Dr Pankaj Srivastava

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Dr Pankaj Srivastava, also known as Holmlands Medical Centre. Our inspection was a planned comprehensive inspection which took place on 15 January 2015. Dr Pankaj Srivastava ("the practice") delivers services under a Primary Medical Services (PMS) contract.

The service provided by Pankaj Srivastava is rated overall as good. We found care and treatment delivered to patients was safe, effective, caring and responsive to patients' needs. Some improvements were required in the area of well-led.

Our key findings were as follows:

- Patient safety was at the heart of the practice's delivery of services. Systems in place supported this and all staff were clear about their responsibilities.
- Care and treatment of patients was effective. We found the 'sit and wait' system of seeing patients had reduced the amount of time lost by GPs due to patients' failure to attend appointments.
- All patients we spoke to on the day of our inspection, and in information from CQC comment cards, confirmed that the practice staff and clinicians were caring and compassionate.
- The practice was responsive to patients' needs. Access to clinicians was very good and patient feedback had been considered by the practice in the development of its services.
- The practice was supportive of those patients who were also carers and had offered those carers training in emergency first aid.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

Comply with regulation 21(b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Request and keep copies from locum supply

Summary of findings

agencies of all checks conducted on any locum supplied, confirmation of their entry on the NHS England Performers List and evidence of adequate indemnity insurance.

In addition the provider should:

Address the non-attendance of district nurses at practice multi-disciplinary team meetings for management of care of patients at end of life.

Make arrangements for the practice nurse to receive annual appraisal with input from a clinician and have systems in place to review the work of the practice nurse, for example by way of clinical audit.

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?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, reviewed and addressed. Risks to patients were assessed and well managed.GPs were committed to the protection of children and vulnerable adults.

Are services effective?

Good

The practice is rated as good for the provision of effective services. Patient's needs were assessed and care was planned and delivered in ways that met their needs. This included assessing capacity and promoting good health. The practice kept lists of patients who required regular health checks, and these appointments were delivered by the practice nurse. The practice GPs engaged with other clinicians to ensure that patients discharged from hospital received the follow-up care they needed. The practice worked with community services to enhance efficiency. For example with local pharmacies who had conducted medicines reviews with patients. The practice recorded details of these medicine reviews with patients and re-visited any points highlighted by the pharmacist, for discussion with the patient at their next consultation.

Are services caring?

Good

The practice is rated as good for the provision of caring services. We received 35 Care Quality Commission (CQC) comment cards, which patients had used to share their views about the practice and the care and treatment they received. All comments were favourable. One comment was neutral and referred to the time waiting in reception areas to see a GP. We saw that patients were treated with dignity and respect and that staff responded compassionately to patients concerns.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients' who needed to see a GP, arrived at the practice at 8.00am and would be seen by a GP before 1.00pm. Appointments were pre-bookable each day between 4.00pm – 6.00pm. The practice staff could workflow messages to GPs about any patient they felt should be seen quickly, allowing GP to make decisions on triage of patient

Summary of findings

calls. The practice ensured GPs had the flexibility to deliver two home visits a day. We saw how this was used to monitor more vulnerable patients during the first 24 hours following discharge from hospital.

Are services well-led?

Requires improvement

The practice is rated as requiring improvement for being well-led.

The practice was supportive of its staff. We found recruitment checks were in place for all staff. However, if a locum GP was used to provide cover the practice manager verbally confirmed with the supply agency that these checks had been done. The checks did not specifically refer to the GPs last appraisal date and entry on the NHS performers list. Copies of the recruitment checks had not been requested and retained by the practice.

Review of the management of serious incident reporting was required to improve learning outcomes. Two examples we reviewed lacked detail and did not probe sufficiently into cause and effect. We were told that community nurses did not attend multi-disciplinary meetings held by the practice to discuss and review patients receiving palliative and end of life care. The work of the practice nurse we spoke with was not subject to peer review or audit. Appraisal for the practice nurse was carried out by the practice manager. However, there was no clinical input into the appraisal, by a clinician who had reviewed the outcomes for patients treated by the nurse on a regular basis.

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

All older patients were assigned a named GP and given access to a direct line for that GP. If older patients were admitted to hospital in an unplanned way this was reviewed by the GP and if required, changes would be made to their treatment plan for example a change in medicines. Health promotional advice and support was given to patients and their carers if appropriate and information leaflets were freely available at the practice. These included signposting older patients and their carers to support services across the local community. Older patients were offered vaccines such as the flu vaccine each year.

