement with the regular female locum GP that they would become a salaried GP in late March 2019.• Staff told us leaders were always approachable; they said the new practice manager was always communicating with staff and encouraging feedback.	

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: At our previous inspection, we found a lack of planning for the practice and no evidence of a shared vision. Communication with staff was lacking. At this inspection, we saw communication with staff had been improved. There were regular meetings	

and an away day had been held to involve staff in the development of the practice.

Staff had been supported to develop new roles and responsibilities; three members of the practice administration team had been supported to become healthcare assistants.

The practice had developed a mission statement which was:

“Elizabeth Street is an established GP practice which is committed to preserve and enhance its excellent reputation for being caring and innovative by providing high quality medical services in a friendly, happy and healthy environment.”

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2018, we found a lack of non-clinical staffing had not been addressed and opportunities to learn from significant events had been missed. We saw evidence of some poor clinical record keeping and staff morale was very low; some staff had left the practice.</p> <p>At this inspection we found evidence of considerable change.</p> <ul style="list-style-type: none"> • Staff told us they felt supported and involved in the practice. They said they were happy to come to work and worked well as a team, supported by leaders in the practice. They told us the new practice manager was always approachable and greeted them every day as part of the team. Staff felt the practice was much better organised and we saw evidence of de-cluttering in many areas of the practice. • The practice manager told us they were planning to introduce further staff meetings in addition to the clinical meetings and whole practice team meetings; from April 2019, a regular nurse meeting and reception staff meeting was planned. All meetings would have standing item agendas to ensure good governance. 	

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
Staff interviews.	Staff told us the surgery was a happy place to work. They said they valued the support given by managers and had noticed a general change for the better in the attitude of everyone at the practice, including the GP, particularly since the new practice manager had started. They told us the re-allocation of duties each day had made their jobs less repetitive and more varied. They valued the new roles

	and responsibilities they had been given.
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Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Our inspection in July 2018 found governance systems for the practice were lacking. Policies and procedures were poor and organised badly and the system to manage communications coming into the practice did not keep people safe. Practice roles and responsibilities had not been reviewed and notices for staff in respect to these were inaccurate. There was a lack of management of responsibilities that had been allocated to staff who were absent from the practice. Non-clinical staff were unable to fulfil their duties because of time pressures and this had not been addressed.</p> <p>At this inspection, we found these concerns had been addressed comprehensively:</p> <ul style="list-style-type: none"> • Practice policies and procedures were well-managed, reviewed and up to date and staff were aware of where to find them. • Policies to ensure good governance, such as the management of post coming into the practice, the policy for patient uncollected prescriptions and the management of patient safety alerts had been developed and shared with staff. • There was a new list of staff roles and responsibilities and staff were aware of them. • There were new staff rotas in place that allowed for services to be delivered safely and effectively and staffing levels were sufficient to cover short-term staff absence. 	

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	

Our inspection in 2018 found a lack of staff appraisals and some staff working without the appropriate DBS checks in place. We found there was no management oversight of staff training and staff were undertaking training in their own time and unpaid. The practice major incident plan was out of date and the last health and safety risk assessment for the premises had been done in 2015. The risks presented by the backlog of post we found at the inspection and over 500 new patient medical records that had not been summarised, had not been addressed. There were no health risk assessments for staff and recruitment processes did not meet regulations. There was a lack of quality improvement work and systems for managing patient complaints and significant incidents were inadequate.

At this inspection, we saw these issues had been addressed comprehensively:

- All but one of the staff appraisals had been carried out. All staff had completed a training needs assessment and an assessment for the safe use of visual display equipment.
- Staff DBS checks had all been renewed and recorded and were appropriate for the role.
- A new matrix of staff training had been developed to give management oversight and staff completing training were paid and given protected time where possible.
- The practice major incident plan had been reviewed and was up-to-date.
- New risk assessments had been carried out for the practice premises and there had been a full infection prevention and control audit repeated in February 2019.
- Recruitment processes had been reviewed and the file for the latest new staff member contained all required documentation. Staff confidential health questionnaires were in use.
- There was a programme of quality improvement work with regular searches set up to aid improvement. The principal GP had protected time every Tuesday to carry out governance and quality improvement tasks. They audited clinical staff consultations during this time.
- Systems to manage patient complaints and significant incidents had been changed to ensure learning was shared with all staff and there was management overview of these to identify possible trends. All staff had been involved in reporting significant incidents and the threshold for reporting events was appropriate.

