

# Four Acre Health Centre

## 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?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Four Acre Health Centre.

We undertook a comprehensive inspection on 24th March 2015. We spoke with patients, staff and the practice management team.

Overall, the practice was rated as Good. A caring, effective, responsive and well- led service was provided that met the needs of the population it served. However, improvements were needed to demonstrate the practice was recruiting staff safely.

Our key findings were as follows:

- There were systems in place to protect patients from avoidable harm, such as from the risks associated with medicines and infection control. However,

improvements were needed to the recruitment of staff as the recruitment records did not demonstrate that all necessary checks were undertaken to demonstrate suitability for their roles.

- Patients care needs were assessed and care and treatment was being considered in line with best practice national guidelines. Staff were proactive in promoting good health and referrals were made to other agencies to ensure patients received the treatments they needed.
- Feedback from patients showed they were very happy with the care given by all staff. They felt listened to, treated with dignity and respect and involved in decision making around their care and treatment.
- The practice planned its services to meet the differing needs of patients. The practice encouraged patients to give their views about the services offered and made changes as a consequence.

# Summary of findings

- There was a clear leadership structure in place. Quality and performance were monitored, risks were identified and managed.

We saw an area of outstanding practice:-

- The practice had researched the support available in the community for patients experiencing poor mental health and as a consequence had set up a mental health advocacy project. This was a weekly two hour clinic that clinical staff could refer patients to. The main purpose being to signpost patients to appropriate community support services and to support patients during the gap of being referred to a specialist support service and waiting to be seen.

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

Importantly, the provider must:

- Take action to ensure its recruitment policy, procedures and arrangements are improved to ensure necessary employment checks are in place for all staff and the required information in respect of workers is held.

The provider should:

- Implement a more robust system for identifying and managing health and safety risks within the premises.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as requires improvement for providing safe services.

There were systems in place to protect patients from avoidable harm and abuse. Staff were aware of procedures for reporting significant events and safeguarding patients from risk of abuse. There were clear processes in place to investigate and act upon any incident and to share learning with staff to mitigate future risk. There were appropriate systems in place to protect patients from the risks associated with medicines and infection control. The staffing numbers and skill mix were reviewed to ensure that patients were safe and their care and treatment needs were met. However, improvements were needed to the recruitment of staff as the recruitment records did not demonstrate that all necessary checks were undertaken to verify suitability for their roles.

Requires improvement



### Are services effective?

The practice is rated as good for providing effective services.

Patients care needs were assessed and care and treatment was being considered in line with best practice national guidelines. There was good communication between staff and staff felt appropriately supported. Staff were proactive in promoting good health and referrals were made to other agencies to ensure patients received the treatments they needed. The practice monitored its performance and had systems in place to improve outcomes for patients. The practice worked with health and social care services to promote patient care.

Good



### Are services caring?

The practice is rated as good for providing caring services.

Patients were very positive about the care they received from the practice. They commented that they were treated with respect and dignity and that staff were caring, supportive and helpful. Patients felt involved in planning and making decisions about their care and treatment. Staff we spoke with were aware of the importance of providing patients with privacy. Patients were provided with support to enable them to cope emotionally with care and treatment.

Good



### Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



# Summary of findings

The practice planned its services to meet the differing needs of patients. They monitored the service to identify patient needs and service improvements that needed to be prioritised. Access to the service was monitored to ensure it met the needs of patients. The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint.

## Are services well-led?

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

There was a clear leadership structure in place. Quality and performance were monitored, risks were identified and managed. Staff told us they felt the practice was well managed with clear leadership from clinical staff and the practice manager. Staff told us they could raise concerns and felt they were listened to. The practice had systems to seek and act upon feedback from patients.

**Good**



# 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

The practice is rated as good for the care of older people. The practice was knowledgeable about the number and health needs of older patients using the service. They kept up to date registers of patients' health conditions and information was held to alert staff if a patient was housebound. Home visits were made to housebound patients as requested and to carry out reviews of their health. The practice ensured each person who was over the age of 75 had a named GP and a care plan where necessary. Every patient with a care plan had an alternative telephone number for the practice in case of emergencies. Patients over 75 were offered a community geriatric assessment which was available every week with the health care assistant and a GP. The practice worked with other agencies and health providers to provide support and access specialist help when needed.

Good



### People with long term conditions

The practice is rated as good for the care of people with long term conditions. The practice held information about the prevalence of specific long term conditions within its patient population such as diabetes, chronic obstructive pulmonary disease (COPD), cardiovascular disease and hypertension. This information was reflected in the services provided, for example, reviews of conditions and treatment, screening programmes and vaccination programmes. The practice had a system in place to make sure no patient missed their regular reviews for long term conditions and to follow up unplanned hospital admissions in a timely manner. The practice also maintained a register of housebound patients to ensure that they received a home visit to review any long term conditions. Clinical staff kept up to date in specialist areas which helped them ensure best practice guidance was always being considered. Multi-disciplinary team and palliative care meetings were held monthly where patient care was reviewed to ensure patients were receiving the support they required.

