Dr G G Francis & Dr J A Hortop

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr G G Francis & Dr J A Hortop, known as Spital Surgery on 7 January 2015. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider should

- Ensure recruitment arrangements include the completion of a Disclosure and Barring (DBS) check before commencement of work where required or have a risk assessment in place supporting their decision not to have this undertaken.
- Ensure the lead safeguarding GP undertakes updated adult safeguarding training
- Ensure legionella testing of the building is undertaken

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- Ensure doctors have available emergency drugs or have in place a risk assessment to support their decision not to have these available for use in a patient's home.
- Review the storage of emergency medicines held at the practice to ensure that when needed they can be accessed swiftly and safely.

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 widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. Improvements were needed for recruitment processes, safeguarding training and aspects of medicines management.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their

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needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy, though not formally documented. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The Patient Participation Group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in improving the care of people aged 75 years and over. The practice had undertaken detailed searches of this population group, including identifying those patients who lived alone, who had caring responsibilities and who had been seen in the last 12 months. We saw how further reviews took place to identify those patients who had four or more long term conditions, those who attended A&E recently and those who were housebound. Following this risk stratification, patients were given a personalised care plan and were being regularly monitored and reviewed by a named GP. The practice also wrote to these patients to provide support information and to inform them of the local voluntary and charitable services they might find support from.

The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. We saw how the practice was involved in the (Care Home Assessment and Review Service (CHARS) process. Good relationships had been built with the manager of local care homes when GPs attend to undertake a weekly 'ward round' review. This was a pilot across 2014 but at the time of our inspection the pilot had been completed.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice had access to specialist advice, for example the specialist diabetic nurse and patients were referred to the local diabetic expert programme. Patients with Chronic Obstructive Pulmonary Disease (COPD) had an annual review and reassessment. They undertook an

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education programme relating to their breathing and were provided with written information and medication to use in an emergency. The practice found that this initiative led to a reduction in emergency admissions to hospital for this population group.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. The practice supported the Wirral campaign for chlamydia screening for 16-24 year olds and they were actively trying to increase take up of this service, via Emis alerts on patient records and making test kits readily accessible.

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 needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice does not participate in the Extended Hours Enhanced Service.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. Annual health checks were offered to patients with Learning Disabilities, this included a new assessment of the severity of the learning disability. We saw a specific learning disabilities care plan with easy read and pictorial images. Each patient who attended was encouraged to bring their carer to the appointment.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary

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organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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). Systems were in place to ensure people experiencing poor mental health had received an annual physical health check. This included identifying those patients on the practice register that may benefit form a dementia needs review. If the assessment highlighted dementia care needs the patient would be sent on to the Memory Assessment Service for further review and support. We saw an alert notification on the patient record identifying the patients who had dementia. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia. A number of patient information leaflets and posters were seen in the waiting area, sign posting patients to agencies that could provide support to the patient or their families. The practice housed support services that could be accessed by patients with poor mental health such as weekly counselling services.

Summary of findings

What people who use the service say

We received 27 completed patient CQC comment cards and spoke with 5 patients who were attending the practice on the day of our inspection. We spoke with people from different population groups, including patients with different physical conditions and long-term care needs. The patients were complimentary about the staff and GPs. They told us that practice staff were caring, getting an appointment was easy and the GPs had the time to listen to patients. Patients told us the practice had compassionate staff, they were courteous, respectful and helpful and mostly they felt they received good care.

Areas for improvement

Action the service SHOULD take to improve

- Ensure recruitment arrangements include the completion of a Disclosure and Barring (DBS) check before commencement of work where required or have a risk assessment in place supporting their decision not to have this undertaken.
- Ensure the lead safeguarding GP undertakes updated adult safeguarding training
- Ensure legionella testing of the building is undertaken
- Ensure doctors have available emergency drugs or have in place a risk assessment to support their decision not to have these available for use in a patient's home.
- Review the storage of emergency medicines held at the practice to ensure that when needed they can be accessed swiftly and safely.

Dr G G Francis & Dr J A Hortop

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr G G Francis & Dr J A Hortop

Dr G G Francis & Dr J A Hortop is registered with the Care Quality Commission to provide primary medical services. The practice is known locally as Spital Surgery. This is a General Medical Services (GMS) contracted service within the centre of Wirral. The practice has a complete primary health team consisting of two GP partners, four salaried doctors and one registrar, a practice nurse, health care assistant, reception secretarial and administration staff and pharmacy technicians. The practice has a lead GP partner with a total of seven GPs working there.

