Park Street Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Park Street Surgery. The practice is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on 18 November 2014 at the practice location in Park Street, Bootle. We spoke with patients, relatives, staff and the practice manager.

The practice was rated as Good. They provided effective, responsive, caring and compassionate care that was well led and addressed the needs of the diverse population it served.

Our key findings were as follows:

- The practice had a good track record for maintaining patient safety. Effective systems were in place to ensure patients were safe from risks and harm. Incidents and significant events were identified, investigated and reported. Lessons learnt were disseminated to staff. However improvements were required to ensure staff were safely recruited and required information was held in relation to staff.
- Patients spoke highly of the practice. They were very pleased with the individualised care given by all staff and they told us staff were kind, compassionate and caring.
- The practice served a diverse population in a deprived area of Liverpool. The practice provided good care to its population taking into account their health and socio economic needs. Patients were listened to and feedback was acted upon. Complaints were managed appropriately.
- Patient's needs were assessed and care was planned and delivered in line with current legislation and guidance.

Summary of findings

- The practice continued to monitor, evaluate and improve services. They worked in collaboration with the CCG and NHS England. Staff enjoyed working for the practice and felt well supported and valued.

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

Importantly, the provider must:

- Ensure full and complete required information relating to workers is obtained and held when recruiting staff. The practice should ensure its recruitment arrangements are in line with Regulation 21 and Schedule 3 of the Health and Social Care Act 2008 to ensure necessary employment checks are in place for all staff. This must include a Disclosure and Barring Service (DBS) check for all staff with chaperoning responsibilities.

In addition the provider should:

- Ensure all audits follow a consistent format and are shared and disseminated across all staff. The audit cycle should be fully completed in order to demonstrate actions taken have enhanced care and improvements have been made.
- Ensure all staff who undertake chaperone duties are trained and competent to do so.
- Ensure the complaints policy was reviewed and in line with recognised guidance and contractual obligations for GPs in England. There should be an up to date information leaflet advising patients of how to complain and other bodies they can go to when their complaint is not resolved

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements.

Information from NHS England and the Clinical Commissioning Group (CCG) indicated that the practice had a good track record for maintaining patient safety. Effective systems were in place to provide oversight of the safety of patients. Incidents and significant events were identified, investigated and reported. Lessons learnt were disseminated to staff. Staff took action to safeguard patients and when appropriate, made safeguarding referrals. Improvements were needed to ensure staff were recruited appropriately and required information in respect of staff was obtained.

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed patient outcomes were mostly average for the locality. The National Institute for Health and Care Excellence (NICE) guidance was accessible, referenced and used routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and health promotion. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice carried out appraisals and personal development plans for all staff. Multidisciplinary and good team working was evident.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients we spoke with and who completed the CQC comment cards were complimentary about the service. They all found the staff to be person-centred and felt they were treated with dignity and respect. We observed a person- centred culture and found evidence that staff were motivated and provided kind and compassionate care. Staff we spoke with were aware of the importance of providing patients with privacy and of confidentiality

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice reviewed the needs of their local population. They engaged with the locality team and the local Clinical Commissioning Group (CCG) to secure service improvements where these were

Summary of findings

identified. The practice had acted to improve access to the appointments system. Extended opening hours, telephone triage and advice was available, appointments and home visits made where the need arose for vulnerable patients.

The practice responded appropriately to complaints about the service. There was an accessible complaints system.

Are services well-led?

Good

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

Staff were clear about the practice values and their responsibilities in relation to these. However there was no formal strategy developed with staff for future service developments and succession planning. Staff felt supported by management. Regular team meetings were held. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients. Staff were well trained, received regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice did not have a high population of elderly patients. The practice population age range was predominately in the 15 to 60 years old group. However we saw that care was tailored to individual needs and circumstances, including patients' expectations, values and choices. Care and treatment was delivered in line with current published guidelines and good practice. For example the Quality and Outcomes Framework (QOF) information indicated the percentage of patients aged 65 and older who had received a seasonal flu vaccination was similar to the national average. The practice offered a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and extended appointments for those with enhanced needs. The practice participated in the Virtual Ward programme for older vulnerable housebound patients.

The practice safeguarded older vulnerable patients from the risk of harm or abuse. There were policies in place, staff had been trained and were knowledgeable regarding vulnerable older people and how to safeguard them.

People with long term conditions

Good

The practice had a higher than average number of patients with long standing health conditions (60% of its population). There was a higher than average number of patients claiming disability allowance (10.9% of its population, national average = 5%). Patients with long term conditions were supported by a healthcare team that cared for them using good practice guidelines and were attentive to their changing needs. There was proactive intervention for patients with long term conditions. Patients had health reviews at regular intervals depending on their health needs and condition. Registers of patients with long term conditions enabled the practice to monitor this population group's needs as a whole. Quality and Outcomes Framework (QOF) indicators showed the practice provided care and treatment for patients with long term health conditions in line with the national average, including for example patients with diabetes having had regular screening and monitoring.