People with long term conditions

Good

The practice had processes in place for the referral of patients with long term conditions that had a sudden deterioration in health. The GP reviewed all unplanned admissions to hospital. Registers of patients with long term conditions were kept and annual reviews of patients were carried out, including a review of medications. If needed these patients were seen more regularly to monitor their conditions. All patients with an unplanned admission to hospital were reviewed by the GP on discharge. We saw health promotional advice, information and referral to support services for example smoking cessation.

Families, children and young people

Good

The practice nurse delivered immunisations and vaccines to children and adult patients. We saw that a system of follow up was in place to capture any patients, particularly child patients, who had failed to attend these appointments.There was a walk-in (sit & wait) system in place from 8.00am each morning between Monday and Friday. All patients arriving at the practice before 10.00am would be seen. Feedback from patients was that they valued this system and on the day of our inspection, we saw that it worked well, particularly in meeting the needs of families with children.

Working age people (including those recently retired and students)

Good

The facility for patients to pre-book appointments between 4.00pm and 6.00pm helped to meet the needs of those patients who had work commitments. Extended hours were available onThursday evenings to see a nurse or doctor from between 6.30pm and 8.00pm. Clinicians at the practice routinely took patients' blood pressure

readings and recorded these along with patients' weights. GPs were encouraged to ask questions about patients' family history to increase the consideration for referral of patients who may show early signs of particular cancers, for example, bowel or lung cancers.

People whose circumstances may make them vulnerable

Good

The deputy practice manager was responsible for maintaining a register of all those patients who were carers. They had arranged first aid and cardio-pulmonary resuscitation training for carers, to be delivered by St Johns Ambulance, free of charge. All carers were offered a longer consultation time with the GP to ensure their own health needs were not overlooked. Where any carer had not attended for a routine annual health check, the deputy practice manager could demonstrate an effective system of follow-up to ensure a further appointment was offered and attended by the carer. When we reviewed the care plans of people who were more vulnerable to unplanned hospital admission, we saw the practice had annotated care plans to show if a patient was living alone. This enabled other clinicians to assess the priority for a home visit, if required.

People experiencing poor mental health (including people with dementia)

Good

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. Clinicians routinely referred patients to counselling and talking therapy services, as well as psychiatric provision. One of the salaried GPs at the practice had acted as the lead for dementia screening of patients, and for timely referral for formal diagnosis of those patients.

Summary of findings

What people who use the service say

We received 35 completed patient CQC comment cards and spoke with seven patients who were attending the practice on the day of our inspection. We spoke with patients from across the population groups, including parents with children, patients with different physical conditions and long-term care needs. Patients were complimentary about the staff and GPs. Patients told us that they had been consulted when Dr Srivastava had taken over the practice from the GP who had recently retired. One of the questions put to patients was whether they wished to keep the 'sit and wait' system of access. Patients told us that their opinions on this had been listened to and as a result, felt that they had a service that delivered care and treatment that met their needs.

Data we considered before our inspection included the results of the last NHS England GP Patient Survey (2013-14). This showed that when patients were asked, 91.4% described their overall experience of their GP practice as good or very good, compared with an England average positive response of only 85.7%. 87.2% of those patients asked said they were involved in decisions about their care and treatment, compared to an England average of just 81.8%. 90% of patients asked said they were treated with care and concern when they were last seen by a GP or nurse at the practice. 90.5% of patients said they were very satisfied or fairly satisfied with the opening hours of their GP practice; the England average score for this was just 79.8% of patients who were satisfied with the opening hours of their practice.

Areas for improvement

Action the service MUST take to improve

The provider must:

Comply with regulation 21(b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Request and keep copies from locum supply agencies of all checks conducted on any locum supplied, confirmation of their entry on the NHS England Performers List and evidence of adequate indemnity insurance.

Action the service SHOULD take to improve

Address the non-attendance of district nurses at practice multi-disciplinary team meetings for management of care of patients at end of life.

Make arrangements for the practice nurse to receive annual appraisal with input from a clinician and have systems in place to review the work of the practice nurse, for example by way of clinical audit.

Dr Pankaj Srivastava

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and the team included a GP and a Practice Manager.