The total practice list size for the practice is 4224. The practice is part of Wirral Clinical Commissioning Group (CCG). The practice is situated in an area that has lower than average areas of deprivation. The practice population is made up of a higher than national average population aged between 50 and 85 years and a lower than national average of younger aged patients.

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.

The practice is open Monday to Friday from 8.00am to 6.30pm with no extended hours as part of their PMS contract. 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.

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 practice keeps up to date registers of those patients with learning disabilities, mental health conditions and those in need of palliative care. Multi-disciplinary team meetings were in place to support these patient groups.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal 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. We carried out an announced inspection on 20 January 2015.

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 CQC comment cards left for us on the day of our inspection.

We spoke with the practice manager, registered manager, GP partners, practice nurses, 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 those patients ringing the practice. We explored 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.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff were encouraged by the management team to share information when incidents and untoward events occurred. They were clear that the practice manager and GP would be notified when events occurred. However all of the reported incidents had involved the GPs only and staff were not involved with formal reporting of such events. Reports from NHS England indicated the practice had a good track record for maintaining patient safety.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Records were kept of significant events that had occurred during the last twelve months and these were made available to us. Staff reported an open and transparent culture when accidents, incidents and complaints occurred. Staff were trained in incident and accident reporting. There was an accident and incident reporting policy and procedure to support staff with which they were familiar. They told us they felt confident in reporting and raising concerns and felt they would be dealt with appropriately and professionally. However reporting in this instance meant reporting the incident to the manager rather than completing the documentation themselves. Of the events we reviewed, we were satisfied that appropriate actions and learning had taken place. All actions were monitored at regular monthly practice meetings, however reception staff did not attend these meetings so the opportunity to share any learning with this staff group was reduced. We tracked five incidents and saw records were completed in a comprehensive and timely manner.

The practice had a process for monitoring serious event analysis (SEA) and when required these were reported to the local Clinical Commissioning Group (CCG). Staff received alert notifications from national safety bodies and all relevant staff were aware of these.

From the review of complaint investigations held at the practice, we saw the practice ensured complainants were given full feedback and learning had taken place.

Reliable safety systems and processes including safeguarding

There was a local policy for child and adult safeguarding. This referenced the Department of Health's guidance. Staff demonstrated knowledge and understanding of safeguarding. They described what constituted abuse and what they would do if they had concerns. They had undertaken electronic learning regarding safeguarding of children and adults as part of their essential (mandatory) training modules. This training was at different levels appropriate to the various roles of staff.

The practice had a dedicated GP appointed as lead for safeguarding vulnerable adults and children. They had the necessary training to enable them to fulfil this role however, this had not included adult safeguarding training. The lead safeguarding GP was aware of vulnerable children and adults and safeguarding records demonstrated good liaison with partner agencies such as the police and social services. All staff we spoke with were aware who the safeguarding lead was and who to speak to in the practice if they had a safeguarding concern. There was a chaperone policy in place. Staff were familiar with this and there were posters advertising this for patients.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments, for example children subject to child protection plans.

Patient's individual 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. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings.

Medicines management

The practice had clear systems in place for the management of medicines. There was a system in place for ensuring a medicine review was recorded in all patients' notes for all patients being prescribed four or more repeat medicines. 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 quarterly basis with the Medicines Management Team from the Clinical Commissioning Group (CCG) to review prescribing trends and medication audits.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. We saw that fridge temperatures were monitored twice daily to ensure safety. The fridge was adequately maintained and staff were aware of the actions to take if the fridge was out of temperature range.

We observed effective prescribing practices in line with published guidance. Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Information leaflets were available to patients relating to their medicines. We reviewed the doctor's bags available to GPs when doing home visits and found they did not routine carry medicines for use in patients' homes. There was also no risk assessment in place to support this decision.

Clear records were kept when any medicines were brought into the practice and administered to patients. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with regulations.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff that generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were appropriate and necessary. All prescriptions were reviewed and signed by a GP before they were given to the patient. We saw that blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice had the equipment and in-date emergency drugs to treat patients in an emergency situation. We saw that emergency medicine, including medicines for anaphylactic shock, were stored safely and were monitored to ensure they were in date and effective. However these medicines were stored in separate areas and locked cupboards; therefore might not be easily accessible should they be needed for an emergency in other parts of the practice. These medicines were monitored for expiry dates and they were all in date on the day of our visit.