We spoke to patients with long term conditions at the inspection, they all said they received good care and treatment; staff treated them with care, compassion and respect. The practice was accessible to disabled patients.

Summary of findings

Families, children and young people

Good

The practice served a higher than average younger population with the majority of patients in the 15 to 64 years of age group. We spoke with four patients who were younger than 64 years old and had children. We received positive feedback regarding their care and treatment at the practice. They told us they were confident with the care and treatment provided to them. We spoke with one mother with a baby who expressed that they received good care and treatment by staff, especially the practice nurses. The practice nurse ran a joint mother and baby clinic with the health visitor. They offered a full range of childhood vaccinations and routine checks.

Staff demonstrated a good understanding of safeguarding and protecting children from the risk of harm or abuse. The practice had a clear means of identifying in records those children (together with their parents and siblings) who were subject to a child protection plan. The practice had appropriate child protection policies in place to support staff and staff were trained to a level relevant to their role in safeguarding and child protection.

Working age people (including those recently retired and students)

Good

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

The practice had a higher than average working age population with the majority of patients falling within the 15 to 64 years of age group. The practice also served those in a high area of deprivation. The practice cared for this population group well with care and compassion. The practice offered extended hours and telephone consultations that were appreciated by those working patients. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

We spoke with patients from this group. They told us they received good care from staff that were kind, caring and compassionate and that they had confidence in.

People whose circumstances may make them vulnerable

Good

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

The practice analysed its activity and monitored patient population groups, this enabled them to direct support and information at different groups needing different support. The majority of patients spoke English, although the practice could access translation services if needed and had GPs who spoke various languages.

Summary of findings

The practice was aware of their vulnerable patients. The practice had been commissioned by the NHS to provide a specialised service to support and care for asylum seekers in the locality. This funding had now ceased due to reduced need but services were still in place if needed. They had previously supported a group of travellers with healthcare services, however this group have since moved on and there were no other registered travellers at the practice currently.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. They carried out annual health checks for people with a learning disability. They offered longer appointments for people with a learning disability when needed.

People experiencing poor mental health (including people with dementia)

Good

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

The practice maintained a register of patients who experienced poor mental health. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. The practice monitored patients with poor mental health according to clinical quality indicators and in line with good practice guidelines. Data we looked at demonstrated over half of patients on the mental health register had so far agreed a care plan with their GP and work continued to ensure all patients would have care plans agreed by the end of the year. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

Summary of findings

What people who use the service say

We spoke with six patients on the day of our inspection and we received 22 completed CQC comment cards. Patients whom we spoke with varied in age and population group. They included older people, those with long term conditions, those of working age and mothers with babies.

All patients were very positive about the practice, the staff and the service they received.

They told us staff were helpful, caring and compassionate, they were treated with dignity and respect and had confidence in the staff and the GPs and nurses who cared for and treated them. A mother with a baby told us how the practice was particularly good at caring for her. They understood her specific needs and treated them with care and compassion.

The main concerns from speaking to patients, from CQC comment cards received on the day and from the patient survey were appointments. Patients told us that it was sometimes difficult to get through on the telephone, appointments were sometimes difficult to get and they sometimes had delays in waiting times to see the GP.

They did say that they understood that because the doctors gave patients time to listen and understand their conditions then sometimes their appointments ran over. However this was not a major concern to those patients we spoke with.

The results of the national GP patient survey published in July 2014 told us that 83% of respondents said the last GP they saw or spoke to was good at treating them with care and concern, 76% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care and 76% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern. Eighty three percent described their overall experience of this practice as good. Seventy five percent were satisfied with the surgery's opening hours.

Patients told us staff listened to them and nothing was too much trouble. Doctors were very professional and caring. Patients told us the environment appeared clean and hygienic.

Areas for improvement

Action the service MUST take to improve

- Ensure full and complete required information relating to workers is obtained and held when recruiting staff. The practice should ensure its recruitment arrangements are in line with Regulation 21 and Schedule 3 of the Health and Social Care Act 2008 to ensure necessary employment checks are in place for all staff.

Action the service SHOULD take to improve

- Ensure audits follow a consistent format and are shared and disseminated across all staff. The audit cycle should be fully completed in order to demonstrate actions taken have enhanced care and improvements have been made.
- Ensure the practice has a strategy for the future or for future developments in service provision that is developed in conjunction with all staff and includes succession planning.
- Ensure all staff who undertake chaperone duties are trained and competent to do so.

Park Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

We undertook an inspection on 18 November 2014.

Our inspection team was led by a CQC Lead Inspector and included a GP and a specialist advisor who was a Practice Nurse.

Background to Park Street Surgery

Park Street Surgery is registered with the Care Quality Commission to provide primary care services. It provides GP services for approximately 5,800 patients living in the Bootle area of Liverpool. The practice has three GP partners, a practice manager, two practice nurses, and administration and reception staff.