Good



### Families, children and young people

The practice is rated as good for the care of families, children and young people. A weekly postnatal and child health surveillance clinic and an immunisation programme were provided. The practice monitored any non-attendance of babies and children at child health and vaccination clinics and worked with the health visiting service to follow up any concerns. The staff were responsive to parents' concerns about their child's health and daily appointments

Good



# Summary of findings

were available to children with acute illnesses especially children under the age of five. Staff were knowledgeable about child protection and a GP took the lead for safeguarding. Staff put alerts onto the patient's electronic record when safeguarding concerns were raised. Regular liaison took place with the health visiting service to discuss any children who were at risk of abuse. The practice encouraged breast feeding and a private room was available for this if needed.

## **Working age people (including those recently retired and students)**

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice provided pre-bookable appointments during extended hours on Tuesday and Thursdays until 20:00 which provided flexibility to working patients and those in full time education. Daily appointments and pre-bookable appointments were available which were helpful for the recently retired. On line bookable appointments and on line prescription requests were available. A system was in operation which enabled temporary residents, such as students, to access medical care on a temporary basis until they returned to their registered GP. Health checks were offered to patients who were over 45 years of age to promote patient well-being and prevent any health concerns.

Good



## **People whose circumstances may make them vulnerable**

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice was aware of patients in vulnerable circumstances and ensured they had appropriate access to health care to meet their needs. For example, a register was maintained of patients with a learning disability and annual health care reviews were provided to these patients. Patients' electronic records contained alerts for staff regarding patients requiring additional assistance in order to ensure the length of the appointment was appropriate. The practice took part in the food bank voucher scheme. One of the staff oversaw the administration of these vouchers to patients in need of this support. Staff were knowledgeable about safeguarding vulnerable adults. They had access to the practice's policy and procedures and had received training in this.

Good



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

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). The practice had researched the support available in the community for patients experiencing poor mental health and as a consequence

Outstanding



# Summary of findings

had set up a mental health advocacy project. This was a weekly two hour clinic that clinical staff could refer patients to. The main purpose being to signpost patients to appropriate community support services and to support patients during the gap of being referred to a specialist support service and waiting to be seen. Two of the GPs specialised in acupuncture and hypnosis and offered this treatment to patients as an alternative to long term use of medication. GPs worked with other services to review care, implement new care pathways and share care with specialist teams. 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. Dementia screening tests were carried out. The practice referred patients to appropriate services such as psychiatry and counselling services. The practice had information for patients in the waiting areas to inform them of other services available. For example, for patients who may experience depression or those who would benefit from counselling services for bereavement.

# Summary of findings

## What people who use the service say

We looked at 37 CQC comment cards that patients had completed prior to the inspection and spoke with five patients. Patients were very positive about the care they received from the practice. They commented that they were treated with respect and dignity and that staff were caring, supportive and helpful. Patients we spoke with told us they had enough time to discuss things fully with the GP, treatments were explained, they felt listened to and they felt involved in decisions about their care.

The National GP Patient Survey in March 2014 found that 80% of patients at the practice stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern. Eighty seven percent of patients stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern. Seventy nine percent of patients described the overall experience of their GP surgery as fairly good or very good. Seventy three percent of practice respondents said the GPs were good or very good at involving them in decisions about their care and 79% felt the nurses were good or very good at involving them in decisions about their care. These responses were about average when compared to other practices nationally.

The National GP Patient Survey in March 2014 found that eighty percent of patients were very satisfied or fairly satisfied with opening hours. This response was average when compared to other practices. Thirty eight percent gave a positive answer to “Generally, how easy is it to get through to someone at your surgery on the phone.” This response was significantly below the national average when compared to other GP practices nationally. Ten of the 37 CQC comment cards completed by patients indicated they had experienced difficulty getting through to the practice by telephone. The practice had introduced measures to improve telephone access and they were working with St Helens Clinical Commissioning Group to develop a further solution to this issue.

The GPs sought feedback from patients as part of their appraisal process. We were shown the patient feedback gathered for one of the GPs. This indicated that patients felt the GP was polite, considerate, gave them enough time during consultations, put them at ease and involved them in decisions about their care.

## Areas for improvement

### Action the service **MUST** take to improve

- Take action to ensure its recruitment policy, procedures and arrangements are improved to ensure necessary employment checks are in place for all staff and the required information in respect of workers is held.

### Action the service **SHOULD** take to improve

- Implement a more robust system for identifying and managing health and safety risks within the premises.