Cleanliness and infection control

The premises were clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a staff member with lead responsibilities for infection control who had undertaken additional training to enable them to provide advice to the practice concerning infection control policy and to carry out staff training. All staff received induction training about infection control specific to their role and there after received annual updates. We saw evidence that the lead for infection control carried out audits for each of the last three years and that any improvements identified for action were completed on time.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy for needle stick injury

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

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). However the practice had not carried out a recent test.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was

routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and the fridge thermometers.

Staffing and recruitment

The practice had a recruitment policy in place. Appropriate pre-employment checks were undertaken, such as references, medical checks, professional registration checks, photographic identification. However not all administration and reception staff whose role required it had a Disclosure and Barring Service (DBS) check completed before commencement of work and there was no risk assessment in place to support this decision. These checks provide employers with access to an individual's full criminal record and other information to assess their suitability for the role.

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.

Monitoring safety and responding to risk

The practice had a system in place for reporting, recording and monitoring significant events. We were told that incidents were reported at regular practice meetings and minutes were shown to us to demonstrate this. However not all practice staff attended these meetings. Health and safety information was displayed for staff to see and there as an identified health and safety representative. Formal risk assessments for the environment and premises were in place, this included a fire risk assessment.

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. We found that systems were in place to ensure that all staff attended refresher training course to ensure they kept up to date.

We saw evidence that staff were able to identify and respond to changing risks in patient's conditions or during and 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. We saw records showing 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). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. However this was a store cupboard in different rooms rather than in an emergency bag or box and we considered that in an emergency situation staff might not be able to gather the required drugs easily. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. A fire risk assessment had been undertaken that included actions required maintaining fire safety. We saw records that showed staff were up to date with fire training, however a recent fire drill had not been undertaken by staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs each led in a specific clinical area, for example diabetes and asthma. The practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. There close working links with the diabetes specialist nurse and the practice nurse regularly sought advice and worked closely to achieve the best outcomes for patients. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. Some of these were older patients and the practice reviewed how many of these were carers or who might live alone but they had not attended the GP for over 12 months. These patients were contacted and invited into the practice for a health assessment. We saw how patients recently discharged from hospital were followed up by the practice including their medicines to review any changes. We saw that regular audits took place reviewing the patients who had attended A&E to identify why they attended and how best they could be supported in the future at the practice.

We saw that the practice had signed up with Cancer UK to take part in the national cancer referral audit. The practice used the provided cancer assessment tool kit provided by Cancer UK to profile the needs of their patients with cancer. This information enabled the practice to be clearer on the demographics of the practice and those who had cancer, the cancer screenings on offer at the practice, the waiting times and diagnosis of patients including new patients.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral. At lunchtime each day meetings were held with the GPs to review the patients who required referral to hospital and community services.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. The practice showed us a number of audits related to medicines management information or alerts issued from the Medicines and Healthcare Products Regulatory Agency (MHRA). After a review of all patients on the identified medicines changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, patients who were taking Temazepam and soluble Aspirin. The GPs showed us data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing, which was comparable to similar practices.

We saw a detailed audit of patients who were diabetic and on a particular medicine for this. This was chosen because NICE guidance for this treatment had changed and the practice wanted to ensure compliance with this update guidance. The new guidance said that all patients should receive a clinical review six months after they commenced on this treatment to assess their response to the new medication. In response the practice undertook a baseline search of these patients on their system, including a case

note review. This information was shared with all GPs and the practice nurse. A number of changes were implemented in line with the NICE guidelines such as the medicines being stopped or continued based on the results of the patient review, ensuring the patient received a review after six months of commencing treatment and ensuring GP referral for patients who needed to continue on the medication.

The practice also used the information they collected for the Quality and Outcomes Framework (QOF) is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). Information shared with us from the CCG showed the practice achieved 99.7% of the total QOF points in 2013/14 and for clinical achievements alone they performed above the England and CCG average. The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes comparable to other services in the area and in some areas they were achieving higher performance. For example the practice had achieved the highest uptake of patients undertaking a cervical screening across the CCG.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses, for example the practice nurse attended annually training and development in the safe administration of patient vaccinations. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, cervical cytology. Those with roles such as monitoring long term conditions such as asthma and diabetes were also able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries and out of hours providers were received both electronically and by post. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. The practice had a system in place to ensure all patients discharged from hospital were seen when they had been discharged from hospital and their conditions reviewed.