The practice is open Monday to Friday from 8.30am to 6.30pm with extended opening hours on Monday until 8pm and Wednesday until 6.30pm for working people. There are also extra telephone/triage sessions available on a Wednesday and Thursday from 7.30am - 8.00am and telephone triage 12.00 - 12.30pm. The practice is closed on Wednesday half a day per month for training and development. Patients can book appointments in person, online or via the phone. The practice provides telephone consultations, pre bookable consultations, urgent consultations and home visits. The practice treats patients of all ages and provides a range of medical services.

The practice is part of South Sefton Clinical Commissioning Group (CCG). The practice is situated in an area of high deprivation. The practice population is made up of a higher than national average younger population and a lower than national average of patients aged over 60 years.

All clinical services are delivered under a PMS contract.

From data we reviewed as part of our inspection we saw that the practice outcomes are in line with those of neighbouring practices within the area. The national patient survey showed that the practice performed average for access to appointments. However there were some negative comments on NHS Choices regarding access to appointments and getting through on the telephone. The practice keeps up to date registers of those patients with learning disabilities, mental health conditions and those in need of palliative care.

The practice does not deliver out-of-hours services. These are delivered by Go To Doc (GTD), a private provider of out of hour's services commissioned by South Sefton CCG. They provide a service locally in Netherton.

Why we carried out this inspection

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

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before our inspection we carried out an analysis of the data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas. We carried out an announced inspection on 18 November 2014.

We reviewed all areas of the practice including the administrative areas. We sought views from patients face-to-face, looked at survey results and reviewed comment cards left for us on the day of our inspection.

We spoke with the practice manager, registered manager, GP partners, practice nurse, administrative staff and reception staff on duty. We spoke with patients who were using the service on the day of the inspection.

We observed how staff handled patient information, spoke to patients face to face and talked to some patients ringing the practice. We discussed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service. We also talked with carers and family members of patients visiting the practice at the time of our inspection.

Requires improvement

Are services safe?

Our findings

Safe track record

Reports from NHS England indicated that the practice had a good track record for maintaining patient safety. Information from the General Practice Outcome Standards (GPOS) showed no concerns. Information from the Quality and Outcomes Framework (QOF), which is a national performance measurement tool, showed that the provider was appropriately identifying and reporting significant events. GPs told us they completed incident reports and carried out significant event analysis routinely and as part of their on-going professional development. We looked at some recent significant events from 2014 which had been analysed, reported and discussed with relevant staff.

The practice had systems in place to monitor patient safety. The practice manager and GPs discussed significant events and showed us documentation to confirm that incidents were appropriately reported. The partner GPs discussed them at their meetings and if relevant at all staff team meetings when they had half day sessions for training and development and meetings. Action was taken to learn lessons and put measures in place to reduce the risk of the event recurring in the future. Staff told us how they actively reported any incidents that might have the potential to adversely impact on patient care. We were told there was an open and 'no blame' culture at the practice that encouraged staff to report adverse events and incidents.

The minutes of practice meetings we reviewed showed that throughout the year new guidelines, complaints, incidents and significant events, were discussed. The staff we spoke with were positive about the use of incident analysis and how this assisted them to develop the care provided. The clinicians were confident that treatment approaches adopted followed best practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw the records for significant events that were summarised including dates, category of event and recommended actions and reflection. We found that although there was a standard form used for recording significant events and incidences, the analysis, investigation and outcomes were recorded and reported on in different ways by the clinical staff with no consistency of reporting outcomes.

We looked at the records of significant events that had occurred in the last 12 months. There was evidence that appropriate learning had taken place where necessary and that findings were disseminated to relevant staff at team meetings. Staff told us they received feedback verbally either at one to one meetings or on occasion at team meetings if the events were relevant to all staff. However, there was no regular review overall of significant events which would enable analysis of themes and trends in order to improve learning and practice.

We saw evidence to confirm that, as individuals and a team, staff were actively reflecting on their practice and looked at what they did to see if any improvements could be made. Significant events, incidents and complaints were investigated and reflected on by the GPs and practice managers.

National patient safety alerts were disseminated by the practice manager to relevant staff. Staff told us alerts were discussed at team meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had up to date child protection and protection of vulnerable adult policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were available to staff on their computers and in hard copy. Staff had easy access to contact details for both child protection and adult safeguarding teams. We saw evidence of such information displayed in clinical, reception and administrative areas.

All staff had received relevant training to their role on safeguarding. Clinical staff had a higher level of training than other staff. Staff we spoke with were knowledgeable about the types of abuse to look out for and how to raise concerns. Staff were made aware through an alert system on the computer and electronic records of vulnerable people.

One of the GPs took the lead for safeguarding and had attended appropriate training to support them in carrying out their work. GPs or other clinical staff at the practice did not attend regular multi-disciplinary safeguarding meetings. The safeguarding lead did not regularly attend local case conferences due to time constraints; however

they did complete reports when necessary. All GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead GP was able to discuss and demonstrate appropriate action regarding a safeguarding concern that had been identified at the practice and raised with the appropriate agencies.

The practice had a current chaperone policy. A chaperone policy notice was displayed in the reception area. Non clinical staff who may be asked to act as a chaperone had not received appropriate training for this role. Some staff we spoke with were unsure of their responsibilities in respect of chaperoning. Non clinical staff acting as chaperones had not had a Criminal Records Bureau (CRB) or Disclosure and Barring Service (DBS) check undertaken.