Background to Dr Pankaj Srivastava

Dr Pankaj Srivastava is registered with the CQC to provide primary care services, delivered under a Primary Medical Services contract (PMS).

The practice GP Dr Srivastava retains the services of three salaried GPs, one female and two males. There were three practice nurses (all female) who provided disease management, health screening, immunisation and vaccine clinics and other health initiatives.

Practice opening hours were from 8.30am to 6.30pm. Extended hours appointments were available each Thursday, when the practice was open until 8.00pm in the evening.

The practice is located within an area rated as being at the mid-point of social deprivation. Life expectancy for males is 77.9 years of age and for females is 81.9 years of age. In terms of age, the population of males and females aged between 60 and 69 years, was higher than the England average, making up almost 19% of the practice register.

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

Out of hours services were not provided by the practice, but by another, external provider.

Why we carried out this inspection

We inspected this service as part of our 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.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 15 January 2015. During our visit we spoke with a range of staff including three GPs, a nurse, the practice manager and three other members of administrative support staff. We also spent time speaking with two members of the patient participant group. We were able to speak to seven patients attending the practice on the day of our inspection.

Detailed findings

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

Reports from NHS England indicated the practice had a good track record for maintaining patient safety. During our inspection we found good systems to monitor patient safety. Staff were encouraged to share information when incidents and untoward events occurred. The practice manager told us that reports about incidents, significant events and complaints were reported and discussed at regular practice meetings. Minutes kept of these meetings confirmed this information.

The practice manager kept records of accidents and incidents concerning staff members. We saw that the practice followed guidance on the Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR). Any incidents or accidents involving staff were clearly described and recorded on a reporting template. Incidents were discussed at staff meetings with a view to raising awareness on safety in the workplace, and any learning points identified.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We reviewed records kept of significant events that had occurred during the last 12 months. Staff reported an open and transparent culture when accidents, incidents and complaints occurred. Staff were trained in incident and accident reporting. Although a process for completing incident reports was in place, they were not particularly detailed. Reports followed a set format but those we reviewed did not prompt staff for levels of detail that enabled conclusions to be drawn from each incident. The practice manager highlighted the use of a specific template in the recording, reporting and investigation into serious incidents, which would provide more detail for use in learning from events. Examples of these were being considered by the practice to ensure that all incident analysis followed a clearly defined pathway, which concluded with points for learning for all staff.

Reliable safety systems and processes including safeguarding

The practice had a policy for child and adult safeguarding. Staff demonstrated knowledge and understanding of safeguarding. They described what constituted abuse and what they would do if they had concerns. Staff had undertaken electronic learning regarding safeguarding of children and adults as part of their essential (mandatory) training modules. GPs had undergone safeguarding training to the appropriate level and the date this was due to be refreshed was recorded within a centrally held staff training record. The practice had a dedicated GP appointed as lead for safeguarding vulnerable adults and children, who was able to demonstrate good liaison with partner agencies such as the police and social services. GPs demonstrated their commitment to safeguarding of children and babies; where there were any concerns about younger children and babies, GPs said they would remove the babies clothing to conduct a full examination, enabling them to spot any unexplained marks or bruising.

There was a system to highlight vulnerable patients on the practice's electronic records system. This included information so staff were aware of any relevant issues when patients attended appointments, for example children subject to child protection plans. The practice also highlighted the records of vulnerable patients who lived alone. This reminded staff and clinicians to be aware of any sign of neglect or potential abuse of that patient.

Patients' records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals.

There was a chaperone policy in place at the practice and this was clearly advertised to patients in reception and waiting areas. Staff were familiar with the policy. All staff that were trained in providing this service had undergone enhanced background checks.

Medicines management

The practice had clear systems in place for the management of medicines. Systems in place ensured a medicines review was recorded in all patients' notes for patients being prescribed four or more repeat medicines. The practice had developed it's relationships with community pharmacies, and recorded in patient notes if a medicines review had been carried out by the pharmacist.

We were told that the number of hours from requesting a prescription to availability for collection by the patient was 48 hours or less (excluding weekends and bank/local holidays). The practice met on a regular basis with the local

Good

Are services safe?

area teams' medicines manager and CCG pharmacists to review prescribing trends and medication audits. We observed that prescribing practices were considered in line with published guidance. Nurses and GPs we spoke to gave information leaflets to patients relating to their medicines, which improved patients understanding of how their medicines worked, and contributed to the optimization of medicines performance.