We found a number of other agencies and organisations within the practice meaning that patients did not have to travel far to access their services. This included counselling, physiotherapy services and support agencies such as Citizens Advice Bureau.

The practice worked closely with other health and social care providers in the local area. The GPs and the practice manager attended various meetings with management and clinical staff involving practices across Wirral CCG.

Good

Are services effective?

(for example, treatment is effective)

These meetings shared information, good practice and national developments and guidelines for implementation and consideration. They were monitored through performance indicators and practices were benchmarked.

The practice attended various multidisciplinary team meetings at regular intervals such as to discuss the needs of complex patients, for example those with end of life care needs, children at risk, older frail patients and those with mental health and learning disabilities. These meetings were attended by community staff such as district nurses, health visitors, social workers and palliative care nurses. We saw good evidence the practice worked with specialist nurses across the community such as the diabetic specialist nurse.

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 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 these. All the clinical staff we spoke with 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. For example, patient vaccinations, a parent's written consent was obtained and documented.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant / practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic health screening to patients who do not attend the practice regularly.

The practice had numerous 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 chronic and long term disease such as asthma. Each of these patients were identified by the practice nurse and annual assessments and reviews were offered. We saw that care plans were put into place and the introduction of the fifteen minute appointment time with the GP meant that many patients with multiple needs were helped to resolve a number of problems during the one appointment time. Data from the Quality Outcomes Framework (QOF) showed the practice achieved good results for patients with long term conditions attending this review. The practice had also set up a phlebotomy (blood test) service for patients who needed to have their bloods taken regularly to avoid them having to travel far.

We found the practice's performance for cervical smear uptake was the highest across the CCG area. The GP and practice nurse would routinely telephone and write to patients with reminders about their need for a smear test and the practice audited patients who do not attend. The practice nurse would follow up all patients that did not attend. A similar mechanism of following up patients who did not attend annual health checks was also used to follow up all patients across 'at risk' groups.

Good

Are services effective?

(for example, treatment is effective)

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 above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

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. We observed staff were discreet and respectful to patients despite the reception area being open plan and not confidential for 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. We received 27 completed CQC comments cards from patient who had attended the practice. All of the patients who completed our comments cards had positive comments to make about the practice. Most of these comments related to how patients felt that practice staff were very caring, compassionate and willing to provide support to families. The recent national patient survey also showed the patients said the last GP they saw or spoke to was good at treating them with care and concern practice. The practice own patient survey which collected the views of 153 patients asked patients about how caring reception staff were and 100% of respondents said they were very friendly and helpful. In the survey 88% of patients said the reception area (which was open plan) was private, some commenting that a private conversation in this area was difficult.

All patient consultations were carried out in private. 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.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so confidential information was kept private.

Patients we spoke with during our visit told us they were always treated with dignity and respect and that staff were caring and compassionate. We found 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

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 90% of practice respondents said the GP involved them in care decisions and 94% said the last GP they saw or spoke to was good at explaining tests and treatments.

Patients we spoke with on the day of our inspection told us health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. This was particularly evident for the management and care of patients with long term conditions who attended the practice on a regular basis. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection and the comment

Good

Are services caring?

cards we received also spoke positively about how they had received good emotional support and care. We saw patient information leaflets and posters sign posting patients and families to support agencies and services.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

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 NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

We saw how appointments were identified for particular patient groups. For example patients with a complex or chronic disease would be given longer appointment times if needed. Where possible they would see their named GP or practice nurse to ensure continuity of care. When patients were too ill to attend the practice home visits would be undertaken by the GP.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example the results of their patient survey they had a 'you said and we did' approach to the comments made by patients. Patients said in the survey that the automatic check in for patients was not used fully. The practice had responded by agreeing to train all of the receptionists to help patients with this log in facility. During our inspection we met with members of the practice PPG. We were told that practice staff had implemented a number of suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the PPG. They spoke positively about how staff engaged with them, regular meetings took place and how they responded to the suggestions that were made.

Tackling inequity and promoting equality

The practice was tackling health inequalities by providing good access to medical care and helping patients navigate a complex health system. Patients we spoke with confirmed that the appointments system was easy to use. They felt staff were supportive from the initial contact and they were satisfied with the choices available to them in terms of access to the service. Patients were given a number of access choices. This included telephone advice, face-to-face contact or a home visit if needed.