Medicines management

We checked medicines stored in the treatment rooms and fridges. We found that they were stored appropriately. There was a current policy and procedures in place for medicines management including cold storage of vaccinations and other drugs requiring this. We saw the checklist that was completed daily to ensure the fridge remained at a safe temperature and staff could tell us of the procedure in place for action to take in the event of a potential failure of the cold chain. All medicines that we checked were found to be in date.

Medicines for use in medical emergencies were kept securely in a cupboard in one of the treatment/ nurse's room. We saw evidence that stock levels and expiry dates were checked and recorded on a regular basis. Staff knew where these were held and how to access them. Medicines carried in the doctors' bags were checked and these checks were recorded routinely by the practice nurse. They were all in date. There was oxygen kept by the practice for use in case of an emergency. This was checked for function and stored in one of the treatment rooms with an appropriate warning sign on the door.

The practice worked with pharmacy support from the Clinical Commissioning Group (CCG) to support the clinical staff in keeping up to date with medication and prescribing trends. The CCG pharmacy support visited the practice and regular meetings were held with them to discuss medicines optimisation plans. We saw evidence of good working with the pharmacy support and recorded notes of meetings.

Spare prescription pads were stored securely and a paper record of when they were received into the practice and taken for use by GPs was evident.

GPs reviewed their prescribing practices as and when medication alerts were received. Patient medicine reviews were undertaken on a regular basis depending on the nature and stability of their condition.

Cleanliness and infection control

Patients commented that the practice was clean and appeared hygienic. The practice had an infection control audit undertaken by the community trust infection control team in 2013. The practice had obtained 95% compliance with the audit. Cleaning was undertaken by a contracted cleaning company, the practice manager and cleaning company monitored the schedule and standard of cleaning.

The practice nurse was lead for infection control. They had received appropriate training in infection control and this was updated annually. They linked closely with the community trust infection control team. We saw evidence of support given to the practice nurse from the community infection control nurse.

There was an up-to-date infection control policy and associated procedures in place. A needle stick injury policy was in place, which outlined what to do and who to contact in the event of accidental injury. Needle stick injury flow charts were displayed in all treatment and consultation rooms. We saw current protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance and were in line with current best practice.

Infection control training was undertaken by all staff. Appropriate frequency of updates was evident for different roles, for example, clinical staff had annual updates whilst non clinical staff had three yearly updates. Staff understood their role in respect of preventing and controlling infection. For example reception staff could describe the process for handling submitted specimens.

We inspected the treatment and clinical rooms. We saw that all areas of the practice were clean and processes were in place to manage the risk of infection. Consultation and treatment rooms had adequate hand washing facilities. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms. We found

protective equipment such as gloves and aprons were available in the treatment/consulting rooms. Couches were washable. However privacy curtains in the treatment rooms were not dated to identify when they were last cleaned.

We were told the practice did not use any instruments which required decontamination between patients and that all instruments were for single use only. Procedures for the safe storage and disposal of needles and waste products were evident in order to protect the staff and patients from harm. We did note that one of the sharps disposal boxes was full; this was brought to the attention of staff and was rectified immediately.

The practice did not undertake regular testing and investigation of legionella (a bacterium found in the environment which can contaminate water systems in buildings) nor had it undertaken a risk assessment. The practice should ensure that regular testing and management of legionella was undertaken to further reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments.

All equipment was tested and maintained regularly and we saw equipment maintenance logs, contracts and other records that confirmed this. The practice had contracts in place for annual checks of fire extinguishers and 'portable appliance testing'. The practice undertook annual calibration and servicing of medical equipment. We saw contracts and service records to demonstrate this

Emergency drugs were stored in a separate cupboard. There was an oxygen cylinder, nebulisers and an automated external defibrillator available at the practice. These were serviced, maintained and checked regularly.

Staffing and recruitment

There was a recruitment policy was in place, this was not current and did not reflect legislation in respect of recruitment of staff such as requirements relating to workers including Criminal Records Bureau (CRB) or Disclosure and Barring (DBS) checks. We looked at a sample of recruitment files for doctors, reception and administrative staff, practice manager and nurses. The practice employed locum GPs. We were told they independently checked the suitability of locum doctors as well as reviewing the NHS performer's lists. We saw evidence of this.

We found gaps in the required information relating to workers in the staff files that we looked at. We looked at six staff records. There were appropriate CRB or DBS checks for the clinical staff (including practice nurses and GPs). There was not a policy in place to identify which roles required which level of DBS check and at what frequency these would be undertaken. Non clinical staff such as reception and administration staff did not have an appropriate CRB or DBS check. There was no evidence of a risk assessment having been undertaken for these staff who had been employed by the practice for some time and prior to the requirement for staff to have such checks undertaken prior to employment. These staff were occasionally asked to undertake chaperone duties and therefore they must have the required checks undertaken.