## Outstanding practice

- The practice had researched the support available in the community for patients experiencing poor mental health and as a consequence had set up a mental health advocacy project. This was a weekly two hour clinic that clinical staff could refer patients to. The

main purpose being to signpost patients to appropriate community support services and to support patients during the gap of being referred to a specialist support service and waiting to be seen.

# Four Acre Health Centre

## 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.

## Background to Four Acre Health Centre

Four Acre Health Centre is based in the Clockface area of St Helens, Merseyside. The practice treats patients of all ages and provides a range of medical services. The staff team includes four GP partners, a practice nurse, a nurse clinician, a healthcare assistant, a practice manager and administrative and reception staff. The practice is a GP training practice and has GP registrars working for them as part of their training and development in general practice.

The practice is open from 08:30 to 18:00 Monday, Wednesday and Friday with extended hours on Tuesday and Thursday until 20:00. Patients can book appointments in person, on-line or by telephone. Patients can access a range of appointments with the GPs and nurses. Face to face appointments are available on the day and are also bookable up to 4 weeks in advance. Telephone consultations are offered where advice and prescriptions, if appropriate, can be issued and a telephone triage system is in operation where a patient's condition is assessed and clinical advice given. Home visits are offered to patients whose condition means they cannot visit the practice. The practice opts in to provide out of hours services via a consortium arrangement known locally as St Helen's Rota. They provide a service locally in St Helens.

The practice is part of St Helens Clinical Commissioning Group. It is responsible for providing primary care services

to approximately 7985 patients. The practice is situated in an economically deprived area. Sixty four percent of patients have a long standing health condition and 59% of patients have health related problems in daily life which are higher than the national average. A higher than the national average number of patients were claiming disability living allowance. The practice has a General Medical Services (GMS) contract.

The practice shares a building with community health care services such as podiatry, chiropody and health visiting. An improvement grant had been applied for to enable the practice to extend the premises and make more room for clinics and other services.

## 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.

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

# Detailed findings

## How we carried out this inspection

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care

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

Before our inspection we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We also reviewed policies, procedures and other information the practice provided before the inspection. This did not raise any areas of concern or risk across the five key question areas. We carried out an announced inspection on 24 March 2015.

We reviewed all areas of the practice including the administrative areas. We sought views from patients, looked at survey results and reviewed comment cards left for us on the day of our inspection. We spoke with the practice manager, registered manager, GPs, practice nurse, administrative staff and reception staff on duty.

We observed how staff handled patient information, spoke to patients face to face and talked to those patients telephoning the practice. We discussed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

# Are services safe?

## Our findings

### Safe Track Record

St Helens Clinical Commissioning Group and NHS England reported no concerns to us about the safety of the service. Clinical staff told us they completed incident reports and carried out significant event analysis in order to reflect on their practice and identify any training or policy changes required. We looked at a sample of significant event reports and saw that a plan of action had been formulated following analysis of the incidents.

Alerts and safety notifications from national safety bodies were dealt with by the clinical staff and the practice manager. Staff confirmed that they were informed about and involved in any required changes to practice or any actions that needed to be implemented. For example we could see the alert regarding the Ebola outbreak in Africa had been actioned and notices were on display in the waiting room.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring safety incidents. A protocol around learning and improving from safety incidents was available for staff to refer to. We looked at a sample of records of significant events that had occurred in the last 12 months. There was evidence that appropriate learning had taken place and that findings were disseminated to relevant staff. We noted that the action arising from one significant event that all GPs giving immunisations and vaccinations received training to update their skills and knowledge had not been addressed. Following our visit we were provided with a date on which all clinical staff will undertake this training.

Staff we spoke with told us they felt able to report significant events and that these incidents were analysed, learning points identified and changes to practice were made as a result. Staff were able to describe the incident reporting process and told us they were encouraged to report incidents. They told us they felt confident in reporting and raising concerns and felt they would be dealt with appropriately and professionally. Staff were able to describe how changes had been made to the practice as a result of reviewing significant events.

There was a central log/summary of significant events that would allow patterns and trends to be identified. We noted that a review of actions taken was not recorded to demonstrate that any actions taken had been appropriately implemented and successful.

### Reliable safety systems and processes including safeguarding

Staff had access to safeguarding policies and procedures produced by St Helens Clinical Commissioning Group for both children and vulnerable adults. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were available to staff on their computers and in hard copy. Staff had access to guidance flow charts and contact details for both child protection and adult safeguarding teams.

Staff we spoke with confirmed they had received training in safeguarding at a level appropriate to their role. Several reception/administrative staff were due for refresher training. The practice manager had identified this and was taking action to address it. Staff we spoke with demonstrated good knowledge and understanding of safeguarding and its application.