We found that staff were aware of local services (including voluntary organisations) that they could refer patients to. Patient's information sign posted patients and families to welfare and benefits advice organisations.

The main parts of the practice were situated on the first and second floors of the building with most services for patients on the first floor. There was a chair lift access to the first and second floors. The practice had wide corridors easily accessible for patients with wheelchairs. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Appointments were available from 8am to 6.30pm each week day. There were no extended hours for patients who might work throughout the day. The practice had a comprehensive website which included this information. This also included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

During our visit patients told us they experienced good access to the service. The most recent national patient survey showed that 97% of patients were satisfied with the practice open times and getting through on the telephone. Ninety one per cent of patient said the experience of making an appointment was good and 94% of respondents were able to get an appointment to see or speak to someone the last time they tried.

We saw that there had been recent changes to the practice GP appointment system. Each patient had a 15 minute appointment, the lead GP explained this meant that patients now had more time to discuss their conditions without experiencing a rushed and hurried consultation. Patients we spoke to during our visit and those who completed our comments cards aligned with these views.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to a number of local care homes on by a named GP and to those patients who needed one.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The practice had a small population of non - English speaking patients and if required they could access interpreter services locally.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system, this included a patient complaints leaflet. Whilst this had good information for patients it did not include details of the next steps patients could take if they were dissatisfied with the investigation or the findings of this the practice had undertaken. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at two complaints received in the last 12 months and found and found that timely and appropriate responses had been made. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified.

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

The practice had an unwritten vision to deliver good patient care and staff were engaged with this. A formal and written patient strategy was not in place. There was a clear leadership structure and staff felt supported by management. We spoke with a number of staff across the visit, they all knew and understood the vision and values and knew what their responsibilities were in relation to these. They shared the same ethos which was to deliver patient centred care in a compassionate and caring way to patients and their families.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. These policies were linked to the local Clinical Commissioning Group (CCG) website so current and up to date was accessible to staff.

We saw transparent and open governance arrangements. We found practice staff were clear about their roles and they understood what they were accountable for. There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example the medication audits and the cancer profiling of the practice population described earlier. We saw good examples of benchmarking work carried out by the GP with support from the CCG.

The practice had arrangements for identifying, recording and managing risks. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. An example of this was the infection control risk assessment which had been completed by the local CCG. We found that the more negative results had been acted upon.

The practice held weekly clinical led management meetings but we found that administration and reception staff attendance had lapsed. A meeting had taken place in October 2014 but no minutes had been taken and staff confirmed had attended practice meetings in the past but these were no longer taking place. We looked at minutes of the existing practice meeting and found that performance, quality and risks had been discussed but the information in these documents was brief and required improving.

Leadership, openness and transparency

We spoke with staff with different roles and they were clear about the lines of accountability and leadership. They spoke of good visible leadership and full access to the senior GP and practice manager. Staff told us they enjoyed working at the practice and they felt valued in their roles. Staff felt supported, motivated and reported being treated fairly and compassionately. They reported an open and 'no-blame' culture where they felt safe to report incidents and mistakes. The practice had a 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 practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, (for example induction policy and management of sickness) which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

Are services well-led?

Good

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

The practice had gathered feedback from patients through a patient survey, via comments cards and on line. Over the last 12 months the surgery has had a Friends & Family Test survey on the homepage of their website. Patient complaints were also reviewed for feedback. We looked at the results of these and the annual patient survey and saw that action actions had been taken for all of the areas patients reported a less positive experience.

The practice had an active Patient Participation Group (PPG) which has steadily increased in size. The PPG included representatives from various population groups; for example older people and those of a working age. The PPG had carried out quarterly surveys and met every quarter. The PPG had been very active in encouraging patients to complete the surveys that they had designed themselves. The PPG encouraged local businesses to donate gifts that could be raffled. Raffle tickets were handed out to patients who agreed to complete a patient survey questionnaire. The surveys included questions regarding the premises, access to the premises, communication to and from the practice and clinical skills of all the clinicians. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

The practice had gathered feedback from staff though formal staff meetings no longer took place and the management team acknowledged this should be re implemented. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. There was an open and no blame culture and staff felt supported to raise concerns. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan.

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 were supervised until they were able to work independently but written records of this were not kept.

The practice had completed reviews of significant events and other incidents and shared with staff via meetings and team away days to ensure the practice improved outcomes for patients.