There were other gaps in the recruitment files such as not all staff had two references obtained prior to employment and we did not see any evidence that checks had been undertaken to ensure potential staff were physically and mentally fit to undertake the roles and responsibilities required. These staff had been employed for some time and prior to the requirements relating to workers information. We looked at the file of the most recently employed staff member; this demonstrated that not all the required information was available, including a DBS checks.

There was a system in place to record professional registration such as for the General Medical Council (GMC) and the Nursing Midwifery Council (NMC). We saw evidence that demonstrated professional registration for clinical staff was up to date and valid.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The staff worked well as a team and as such supported each other in times of absence and unexpected increased need and demand. The practice manager and GP oversaw the rota for clinicians and we saw they ensured that sufficient staff were on duty to deal with expected demand including home visits and chaperoning.

Requires improvement

Are services safe?

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff. A basic risk assessment log was seen. Risks were assessed, rated and control measure recorded to reduce and manage the risk.

The practice used electronic record systems that were protected by passwords and Smart cards on the computer system. Historic paper records were stored securely in the office area.

The practice worked with the Clinical Commissioning Group (CCG) in the locality to identify patients at risk of inappropriate A&E attendances. They monitored, analysed and implemented measures to prevent these.

Arrangements to deal with emergencies and major incidents

There was an emergency incident procedure in place. Staff could describe how they would alert others to emergency situations by use of the panic button on the computer system.

A current business continuity plan was in place. The plan covered business continuity, staffing, records/electronic systems, clinical and environmental events. Key contact numbers were included and paper and electronic copies of the plan were kept in the practice and by the practice manager and GPs.

Staff had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). There was suitable emergency equipment and medicines available, that were checked and maintained.

There was a current fire procedures policy in place which identified key personnel, such as fire marshals and their duties in the event of a fire. Fire alarm tests were carried out and equipment was maintained by the contracted company.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinicians were familiar with, and using current best practice guidance. The GPs we spoke with could clearly outline the rationale for their treatment approaches. The staff we spoke with and evidence we reviewed confirmed that these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions that staff completed, in line with The National Institute for Health and Clinical Excellence (NICE) and local commissioners' guidelines, assessments of patients' needs and these were reviewed appropriately. New guidance was discussed at the partner's meetings and if relevant at all staff team meetings. There were no joint clinical meetings held between GPs and nurses at which they could share clinical issues and review patients' needs. We saw evidence of audits undertaken of NICE guidelines for example anti-hypertensive treatment.

The practice nurse managed specialist clinical areas such as diabetes, heart disease and asthma. This meant they were able to focus on specific conditions and provide patients with regular support based on up to date information. GPs also specialised and led in clinical areas such as safeguarding, and various chronic diseases.

The practice provided a service for all age groups. It provided services for patients in the local community including a younger than average population with a higher than average number of unemployed, patients living in deprived areas and those experiencing poor health with a lower than average life expectancy . We found GPs and other staff, were familiar with the needs of each patient and the impact of the socio-economic environment. The practice had access to language translator services with which they had a contract. The practice nurses had completed accredited training around assessment of patient's physical health and specific disease/condition management.

The practice referred patients appropriately to secondary care and other services. We saw that the practice's referral rates for healthcare conditions were in line with the national standards for referral rates. All GPs we spoke with used national standards for referral, for example suspected cancers. There was an electronic audit trail for acting on test results and hospital consultation letters. Any information not received electronically was scanned into the system daily and alerted to the named GP. In the absence of the named GP, the on call duty doctor assessed and acted on any such information.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

We saw that the GPs and clinicians ensured consent was obtained and recorded for all treatment. One of the GPs undertook contraceptive implants. They did this in line with their registration and NICE guidance and obtained written consent for the procedures. The GP was appropriately trained to carry out this procedure and they ensured their skills and knowledge was kept up to date.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients' care and treatment. QOF data showed the practice performance was in line with that of local practices. We found that they did not regularly review their QOF status. This was highlighted when we examined QOF data in relation to patients with learning disabilities and mental health illness. The practice was not aware of their status but could retrieve the relevant data we required from the computer system. The practice manager identified this needed improvement and would implement a system to ensure QOF information is reviewed on a regular frequent basis.

Examples of clinical audits included; the appointment system, A & E attendances and a variety of medicines management audits. The practice showed us four of the clinical audits that had been undertaken in the last 12 months. There was evidence of re audit in one example only where the practice was able to demonstrate the changes/improvements that resulted since the initial audit.

Clinical audits were often linked to medicines management information, local Clinical Commissioning Group (CCG) and locality performance indicators or as a result of QOF performance. Medicines management audits were undertaken in conjunction with the medicines management support from the local CCG. As an example,

Good

Are services effective?

(for example, treatment is effective)

we saw an audit assessing antihypertensive treatment compliance with NICE guidance in general practice. Evidence was seen of dissemination and discussion with all GPS to ensure full adherence to the guidance.