The practice had a dedicated GP as lead in safeguarding. They had attended appropriate training to support them in this role, as recommended by their professional registration safeguarding guidance. When the safeguarding lead was unable to attend safeguarding meetings they completed a report detailing the involvement of the practice in the patient's healthcare and any concerns identified. All staff we spoke to were aware of the lead and who to speak to in the practice if they had a safeguarding concern.

Regular liaison took place with the health visitor to discuss any children who were at risk of abuse and to review if an appropriate level of GP service had been provided. Codes and alerts were applied to the electronic case management system to ensure identified risks to children, young people and vulnerable adults were clearly flagged and reviewed. Staff were proactive in monitoring if children or vulnerable adults attended Accident and Emergency or missed appointments frequently. These were then brought to the GPs attention.

### Medicines Management

## Are services safe?

The GPs told us they re-authorised medicines in accordance with the needs of patients and a system was in place to highlight patients requiring medicines reviews. GPs worked with pharmacy support from the Clinical Commissioning Group (CCG) to review prescribing trends and medication audits.

We looked at how the practice stored and monitored emergency drugs and vaccines. Emergency drugs were in date and held securely. Vaccines were in date and organised with stock rotation evident. We saw the fridges were checked daily to ensure the temperature was within the required range for the safe storage of the vaccines. We spoke to staff who managed the vaccines and they told us that a cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was in place for the safe management of vaccines. They had a clear understanding of the actions they needed to take to keep vaccines safe. They had recently taken advice from the medicines management team about obtaining a device that can record daily fridge temperatures to further improve the monitoring of this medication.

Prescriptions were securely held. GPs bags contained all the necessary emergency medication that was in date and safe for use.

### Cleanliness & Infection Control

There was a current infection control policy with supporting processes and guidance which staff were able to easily access. There was a lead member of staff for infection control who had completed training relevant to this role and who attended regular infection control meetings with the Clinical Commissioning Group. Non-clinical staff had received in-house training in infection control which was being updated at the next practice learning day. The non-clinical staff we spoke with demonstrated general knowledge around infection control to support them in their role.

The patients we spoke with commented that the practice was clean and appeared hygienic. We looked around the premises and found them to be clean. The decoration in some areas of the building looked a little tired and we were informed that this had been identified for an improvement when the proposed extension took place. The treatment and consulting rooms, waiting areas and toilets seen generally supported good infection control practices.

Surfaces were intact, easy to clean and the premises were uncluttered. Some consulting rooms were carpeted and this was regularly cleaned. Staff had access to gloves and aprons and there were appropriate segregated waste disposal systems for clinical and non-clinical waste. We observed good hand washing facilities to promote good standards of hygiene. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms.

The practice carried out infection control audits with the last one undertaken in March 2015. This audit had been sent to the Clinical Commissioning Group and indicated that overall the practice was meeting effective infection control standards. An action plan had been put in place to address the shortfalls identified. A cleaning schedule was not being completed by the cleaners and this had been identified in the audit as an action to be addressed. Practice staff made checks of the premises to ensure cleaning was carried out to a satisfactory standard.

We were told the practice did not use any instruments which required decontamination between patients and that all instruments were for single use only. Checks were carried out to ensure items such as instruments, gloves and hand gels were available and in date. Procedures for the safe storage and disposal of needles and waste products were evident in order to protect the staff and patients from harm.

Legionella testing was carried out to ensure the safety of the water supply.

### 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. We were shown a certificate to demonstrate that equipment such as the weighing scales, spirometer and blood pressure machines had been tested and calibrated. All portable electrical equipment was routinely tested.

### Staffing & Recruitment

Staffing levels were reviewed to ensure patients were kept safe and their needs were met. In the event of unplanned absences staff covered from within the service. Duty rotas took into account planned absence such as holidays. GPs and the practice manager told us that patient demand was

## Are services safe?

monitored through the appointment system and staff and patient feedback to ensure that sufficient staffing levels were in place. We were told by staff that in the event of extremely busy periods of activity, changes were made to the service to ensure patient safety. For example, the practice had opened on a Saturday to meet the demands of high numbers of patients requiring flu vaccination.

The practice had a recruitment procedure. We found that this did not detail all the necessary checks to be undertaken to ensure the safe recruitment of staff. The procedure did not refer to undertaking identity checks, checking qualifications and professional registrations or carrying out Disclosure and Barring service (DBS), formerly Criminal Records Bureau (CRB) checks (these checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post).

We looked at the recruitment records of two reception/administrative staff who were the last two staff to be employed and we looked at the records of a GP and a nurse. We found that these records lacked organisation and some records were held electronically and some were in paper format. The practice manager had been in post for six months and they had identified shortfalls in the recruitment records that they were in the process of addressing. None of the records we looked at contained evidence of physical and mental fitness. No references were found in one of the reception/administrative member of staff's records. We found no information confirming identity on any records. The practice manager advised us that this information had been obtained but that it was not accessible on the day of our visit. Staff spoken with confirmed that they had supplied this information as part of their applications for DBS checks and NHS smartcards (these cards provide secure access to confidential information).