Practice staff showed us how they ordered, stored and maintained sufficient stocks of medicines, for example, vaccinations and immunisations. These were kept in a dedicated fridge which was temperature controlled. Records were kept of checks made to ensure the fridge stayed within safe temperature limits. Stock within the fridge was rotated correctly to ensure that medicines would be used in 'best before' date order. We also noted that those medicines with similar packaging where stored on separate shelves. The nurses had printed off and taped to the fridge, the time limits in place between courses of vaccinations. This acted as a further check prompt for nurses delivering vaccines.

Emergency medicines were securely stored but available quickly to all staff. We checked the medicines and found them to be in date and suitable for use.

Cleanliness and infection control

The practice had an infection control policy in place. Cleaning of the practice was managed and monitored by the practice managers. Cleaning schedules were in place for all parts of the building, treatment rooms and consulting areas. Our visual inspection showed the practice was clean, tidy and well maintained.

In treatment rooms we saw that appropriate segregation of general and clinical waste was in place. Bins were all foot pedal operated and contracts were in place for the removal of clinical waste and sharps bins. We saw that all sinks in consulting and treatment rooms had adequate hand washing materials and paper towels available for use. We saw that a cupboard for cleaning materials was well stocked and all products were clearly labelled. The last infection control audit at the practice showed some (minor) areas for improvement. We reviewed the infection control audit of October 2013 and the report of January 2014. We saw that all improvements had been implemented.

Legionella checks were in place and an annual test was carried out by an external contractor to confirm the safety of water systems at the practice.

Equipment

When we checked equipment at the practice, we saw this was clean, well maintained and suitable for use. Records showed that all equipment used for measurement, such as spirometry equipment, blood pressure cuffs and weighing scales had been recently tested and calibrated to ensure accuracy. All electrical appliances had been tested. Further clinical items, such as syringes were for single use and these were disposed of in the correct containers. All single use items were in plentiful supply in each consulting and treatment room. The doctors and nurses consulting and treatment rooms had been checked by the practice managers on a regular basis to ensure stocks of equipment and cleaning standards were maintained.

Staffing and recruitment

The practice had a recruitment policy in place. Appropriate pre-employment checks were undertaken and completed before employment. All appropriate checks were in place for permanent salaried GPs. On occasions when the practice required holiday cover, or cover for unexpected absences of a GP, the practice used the services of a locum agency. The practice manager told us that the checks named above were confirmed by the supply agency. However additional checks, particularly those that refer to the locum GPs last appraisal date and entry on the NHS performers list, and level of indemnity cover were not automatically confirmed by the supply agency. The practice manager did not keep copies of the checks carried out by the supply agency.

From review of staffing rotas we could see that there were sufficient administrative and clinical staff available at all times to ensure the safety of patients. The practice had recently recruited an apprentice. We were able to confirm that this staff member had received a full, comprehensive induction and was appropriately supported through learning and development opportunities.

The practice had procedures in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. Staffing levels were set and reviewed to ensure patients were kept safe and their needs met.

Monitoring safety and responding to risk

Good

Are services safe?

We saw the practice had their own health and safety audit which included a walk around the practice looking for any faults or issues. Health and safety information was displayed for staff to see and there was an identified health and safety lead at the practice. Formal risk assessments for the environment and premises were in place; this included a fire risk assessment and a completed legionella test for the building. We saw that regular fire alarm testing and maintenance checks of fire extinguishers were in place. Health and safety visual inspections by the practice manager included the waiting areas for patients. CCTV was in place to ensure waiting areas out of immediate view could be monitored, for example, to maintain safety. Patients were aware that CCTV was in place and told us they did not find it intrusive or that it breached their privacy.

We saw evidence that staff were able to identify and respond to changing risks in patient's conditions or during a medical emergency. For example timely referrals were made for all patients attending hospital as a referred patient or as an emergency. All acutely ill children would be seen on the same day as they requested.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance. Patients received a full health check assessment when registering at the practice. Any patient's diagnosis of long term conditions were confirmed and checked; for example, in the cases of children who had been recorded as having asthma, this diagnosis was checked through testing. All patients with a history of breathing difficulties underwent spirometry testing. The practice screened patients for cardio-vascular disease (CVD), chronic obstructive pulmonary disease (COPD), for asthma detection in children, for vitamin D deficiency in the Asian population and for vitamin B12 deficiency in diabetics and the elderly population. Patients whose condition made them more vulnerable to illness such as flu were added to a register to trigger a reminder to attend annually for a flu vaccine. Those patients whose condition merited it, were entered on a specific disease register, enabling them to receive continuity of care through the practice nurses. The nurse who provided care for patients with longer term conditions was able to describe and show us the care pathways used for those patients, and instances of where patients had been referred to the GPs at the practice for overview, to ensure care continued to meet patients' needs.