Discussion of audits, performance indicators and quality initiatives was evident in partner meeting minutes. Staff told us they received feedback through discussions and at meetings. However we found that there was no overarching governance framework that pulled together all audits undertaken and shared this information and learning between all the staff. For example practice nurses had undertaken and completed their own audits but there was no evidence of these being discussed or shared between the clinical team and wider staff team.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice had achieved and implemented the gold standards framework for end of life care. One of the GPs took the lead for this group of patients supported administratively by the reception/administration team. They had a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw evidence of these meetings and saw evidence of patients and families identified as having these particular needs. Special notes were used to inform out of hours services of any particular needs of patients who were nearing the end of their lives.

Effective staffing

The induction programme covered a wide range of topics including policies and procedures, confidentiality, staff training, organisational induction and job specific induction. We saw an example of a more recent employee's induction checklist that had been completed.

We saw in individual staff records that mandatory training had been undertaken by all staff according to their roles. These topics included for example annual basic life support, infection control, health and safety, information governance and safeguarding of vulnerable adults and children. We noted there was no mandatory training matrix which would have identified which subjects should be undertaken by which roles and the required frequency. The training matrix could be used to monitor and demonstrate that staff were up to date with attending their mandatory courses. Staff also had access to additional training related to their role. For example reception staff told us they had received conflict resolution and customer care training. Staff we spoke with told us they felt they were well trained and received good support to undertake training including that which was required by the practice and for training and development specific to their role.

The staff files we reviewed showed that staff of all disciplines had received an annual appraisal. Nursing staff did not have access to regular formal clinical supervision sessions except at team meetings where they could discuss clinical issues and incidents. The administrative staff told us they were well-supported and regularly had conversations about their performance with their line manager.

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

The practice nurses performed defined duties and extended roles. They were able to demonstrate that they were appropriately trained to fulfil these duties. For example, on administration of vaccines and cervical cytology.

The practice manager and principal GP had ensured that all of the clinical equipment used in the practice was regularly calibrated and that relevant staff were competent to use it.

Working with colleagues and other services

The practice worked with other agencies and professionals to support continuity of care for patients. We were shown how the practice provided the 'out of hours' service with information, to support, for example, end of life care. Information received from other agencies, for example accident and emergency department or hospital outpatient departments were read and actioned by the GPs in a timely manner. Information was scanned onto electronic patient records in a timely manner.

The practice worked closely with other health care providers in the local area. The GPs and the practice manager attended various meetings for management and

Good

Are services effective?

(for example, treatment is effective)

clinical staff involving practices across South Sefton CCG. South Sefton CCG organised themselves into localities and the practice met regularly with the CCG and other practices. These meetings shared information, good practice and national developments and guidelines for implementation and consideration. They were monitored through performance indicators and each practice was benchmarked. We saw evidence of performance monitoring with action plans developed for areas needing improvement.

The practice held multi-disciplinary team meetings three monthly to discuss the needs of complex patients with end of life care needs. However we found that no multi-disciplinary meetings were held for safeguarding children and vulnerable adults at risk.

Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice has signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had appropriate policies and procedures for information governance, confidentiality and data protection.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. They gave examples in their practice of when best interest decisions were made and mental capacity was assessed prior to consent being obtained for an invasive procedure. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for invasive implantations, a patient's written consent was obtained and documented.

Health promotion and prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets and information in the waiting area about the services available.

The practice also provided patients with information about other health and social care services such as carers' support. Staff we spoke with were knowledgeable about other services, how to access them and how to direct patients to relevant services.

The practice used the coding of health conditions in patients' electronic records and disease registers to plan and manage services. For example, patients on disease registers were offered review appointments with the nurse.

The practice offered a health check and assessment to all new patients registering with the practice and also offered NHS Health Checks to all its patients aged 40-75. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was average for the CCG.

The practice had ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability. They were all offered an annual health check and data demonstrated that 24 out of 40 patients on the learning disability register had received their planned health check. We saw that of the 93 patients who were registered as having a mental health condition, 56 had agreed a specific care plan with the GP. There were local health and support groups that the practice accessed and referred patients with mental health and learning disabilities needs.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Consultations took place in purposely designed rooms with an appropriate couch for examinations and screens to maintain privacy and dignity. Staff we spoke with were aware of the importance of providing patients with privacy and of confidentiality. There was a separate room available if patients wanted to speak in private when they presented at reception. We observed staff were discreet and respectful to patients. Reception staff had received customer care training.

The practice offered patients a chaperone prior to any examination or procedure. Information about having a chaperone was seen displayed in the reception area. Non-clinical staff we spoke with were unsure about the role of a chaperone and had not received training to carry out this work. They were asked to act as chaperones on occasions.

Patients we spoke with told us they were always treated with dignity and respect and that staff were caring and compassionate. We found that staff knew the majority of their patients well and patients told us the practice had a family feel to it, the staff were all welcoming, caring and compassionate.

The most recent practice patient survey showed that 83% of patients who responded said overall satisfaction with the practice was good. Ninety percent of patients said the last GP they saw was good at listening to them. This was echoed by patients we spoke with on the day that told us staff gave them time and listened to them.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decisions about their own treatment, they received full explanations about diagnosis and treatments and that staff listened to them and gave them time to think about decisions. Eighty six percent of patients (at the last patient survey) told us the GP was good at explaining test and treatment and 76% were good at involving them in decisions about their care.