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Explanation of any answers and additional evidence:

At our inspection in July 2018, we saw little evidence of practice meetings. We found evidence of some patient medical records that contained insufficient information to enable safe care and treatment. Staff had not reported a recent statutory incident to the CQC.

We found this had changed at this inspection:

- Practice meetings had been re-started and there were comprehensive minutes kept which were shared with staff. There was evidence of discussion of performance such as against the QOF and the local contract with the clinical commissioning group (CCG).
- A programme of regular review of clinical record-keeping had been introduced and records we

viewed showed the entries made by clinicians complied with best practice guidelines and contained all relevant information.

- Staff we spoke with were aware of their duty to report certain events as statutory notifications.

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

Explanation of any answers and additional evidence:

At our inspection in July 2018, we found there had been no meetings with the patient representative group (PPG) for some time. PPG members told us they felt the practice had not been open with them regarding staff changes in the practice and there had been no practice newsletter for some considerable time. Staff reported a lack of communication and said they felt they had not been listened to.

We found at this inspection the practice had acted to address these concerns:

- The PPG group meetings had been restarted in February 2019 and further meetings were planned quarterly. We saw minutes of this meeting showing PPG members had been consulted in proposed developments in service delivery and engagement with other local health and social care services. The PPG also suggested possible improvements in the service which were either accepted or taken forward for further discussion.
- A staff audit questionnaire had been sent to all staff at the start of March 2019. This questionnaire asked staff for their opinion of the long-term purpose of the practice and asked them to identify the strengths, weaknesses, opportunities and threats to the management of the practice (SWOT analysis). There was also a section for staff to examine their position within the practice and identify support structures and any frustrations with the role. At the time of our inspection, the practice was waiting for all questionnaires to be returned before collating the results.
- Two members of the practice team were appointed as patient liaison representatives and could be the first point of call for sharing patient feedback with the team and for patient contact. One of these staff was also the young person's sexual health contact and there were notices to this effect in the patient waiting area.
- The practice worked within a collaboration of local practices to help shape services for the local population and to share information about existing services and we saw minutes of these meetings.

Feedback from Patient Participation Group.

Feedback
The four members of the PPG we spoke with noted improvements in the management of the practice. They were happy to be involved in developing future services and expressed views on how services could be developed. They told us they hoped the membership of the group could be extended to be more representative of the practice patients and said the group was to be promoted to patients. The PPG meeting minutes also expressed appreciation by the PPG for the hard work done by practice

staff. They said they valued the telephone consultations with the principal GP and the clinical pharmacist and appreciated the practice care navigation system that allowed them to see clinicians such as the advanced nurse practitioners whom they complimented on their abilities. We saw a newsletter recently produced by the practice that explained the role of the PPG and asked patients to become members.

Continuous improvement and innovation

There were evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Since our inspection in July 2018, the practice had worked to address all the areas of concern we had identified; this had started immediately following our inspection. Change had been effected more rapidly and with improved governance since the new practice manager started in February 2019 and a considerable number of governance systems had been reviewed in the five weeks preceding our inspection.</p> <p>We saw systems were in place to ensure learning was shared, communication within the practice was good and staff felt involved in the change process. Opportunities were taken to learn from significant events, patient complaints and quality improvement work.</p>	

Examples of continuous learning and improvement

Evidence seen at this inspection all indicated a period of continuous learning and improvement. We saw a changed practice at this inspection and a positive and happy team of staff. The new practice manager had reviewed how services were delivered from the practice and had changed the baby clinics so they could be run on the ground floor of the practice rather than on the first floor making access easier. The principal GP had continued to develop the software health application for patients to allow patients to book a telephone appointment, add details of problems and upload photos and/or videos if appropriate. Three of the practice non-clinical staff had trained to become healthcare assistants, the third staff member was waiting for the period of observed practice to be undertaken to fully qualify and start clinical work. We spoke to two of these staff who told us how much they had appreciated the practice support and how they enjoyed the new role. The practice had plans in place to upskill further staff members. There was an agreement with the long-term female locum GP to become a salaried GP at the end of March 2019. The practice planned to become more integrated with other local health and social care agencies such as Streetlife for young homeless people in Blackpool and Smile Blackpool who offered services for patients with chronic pain. Planning meetings with these services had already taken place.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

	Variation Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	No statistical variation	$-2 < Z < 2$
4	Variation (negative)	$2 \leq Z < 3$
5	Significant variation (negative)	$Z \geq 3$
6	No data	Null

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:
<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.