Management, monitoring and improving outcomes for people

The practice focused on screening for conditions that became more prevalent in certain age groups, for example, by ordering annual blood tests for thyroid, liver and renal functions. The practice was able to demonstrate effective screening of patients aged 65 and over, who reported any memory problems. This enabled the practice to refer people to a memory clinic for correct, accurate and timely diagnosis of dementia. At each appointment, GPs and nurses conducted a pulse and blood pressure check on each patient and recorded each patients' weight and BMI. This contributed to the early detection of heart disease, as well as other common conditions. In data we reviewed we saw that referral rates for common diseases were high, which related to the screening of patients at the practice, which clinicians considered as routine. The practice was able to demonstrate how other conditions would be screened for, where the family history of a patient indicated this would be of use, for example, testing for chronic kidney disease, ovarian and breast cancers.

The practice GPs shared the results of audits recently carried out; one related to medicines prescribed to patients and had been revisited to complete the audit cycle. Another audit related to minor surgery cases and had two aims. The first was to monitor patient healing and recovery times and whether any infection followed the surgery. The second was to check if biopsies of any tissue were performed and results followed up correctly. This audit showed that no patients had reported any infection following surgery and that tissue samples had been referred appropriately for further testing.

Dr Srivastava employed a practice pharmacist for eight hours each month to work on reviews of medicines that could be substituted with other, more cost effective alternatives. We saw that patients were given an explanation of what the change in medication might involve and whether it would impact on other aspects of their health. We noted that the practice nurse had reviewed patients receiving a particular medicine for control of their long term health condition. When the pharmacist had presented alternative medicines that could be used to similar effect the nurse had considered other health factors involved for particular patients. The nurse told us that in this particular case, the issue had been discussed with the patient. As a result the patient had expressed a wish not to have their medicine changed. The practice supported this and the patient remained on their prescribed medicines. This demonstrated the level of patient involvement, the openness and transparency afforded to patients in communication with their clinicians, and the wider application of patient consent to care and treatment.

Effective staffing

The practice had a mix of administration and reception staff working with a practice manager. We looked at the induction programme which included mandatory training, role-specific training, risk assessments and health and safety training. An apprentice had recently been taken on as an additional member of the administrative support team and we saw that they had been through a period of

induction, which covered role specific training, with further training planned throughout the year. This new member of staff had access to a mentor and was supported to complete national level qualifications.

All administrative support staff had been referenced and identity checked. All staff had undergone basic level security checks. The practice manager followed best practice guidance of the Clinical Commissioning Group (CCG) by refreshing Disclosure and Barring Service (DBS) checks every three years. All staff had access to and had completed what would be considered mandatory training, for example, in child and vulnerable adult safeguarding, infection control and emergency first aid.

The practice had recently taken on an additional permanent salaried GP. We saw the practice manager had carried out all appropriate checks on the new GP, and copies of these were held at the practice. Records of appraisal were held and notes of who the appointed appraiser was. References and enhanced background checks had been carried out and the practice had confirmed that the GP was on the GP Performers list, i.e. NHS England (Merseyside). All practicing GP's must be on the NHS England Performers list. The practice used locum GPs on occasion to cover for unplanned absences. The practice manager confirmed verbally that the locum supply agency had conducted all required employment checks, but did not have copies of these. Also, the locum agency did not appear to confirm that the indemnity cover of the locum supplied, was sufficient i.e. how many locum sessions the GP could work.

The practice also retained the services of a female GP, who was available for those patients that chose to be seen by a female GP. This GP had lead responsibility for six week post natal checks and the initial 6 week baby check-up. A dedicated health visitor visited the practice to deliver initial baby vaccines and immunisations, as well as providing new parents with advice and support. A dedicated area midwife also delivered antenatal care at the practice and provided advice and support to new mothers.