The patients told us they felt all staff were competent and knowledgeable. Most patients found that they had been able to see their preferred GP however they sometimes had to book up to two weeks in advance in order to get an appointment with their preferred GP. The rotas we reviewed showed that sufficient GPs and other clinicians were on duty to cover all the appointments including the extended hour's service.

Staff were knowledgeable about how to ensure patients were involved in making decisions and the requirements of the Mental Capacity Act 2005 and the Children's Act 1989 and 2005. GPs told us relatives, carers or advocates were involved helping patients who required support with making decisions. For example when someone on the register for learning disabilities was called for their review the practice encouraged the patient's carer to attend also.

The practice had an 'access to records' policy that informed patients how their information was used, who may have access to that information, and their own rights to see and obtain copies of their records. Information was available for patients on the practice website and in leaflets.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the care they received from the practice. They commented that they were treated with respect and dignity. Patients we spoke with told us they had enough time to discuss things fully with the GP and most patients felt listened to and felt clinicians were empathetic and compassionate. They told us all the staff were compassionate and caring.

We observed that the reception staff treated people with respect and tried to ensure conversations were conducted in a confidential manner. We observed that privacy and confidentiality were maintained for patients using the service on the day of the visit.

The practice had achieved and implemented the gold standards framework for end of life care. They had a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families. Special notes were used to inform out of hours services of any particular needs of patients who were coming towards the end of their lives. The practice aimed to support patients to die in their place of choice, frequently this was their home.

We discussed an example of successful implementation of the gold standards framework for a particular patient. It was a complex case with risks to patient and carers

Good

Are services caring?

however the patient was able to remain in their home, their preferred place of care. The additional support and care from the multidisciplinary teams ensured a positive outcome for the patient.

Clinical staff had various ad hoc methods of supporting bereaved patients. Some would contact them personally.

The practice nurse was knowledgeable about the support available for bereaved patients. They were familiar with support services and knew how to direct patients to these. However the practice did not have a consistent protocol for communication and the care of bereaved patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice held information about the prevalence of specific diseases and population groups. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions and mental health conditions.

Patients with dementia and enduring mental health conditions were offered annual reviews. They were encouraged to bring carers with them to these reviews. The practice had implemented the 'named GP' for patients over 75 to support continuity of care. The practice was proactive in contacting patients who failed to attend vaccination and screening programmes. The practice participated in the Virtual Ward service which was set up with the community matron attached to the practice. (A Virtual Ward is a group of health and social care professionals that provide support in the community to patients with the most complex medical and social needs. Virtual wards use the systems and staffing of a hospital ward, but without the physical building: they provide preventative care for people in their own homes). Monthly meetings were evident and access was available to multidisciplinary teams. Older vulnerable housebound patients who were at risk of avoidable hospital admissions benefitted from this proactive service. This service was instigated by the CCG and practices involved analysing A&E attendances and hospital admissions.

The practice did not have an active Patient Participation Group (PPG). The practice used other methods to engage patients to enable them to contribute to and feedback regarding the service provided. This included undertaking their own patients' survey to gain feedback on the quality of care and appointment systems and a comments /suggestions box available in reception area. Comments and suggestions were encouraged through the website and in the practice information leaflet.

Tackling inequity and promoting equality

The practice was aware of the challenges they faced with their diverse population. They are situated in the Bootle locality of Liverpool which is in a deprived area of the city. This presented various challenges due to socio economic disparity. The practice ethos strived to provide quality and responsive care to all patients. The practice analysed its activity and monitored patient population groups. This enabled them to direct appropriate support and information to the different groups of patients. The practice had a majority population of English speaking patients though it could cater for other languages as it had access to translation services.

The premises and services had been adapted to meet the needs of people with disabilities. All treatment and consultation rooms were located on the ground floor with doorways wide enough for wheelchair access. There were disabled parking and toilet facilities available.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was out of date and not in line with recognised guidance and contractual obligations for GPs in England. The practice manager dealt with complaints in the practice and liaised with all relevant staff in dealing with the complaints on an individual basis.

We looked at the complaints records for the last 12 months and found that complaints had been dealt with and responded to appropriately. The practice took action in response to complaints to help improve the service. Complaints were investigated thoroughly. A summary and overview log was recorded which broke down the complaints into subjects and themes, however there was no regular review overall of complaints, such as annually, to analyse themes and trends in order to improve learning and practice.

Patients we spoke with were all aware of the complaints procedure. An information leaflet detailing the process for making complaints or comments about the practice was available to take away at the reception desk. Staff we spoke with were able to tell us how they would handle initial complaints made at reception or by telephone and what information they would give to patients wishing to make a complaint.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

The practice offered pre-bookable and urgent (on the day) appointments, telephone consultations and home visits. The practice had recently improved access to appointments by additional hours opening and additional telephone triage access. They were open Monday to Friday 8.30am until 6.30pm with extended hours opening on a Monday until 8pm.They also provide telephone and triage sessions on a Wednesday and Thursday from 7.30am - 8.00am. This had proved useful for children who woke early with an illness. In addition there was a telephone triage at 12.00 - 12.30pm with the GPs and with the Nurse Practitioner 12.30 - 1.00pm Monday, Tuesday and Thursday.