We found that there was no evidence of the four GP partners having received a DBS check. Following our visit evidence was provided that these checks had been requested. We also found there were no DBS checks in place for two administrative staff, these staff did not act as chaperones and following our visit a risk assessment was provided to us.

The professional registration of clinical staff was checked prior to appointment and there was a system in place to record checks of on going professional registration with the General Medical Council (GMC) and Nursing Midwifery Council (NMC).

### Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included medicines management, infection control, dealing with emergencies and monitoring the safety of equipment.

Health and safety information was displayed for staff to see around the premises. A health and safety policy and procedure was available. The practice manager was the lead for health and safety and these issues were discussed at staff meetings. The building was shared with Bridgewater Community Trust and some building checks had been organised by them and some were organised by the practice. The practice manager was new in post and had identified that a more co-ordinated approach was needed to be certain that all necessary building checks were undertaken. We saw that a health and safety audit had been undertaken in the last 12 months which had identified some acceptable and a few manageable risks. A record of whether the actions had been carried out had not been made. Checks were undertaken of the fire safety systems, however, the most recent periodic checks undertaken by the contractors were not available for inspection. Monthly checks of the emergency lighting were not recorded. Fire drills took place and the practice had designated fire Marshalls. The practice manager had arranged fire safety training to update all staff.

The practice used electronic record systems that were protected by passwords and smart cards on the computer system.

### Arrangements to deal with emergencies and major incidents

Emergency medicines were available and staff knew of their location. 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. The practice had access to oxygen in the event of an emergency and an automated external defibrillator (used to attempt to restart a person's heart in an emergency).

## Are services safe?

Staff told us they had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). Some staff were due for refresher training and records demonstrated that this had been organised. We noted that drills to test out the accessibility of emergency equipment and staff response times were not undertaken.

A disaster recovery and business continuity plan was in place. The plan included the actions to be taken following loss of building, loss of telephone system, loss of computer and electrical equipment and loss of utilities. Key contact numbers were included for staff to refer to.

Panic buttons were available for staff in treatment rooms and in the reception area for staff to call for assistance.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

Once patients were registered with the practice, the health care assistant carried out a health check which included reviewing information about the patient's individual lifestyle as well as their medical conditions. Patients were able to discuss their needs and to also be introduced to what services were available in order for patients to make best use of the practice. The health care assistant referred the patient to the GP when this was necessary or when a new patient had complex health needs.

Clinical staff we spoke with told us how they accessed best practice guidelines to inform their practice. Clinical staff attended regular training and educational events provided by the Clinical Commissioning Group and they had access to recognised good practice clinical guidelines, such as National Institute for Health and Care Excellence (NICE) guidelines on their computers. The GPs, nurses and health care assistant met to discuss new clinical protocols, review complex patient needs and keep up to date with best practice guidelines and relevant legislation.

The GPs used national standards for the referral of patients for tests for health conditions, for example patients with suspected cancers were referred to hospital and the referrals were monitored to ensure an appointment was provided within two weeks.

The practice nurse and nurse clinician managed specialist clinical areas such as diabetes, COPD (Chronic obstructive pulmonary disease) and asthma. This meant that the clinicians were able to focus on specific conditions and provide patients with regular support based on up to date information.

The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients with learning disabilities and those who were on the palliative care register.

### Management, monitoring and improving outcomes for people

The practice had systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. The practice kept up to date disease registers for patients with long term conditions such as asthma and

chronic heart disease which were used to arrange annual health reviews. They also provided annual reviews to check the health of patients with learning disabilities and patients on long term medication, for example for mental health conditions.

Clinical audits were carried out and the outcomes shared amongst all clinical staff. The Clinical Commissioning Group (CCG) pharmacist worked with clinical staff to ensure medication was effectively managed. This included carrying out audits of medication to ensure prescribing met patients' needs.

The practice worked with the Clinical Commissioning Group (CCG) to monitor and improve outcomes for patients. The GPs told us about how they worked with other local practices and the CCG to identify patient needs and to work on solutions to address them.

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system for the performance management of GPs intended to improve the quality of general practice and reward good practice. QOF data from 2013/2014 showed the practice was performing about average when compared to other practices nationally. The practice performed better than average in maintaining a register for patients with a learning disability, a register of all patients in need of palliative care/support and having regular multidisciplinary reviews of patients on the palliative care register.

The GPs and nurses had key roles in monitoring and improving outcomes for patients. These roles included managing long term conditions, safeguarding and palliative care. The practice had been awarded three Practice Team Awards in October 2013 and October 2013 by the Royal College of General Practitioners Mersey Faculty. These were for Benzodiazepine prescription reduction, screening for early signs of Dementia and for proactive care in Diabetes for housebound patients.