The skills of the nursing team and GPs were sufficient to meet the varied needs of the patient list. Nurses were able to show evidence of annual appraisal. We did discuss the merits of the nurses being appraised with input by GPs to give full oversight and reflection on the nurse's work. The evidence of nurses presented at appraisal was sufficient to show effective care of patients, but overview by the GPs would present greater opportunity of identifying areas for development and furthering their practice qualifications.

Working with colleagues and other services

All staff at the practice were aware of their duties. Incoming correspondence was dealt with by designated staff and distributed to the team to scan onto patients records, once returned from GP scrutiny. We saw that this system worked well and that there was no significant delay in adding blood test results or medical reports from hospital specialists to patients' notes. We reviewed one incident that was recorded as a significant event, which involved a delay in a GP seeing the correspondence from a consultant. We saw how some lessons had been learned from this and shared amongst all staff. The practice used the Choose and Book system of referring patients to secondary care. At the time of this inspection, 100% of referrals were through this system. The system presents choices where available, to patients on where they can be seen by a specialist for further tests, surgery or follow-up care.

The practice hosted a number of services at its site, which provided easy access to secondary care for patients. These services included physiotherapy, counselling, ultrasound scanning, phlebotomy, warfarin clinic and advice from community services such as Citizens Advice Bureau.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. Information was shared in this way with hospital and other healthcare providers. We saw that all new patients were assessed and patients' records were set up. This routinely included paper and electronic records with assessments, case notes and blood test results. We saw that all letters relating to blood results and patient hospital discharge letters were reviewed on a daily basis by doctors in the practice. We found that when patients moved between teams and services, including at referral stage, this was done in a prompt and timely way.

We found that staff had all the information they needed to deliver effective care and treatment to patients. For emergency patients, patient summary records were in place. This electronic record was stored at a central

Good

Are services effective?

(for example, treatment is effective)

location. The records could be accessed by other services to ensure patients could receive healthcare faster, for instance in an emergency situation or when the practice was closed.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling this. 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 legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. We also saw how consent was considered when reviewing patient medicines; we found the needs of the patient and their understanding of their treatment was confirmed as part of the consent process.

Health promotion and prevention

We saw how staff used each intervention to support patients in taking control of their health and well-being. The practice manager showed us how information notice boards were kept up to date. Literature was available to take home and read, which covered initiatives to help patients stop smoking, manage alcohol consumption and support for patients suffering from anxiety and depression. Details on support available included information from Wirral advocacy services and a self-help group that gave patients access to structured exercise activities, aimed at reducing anxiety levels.

GPs screened patients for a number of common health conditions with a view to early diagnosis and effective early intervention. The practice also considered the family history of patients when considering referral for further clinical investigations. The practice GPs conducted discharge reviews. When patients had been discharged from hospital, they received a telephone call from the GP. If a house call was needed this was carried out on the day of discharge wherever possible. We saw several examples of how discharge follow-up had been used to ensure patients well-being. This early intervention had prevented patients returning to hospital due to insufficient support being in place for the patient.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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.

We reviewed the most recent data available for the practice on patient satisfaction. These included data sources such as the national patient survey, the practice survey and the CQC comments cards completed during our inspection. Overall patients reported being treated by staff with dignity and respect and in general they were satisfied with the care they received. Most commented on the friendly and caring approach of staff. 91.4% of patients asked in the last NHS England GP Patient Survey described their overall experience of their GP surgery as good or very good. This result is higher than the England score of 85.7%.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The practice offered patients a chaperone prior to any examination or procedure. Information about having a chaperone was seen displayed in the reception area. 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.

Care planning and involvement in decisions about care and treatment

Patients we spoke with felt confident they had been involved in any decisions about their treatment and care. We looked at the Quality and Outcomes Framework (QOF) information and this showed adequate results for patients reporting that the nurse of doctor was good or very good at involving patients in decisions about their care.

We found that staff were at clear 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.

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.

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.

Clinical staff used a number of methods to support bereaved patients. Some would contact them personally. The reception staff were knowledgeable in support processes for bereaved patients. They were familiar with support services and knew how to direct patients to these. Information was available to patients in leaflet form that they could take away with them. Staff described how they would explain to patients how services could be accessed, if there was a referral pathway in place.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice considered the needs of its patients when planning resource. The practice had recently recruited a further permanent salaried GP. The practice also retained the services of a female GP to ensure access to female clinicians was available to patients. The practice had an active patient participant group, who assisted the practice in the gathering of patient views. The practice manager told us how recently they had consulted with patients on how the premises could be improved.