The practice was closed one Wednesday afternoon per month for training and development. Information was available to patients about appointments on the practice website and in the practice information leaflet. This included who to contact for advice/appointments out of normal working hours when the practice was closed. We noted the contact details on the website and in the information leaflet for the out of hours service provider were incorrect. The out of hour's provider is Go To Doc.

Appointments were tailored to meet the needs of patients, for example those with long term conditions and those requiring assistance from translators were offered longer appointments. Home visits were made to care homes, older patients and those vulnerable housebound patients.

Patients with whom we spoke with, CQC comment cards and the patient survey results told us they there was some difficulty getting through to the practice on the telephone and for making appointments. The practice had recently used feedback from patients to improve access to the surgery by improving the appointments system and number of appointments available. This was yet to be evaluated for effectiveness.

Are services well-led?

Good

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

Our findings

Vision and strategy

Staff were able to articulate the values of the practice. The lead GP told us how they aimed to deliver high quality care that was responsive to needs. However the practice did not have a formal documented strategy for the future or for future developments in service provision that included succession planning.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computer and in hard copy in the offices. Policies and procedures were dated however some of these required review and updating. Staff confirmed they had read them and were aware of how to access them.

The organisational structure was not clearly defined or written down. Staff did have identified lead roles, for example there was a lead nurse for infection control and a GP partner was the lead for safeguarding. However the senior staff did not have identified leads for non-clinical activity such as finance, complaints and human resources. We spoke with staff of varying roles and they were all clear about their own roles and responsibilities. They all told us there was a friendly, open culture within the practice and they felt very much part of a team. They all felt valued, well supported and knew who to go to in the practice with any concerns. They felt any concerns raised would be dealt with appropriately.

Clinical audits were undertaken regularly by nursing and medical staff. However there was no planned programme of audit focussing on priorities for the practice both nationally and locally. We looked at a selection of these. Audits undertaken by medical staff were mostly medicines management audits decided on either by local CCG or national priorities.

Staff attended a number of meetings both internally and externally and with multi-disciplinary teams. They met regularly with the CCG and other local practices for benchmarking and service developments. However GPs and practice nurses did not meet on a formal and regular basis to discuss clinical issues.

The practice had arrangements in place for identifying and managing risks. We saw a basic risk log which addressed potential issues. Risk assessments had been carried out where risks were identified and control measures in place.

Leadership, openness and transparency

The management structure was not clearly identified however staff knew who their leader was and understood the lines of responsibility.

Staff felt well supported in their role. They felt confident in the senior team's ability to deal with any issues, including serious incidents and concerns regarding clinical practice. Staff reported an open and no-blame culture where they felt safe to report incidents and mistakes. All the staff we spoke with told us they felt they were valued and their views about how to develop the service acted upon.

Examples of various practice meeting minutes demonstrated information exchange, improvements to service, practice developments and learning from significant events. Regular monthly team meetings were held at which staff had the opportunity and were happy to raise any suggestions or concerns they had.

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

The practice recognised the importance of gaining the views of patients, carers and the public to build on and improve services. However the practice did not have an active Patient Participation Group (PPG). The practice had found it difficult to establish a group and had little interest from patients in setting this up. They had taken other steps to communicate with their patients and gain feedback from them. For example, directing comments and suggestions through the website, in comments boxes within the practice and through surveys both national and ones they had conducted themselves.

The practice regularly reviewed the results of the patient survey and we saw actions taken in response. For example, the appointment system was reviewed to try to improve the service and access to appointments.

We looked at complaints and found that the practice investigated and responded to them in a timely manner, and complainants were satisfied with the outcomes. These were discussed at staff meetings and were used to ensure staff learned from the event.

Are services well-led?

Good

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

There was a whistleblowing policy in place. Staff told us they had no concerns about reporting any issues internally. The practice gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

Staff told us they had annual appraisals which included looking at their performance and development needs. We saw these were up to date. The practice had an induction programme and a mandatory training programme to ensure staff were equipped with the knowledge and skills needed for their specific individual roles. Mandatory training was up to date for all staff.

Staff told us they had good access to training and were well supported to undertake further development in relation to their role. The practice manager knew the training compliance of their staff however there was no training matrix in place. A matrix would ensure that mandatory training was easily monitored and would identify which staff required which training and at what frequency this needed to be done.

The practice had completed reviews of significant events, complaints and other incidents and shared with staff at meetings. However significant events and complaints were not reviewed overall on an annual or more frequent basis in order to analyse themes and trends to improve learning and practice. There was a half day each month when the practice closed and this time was used for learning and development and staff meetings.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers • People who use services and others were not protected against the risks associated with unsuitable staff because the provider did not have an effective procedure in place to assess the suitability of staff for their role. Not all the required information relating to workers was obtained and held by the practice.