Multi-disciplinary team and palliative care meetings were held monthly where patient care was reviewed to ensure patients were receiving the support they required. These meetings included the district nursing team, community matrons, health improvement team, health visiting team and Macmillan services.

### Effective staffing

# Are services effective?

## (for example, treatment is effective)

An appraisal policy was in place. Staff were offered annual appraisals to review performance and identify development needs for the coming year. We spoke to four reception/administrative staff who told us the practice was supportive of their learning and development needs. They said they had received an appraisal in the last 12 months and that a personal development plan had been drawn up as a result which identified any training needed.

We spoke to three GPs and the practice nurse who told us they had annual appraisals and we saw records to demonstrate that they undertook training/learning to inform their practice. GPs told us they had protected learning time and met with their external appraisers to reflect on their practice, review training needs and identify areas for development. Revalidations had taken place. Revalidation is the process by which all registered doctors have to demonstrate to the General Medical Council (GMC) that their knowledge is up to date, they are fit to practise and are complying with the relevant professional standards.

The staff we spoke with told us they felt well supported in their roles. Clinical and non-clinical staff told us they worked well as a team and had good access to support from each other. Regular developmental and governance meetings took place to share information, look at what was working well and where any improvements needed to be made. For example, the practice closed one afternoon per month for in-house developmental meetings or to enable staff to attend external training events. The clinical staff met weekly to discuss new protocols, to review complex patient needs and keep up to date with best practice guidelines. The practice manager met with the reception/administrative staff every 6-8 weeks which was an opportunity to identify any support staff needed in their day to day roles.

A training matrix was maintained that identified training undertaken. However, this was not dated and all training undertaken was not recorded which meant it was difficult to determine when staff needed refresher training. The practice manager had identified that some staff needed refresher training in mandatory areas such as CPR, information governance and infection control. Training had been scheduled to address this. Training records and/or a discussion with clinical and non-clinical staff indicated they generally had the training they needed to support them in their roles. We noted that the action arising from one

significant event that all GPs giving immunisations and vaccinations received training to update their skills and knowledge had not been addressed. Following our visit we were provided with a date on which all clinical staff will undertake this training. We noted a good skill mix among the doctors with each having special interests in different fields of general practice.

### Working with colleagues and other services

The practice worked with other agencies and professionals to support continuity of care for patients. Staff described how the practice provided the 'out of hours' service with information, to support, for example 'end of life care.' There were processes in place to ensure that information received from other agencies, such as A&E or hospital outpatient departments were read and actioned in a timely manner. GPs described how blood result information would be sent through to them and the system in place to respond to any concerns identified. There was a system in place to identify patients at risk of unplanned hospital admissions and to follow up the healthcare needs of these patients.

Multi-professional working took place to support patients and promote their welfare. Clinical staff met with and liaised with health visitors, district nurses, Macmillan nurses and social workers to discuss any concerns about patient welfare and identify where further support may be required. The district nursing team and health visiting team were based in the same building as the practice which assisted good communication.

GPs were invited to attend reviews of patients with mental health needs and child and vulnerable adult safeguarding conferences, when they were unable to attend these meetings they provided a report detailing their involvement with the patient. Multi-disciplinary team and palliative care meetings were held monthly where patient care was reviewed to ensure patients were receiving the support they required.

The practice had set up a mental health advocacy group and invited community services into the practice to provide information to patients.

### Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage

# Are services effective?

## (for example, treatment is effective)

patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the computer system for future reference. All members of staff were trained on the system, and could demonstrate how information was shared.

The practice had systems in place to communicate with other providers. For example, there was a system for communicating with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. Electronic and paper systems were in place for making referrals on to other health care services.

The practice was implementing the electronic Summary Care Record and information was available for patients to refer to (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

### Consent to care and treatment

The practice had a consent to treatment policy which set out how patients were involved in their treatment choices so that they could give informed consent. The policy identified where best interest decisions may need to be made in line with the Mental Capacity Act 2005 when someone may lack capacity to make their own decisions. The GPs spoken with were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. They understood the key parts of the legislation and were able to describe how they would implement it in their practice. They also 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). Patients completed consent forms for minor surgical procedures. Clinical staff told us that verbal consent for immunisations and vaccinations was recorded in patient notes.

### Health Promotion & Prevention

The practice supported patients to manage their health and well-being. The practice offered national screening

programmes, vaccination programmes, children's immunisations, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets in the waiting area about the services available.

The practice monitored how it performed in relation to health promotion. It used the information from Quality and Outcomes Framework (QOF) and other sources to identify where improvements were needed and to take action. QOF is a national performance measurement standard. For example, as a result of identifying that the number of patients receiving cervical screening could be improved, late evening services were provided and information advertising this service was made available for patients. Similarly, in order to improve hypnotic and antibacterial prescribing the practice had developed an action plan.