The practice worked with the local clinical commissioning group to host or provide a range of services in-house. These included but were not limited to physiotherapy services, phlebotomy, counselling and ultrasound scanning. As part of our inspection, patients were left CQC comment cards to share their views of the service. Patients particularly commented on the ease of access to the service, not only through appointments with GPs but also their access to additional services and how much they appreciated this.

Tackling inequity and promoting equality

The practice operated a 'sit and wait' surgery for patients each morning. If a patient came to the practice before 10.00am, they would be seen that morning or by 1.30pm that day. The afternoon surgery which ran between 4.00pm and 6.00pm was run on an appointment system. We asked patients how this worked in practice. Patients we spoke to told us they had been given the option to move to an appointment only system when the lead GP took over the practice two years ago. Patients fed back to the practice that they wanted to remain on the 'sit and wait' system, and this had been facilitated. Patients told us they valued the system; we were told by parents with very young children that if their child was particularly unwell, they would phone the practice to say they would be attending that morning, and the child would be seen ahead of other patients if required. Other patients told us they may wait for a considerable time, but valued being seen on the same day.

We conducted an analysis of the previous week's patient attendance figures. The total number of available patient appointments for the previous week was audited. There were no instances of patients failing to attend during the morning surgeries but there were instances of failure to attend during the later afternoon surgeries. This indicated that pre bookable appointments had a higher rate of non-attendance by patients.

The appointment availability, measured by number of patients seen each morning, well exceeded the required average of 75 appointments per 1000 registered patients, per week. We asked patients about the amount of time afforded to them within the appointment. Of the seven patients we spoke with, none of them complained that they felt rushed or that the GP did not give them sufficient time to discuss their healthcare needs.

Access to the service

Access to the practice building is via an automated doorway and there is a ramp for ease of access for disabled patients. There is a chair lift to the second floor for disabled and elderly patients. We observed staff were aware of the need for patient confidentiality when speaking with patients and assessing their needs. The seating area in reception was set back from the immediate reception desk to facilitate this.

The practice manager and clinicians ensured that patients' access to care and treatment was considered in line with their physical and cultural needs. The practice kept specific patient registers, and those GP's with a lead interest would see them for annual health checks and wherever possible, for routine appointments. For example, there was a lead GP for patients with a learning disability. The practice also had a GP who took the lead in the care and treatment of teenagers. The needs of patients who experienced other social problems were also considered, for example, those patients with alcohol dependency who had other clinical illnesses. These patients were classed as more vulnerable and care plans were in place to ensure they received the clinical care they needed at the time it was needed.

We looked at systems in place for referral of patients to specialists and other secondary care. The staff involved understood the importance of the timeliness of referrals and followed procedures in place to ensure no unnecessary delays were caused. Where any delay had occurred, the referral was reviewed and lessons learnt. Communications with patients regarding referrals was prompt. The referral of patients often provided choice and the options available were discussed with patients. Wherever possible, patients' needs were considered, for

Good

Are services responsive to people's needs?

(for example, to feedback?)

example in referring a patient to a facility outside of the immediate area. Patients we spoke with told us they had used the Choose and Book system and any choices available had been explained to them fully.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

Staff were knowledgeable regarding the complaints process. We saw posters advising patients how they could make a complaint. We looked at a number of complaints that had been made. We considered that the practice response to complaints was appropriate and actions had been taken to make improvements as required.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice GPs, nurses and practice staff were aware of their duties and how their role contributed to the overall aims, objectives and achievements of the practice. The practice development plans had been carefully considered by the lead GP, following a period of absence due to ill-health. This included the recruitment of a further, permanent salaried GP with additional areas of specialism, who could help deliver a wide range of services to patients. The accessibility of GPs to patients had been considered. This had resulted in the services of a female GP being retained to offer health and care to those patients wishing to be seen by a female GP. The practice mission statement is "to provide people registered with the practice with personal health care of high quality and to seek continuous improvement on the health status of the practice population overall." Staff we spoke with throughout the day referred to this; support staff we observed through the day dealt with patients compassionately and treated them with dignity and respect. We found that all patients we spoke with were appreciative of staff at the practice. Staff acknowledged that in being compassionate and caring towards patients, patients treated staff with courtesy and respect.

Governance arrangements

The practice had policies and procedures in place to support the safe, effective delivery of services and these were available to staff via the desktop on any computer within the practice. Policies were up to date and had regular review dates. The practice held monthly practice meetings during which time governance and risk management issues were discussed. Risks that had been identified were discussed and actions taken. Patient complaints were also discussed so that learning could be disseminated to all staff. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

The GPs attended a meeting with neighbouring GPs to review performance and best and updated clinical guidance. The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line or at times above average with national standards. We saw that QOF data was regularly discussed at practice team meetings and action plans were produced to maintain or improve outcomes.

Investigation of significant events was completed but we found the forms to record these did not pose open questions to draw out pertinent details, for example questions on what, why, who when, where and how were not asked. Examples of significant event analysis we reviewed lacked detail and as a result of this, learning points were limited. Incident reports did not follow a consistent order; details around what was happening on the day were present in the incident recording, but did not add value. As a result, any learning that could be drawn from an incident was limited.

The practice nurses received annual appraisal from the practice manager, rather than a clinician. Systems were not in place to review the work of the practice nurse, for example by way of clinical audit. Although the achievement of targets (evidenced by QOF) could be checked on at appraisal, the significance of these, or the confirmed effectiveness of treatment of patients by the nurses, was limited due to the lack of clinical oversight.

The practice relied on one locum agency for supply of locum GPs in the event of unplanned absence of one of the practice GPs. When we reviewed records kept of recruitment checks undertaken by the agency, we found the practice did not ask for copies of these. The practice manager told us they had accepted that pre-recruitment checks would have been completed by the agency and did not ask for copies of these each time a locum GP was used. We pointed out that separate legislation applicable to supply agencies, did not exempt the practice from the provisions of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Leadership, openness and transparency

The management model in place was supportive of staff. Staff we spoke with said they enjoyed working at the practice, many had worked there for a long period of time. Annual and more regular team events took place, staff spoke positively of these events and how valued and supported they felt working there. The practice had a

Are services well-led?

Requires improvement

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

strong team who worked together in the best interest of the patient. All staff were aware of the practice whistleblowing policy and they were sufficiently confident to use this should the need arise.

The lack of attendance by district nurses at practice multi-disciplinary team meetings for management of care of patients at end of life had not been addressed by the GPs. Although the lead GP had been absent from the practice due to ill-health, in his absence, this had not been addressed. We understand that following our inspection, this matter had been raised with the CCG, and attendance of the community nurses at practice led multi- disciplinary team meetings, particularly in respect of patients receiving palliative care or end of life care had been arranged.

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

Staff reported a culture where their views were listened to and if needed action would be taken. We saw how staff interacted and found there was care and compassion not only between patients and staff but also amongst staff themselves. We were told that regular clinical and non-clinical meetings took place. At these meetings any new changes or developments were discussed giving staff the opportunity to be involved. All incidents, complaints and positive feedback from surveys were discussed.

We found the practice proactively engaged with the general public, patients and staff to gain feedback. An annual patient survey had been carried out and appropriate action plans were in place. The practice had an active Patient Participation Group (PPG) and during our inspection with met with two of their members. They spoke positively on how the practice engaged with them at meetings and how they took account of any recommendations or changes they asked them to consider.

Management lead through learning and improvement

Staff had access to a programme of induction and training and development. Mandatory training was undertaken and monitored to ensure staff were equipped with the knowledge and skills needed for their specific individual roles. Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We looked at a number of staff files and saw that regular appraisals took place. However, we noted that nurses were not appraised by a GP but by the practice manager, which limited the insight that GPs had into the possible areas for development for nursing staff.

The practice held regular staff meetings and clinical meetings. Minutes of meetings were kept and available for review by staff that may have recently been on leave. The all staff meetings were used to discuss any complaints, how these were responded to and any changes to the practice way of working. Performance was also discussed at meetings, for example, the latest QOF results or other information made available for example, through the local CCG. Staff we spoke with told us they received positive leadership from the clinicians and practice managers and felt part of a team, which contributed to their level of commitment to the practice.

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 **Regulation 21(b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.** **The practice must ensure that copies of checks carried out by locum supply agencies are kept. This should include copies of indemnity cover, entry on the NHSE performers list, GMC registration (and any conditions) and all other items covered by this regulation and Schedule 3.**