Quality and Outcomes Framework (QOF) information showed the practice was meeting its targets regarding health promotion and ill health prevention initiatives. For example, in providing diabetes checks, flu vaccinations to high risk patients and providing other preventative health checks/screening of patients with physical and/or mental health conditions.

New patients registering with the practice completed a health questionnaire and were given a new patient medical appointment. This provided the practice with important information about their medical history, current health concerns and lifestyle choices. This ensured the patients' individual needs were assessed and access to support and treatment was available as soon as possible.

The practice identified patients who needed on-going support with their health. The practice kept up to date disease registers for patients with long term conditions such as diabetes, asthma and chronic heart disease which were used to arrange annual health reviews. The practice also kept registers of vulnerable patients such as those with mental health needs and learning disabilities and used these to plan annual health checks.

# Are services caring?

## Our findings

### Respect, Dignity, Compassion & Empathy

We looked at 37 CQC comment cards that patients had completed prior to the inspection and spoke with five patients. Patients were very positive about the care they received from the practice. They commented that they were treated with respect and dignity and that staff were caring, supportive and helpful. Patients we spoke with told us they had enough time to discuss things fully with the GP, treatments were explained and that they felt listened to.

The National GP Patient Survey in March 2014 found that 80% of patients at the practice stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern. Eighty seven percent of patients stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern. Seventy nine percent of patients who responded to this survey described the overall experience of their GP surgery as fairly good or very good. These responses were about average when compared to other practices nationally.

The GPs sought feedback from patients as part of their appraisal process. We were shown the patient feedback gathered for one of the GPs. This indicated that patients felt the GP was polite, considerate, gave them enough time during consultations and put them at ease.

We observed that privacy and confidentiality were maintained for patients using the service on the day of the visit. Staff we spoke with were aware of the importance of providing patients with privacy. They told us there was an area available if patients wished to discuss something with them away from the reception area. The telephones were answered in a room behind the reception area which promoted patient privacy and confidentiality.

We observed that consultation / treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity were maintained during examinations, investigations and treatments.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

### 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 rated the practice well in these areas. For example, data from the National GP Patient Survey in March 2014 showed 73% of practice respondents said the GPs were good or very good at involving them in decisions about their care and 79% felt the nurses were good or very good at involving them in decisions about their care.

Patients we spoke with told us that health issues were discussed with them, treatments were explained, they felt listened to and they felt involved in decision making about the care and treatment they received.

We looked at the patient feedback gathered for one of the GPs as part of their appraisal process. This indicated that patients felt the GP involved them in decisions about their care by explaining risks, encouraging the patients to ask questions and by giving clear explanations.

### Patient/carer support to cope emotionally with care and treatment

Information about the support available to patients to help them to cope emotionally with care and treatment was on display in the waiting area. This included, information about the Citizen's Advice Bureau, advocacy services, mental health support services and bereavement services. GPs and nursing staff were able to refer patients on to counselling services. There was a carer's noticeboard providing information for carers about the various avenues of support available to them.

Staff spoken with told us that bereaved relatives known to the practice were offered support following bereavement. GPs and the practice nurse were able to refer patients on to counselling services.

The practice took part in the food bank voucher scheme. One of the staff oversaw the administration of these vouchers to patients in need of this support.

The practice had set up a mental health advocacy project. This was a weekly two hour clinic that clinical staff could refer patients to. The main purpose being to signpost patients to appropriate community support services and to

## Are services caring?

support patients during the gap of being referred to a specialist support service and waiting to be seen. The project had been nominated by the CCG for an innovative idea award.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The clinical staff told us how they engaged with St Helens Clinical Commissioning Group (CCG) to address local needs and service improvements that needed to be prioritised. The practice had assessed the needs of its patient population and tailored the services provided to meet these needs. For example, the practice was aware from feedback from national prescribing indicators that their prescribing of hypnotic medication was high. Two of the GPs had been trained in providing hypnosis and one in acupuncture. This treatment was provided to patients who would benefit from this as a possible alternative to using certain medications, such as hypnotics. The practice was planning to audit the effectiveness of this alternative treatment in reducing prescribing of hypnotic medications.

The practice had researched the support available in the community for patients experiencing poor mental health and as a consequence had set up a mental health advocacy project. This was a weekly two hour clinic that clinical staff could refer patients to. The main purpose being to signpost patients to appropriate community support services and to support patients during the gap of being referred to a specialist support service and waiting to be seen.

There was a proactive response to patient discharges from hospital. A system had been put in place to review discharge letters/summaries promptly, carry out identified actions or forward these for relevant staff to undertake. All patients received a courtesy call from the practice to ensure any issues identified had been attended to, for example, a change to medication. We were told that this process has now been adopted by the CCG.

The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions. The practice was proactive in contacting patients who failed to attend vaccination and screening programmes.

Referrals for investigations or treatment were mostly done through the "Choose and Book" system which gave

patients the opportunity to decide where they would like to go for further treatment. Administrative staff monitored referrals to ensure all referral letters were completed in a timely manner.

Multi-disciplinary team and palliative care meetings were held monthly where patient care was reviewed to ensure patients were receiving the support they required. These meetings included the district nursing team, community matrons, health improvement team, health visiting team and Macmillan services.

The practice offered patients a chaperone prior to any examination or procedure. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Staff we spoke with said they had received sufficient training around carrying out this role.

The practice had an active Patient Forum. The purpose of the Patient Forum was to meet with practice staff to review the services provided, develop a practice action plan, and help determine the commissioning of future services in the neighbourhood. Records showed how the Patient Forum had been consulted over the type of questions to include in the patients survey. Records also showed how the Patient Forum had worked with the practice to make improvements to access to services and communication with patients.

### Tackling inequity and promoting equality

The practice provided disabled access in the reception and waiting areas, as well as to the consulting and treatment rooms. There was disabled car parking available. A disabled toilet was available, following feedback from the Patient Forum the practice manager was going to assess this facility to ensure it fully met the needs of patients. An audio induction loop was available for patients with reduced ranges of hearing. There were baby changing facilities and a room could be made available for breast feeding mothers.

Staff were knowledgeable about interpreter services for patients where English was not their first language. Information about interpreting services was available in the waiting area. The practice information leaflet was available in braille and audio format.

Patients' electronic records contained alerts for staff regarding patients requiring additional assistance in order

# Are services responsive to people's needs?

## (for example, to feedback?)

to ensure the length of the appointment was appropriate. For example, if a patient had a learning disability then a double appointment was offered to the patient to ensure there was sufficient time for the consultation. Annual health reviews were carried out in a patient's home in accordance with their needs.

### Access to the service

The practice was open from 08:30 to 18:00 Monday, Wednesday and Friday with extended hours on Tuesday and Thursday until 20:00. Patients could book appointments in person, on-line or by telephone. Patients could access a range of services with the GPs and nurses. Face to face appointments were available on the day and were also bookable up to 4 weeks in advance. Telephone consultations were offered where advice and prescriptions, if appropriate, could be issued and a telephone triage system was in operation where a patient's condition was assessed and clinical advice given. Home visits were offered to patients whose condition meant they could not visit the practice. Priority was given to children, babies and vulnerable patients identified as at risk due to their condition and these patients were always prioritised for an appointment. The practice had opted in to provide out of hours services via a consortium arrangement known locally as St Helen's Rota. They provided a service locally in St Helens.

The National GP Patient Survey in March 2014 found that 80% of patients were very satisfied or fairly satisfied with opening hours. Thirty eight percent rated their ability to get through on the telephone easy or very easy which was worse than the national average.

We looked at 37 CQC comment cards that patients had completed prior to the inspection. Ten comment cards indicated that patients had experienced a problem trying to get through to the service by telephone. We spoke with five patients. They all said they were able to get an

appointment when one was needed but that they had experienced problems with getting through to the practice by telephone. Patients said they were generally satisfied with arrangements for repeat prescriptions and that if a referral to another service was needed this had been done in a timely manner.

Discussions with the practice manager and records showed that the practice was aware of the difficulties patients were experiencing when trying to contact the practice by telephone. The practice was working with St Helens CCG to resolve this issue.

Patient demand was monitored through the appointment system and staff and patient feedback. Changes were being introduced to the appointment system in April 2015 to further improve access to appointments. An improvement grant had been applied for to enable the practice to extend the premises and make more room for clinics and other services.

### Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The complaint policy and procedure were available in the reception area. Reference was made to how to make a complaint and the complaint policy on the practice's website and in the patient information leaflet. The policy included contact details for the Patient Advisory Liaison Service (PALS) and the Health Service Ombudsman, should patients wish to take their concerns outside of the practice. We noted that contact details for NHS England were not included.

We looked at the record of complaints and found documentation to record the details of the concerns raised and the action taken. Staff we spoke with were knowledgeable about the policy and the procedures for patients to make a complaint.

# 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 a clear vision and ethos that included providing a high quality service, ensuring patients were respected and involved in their healthcare, ensuring that patients were seen by the most appropriate healthcare professional as quickly as possible and ensuring that all members of the practice had the right skills and training to carry out their duties competently. We did not find that the vision or a mission statement was displayed for staff and patients to see. However, the practice had a statement of purpose that included the aims and objectives of the service and was available if requested. Staff we spoke with were able to articulate the vision and values of the practice.

### Governance Arrangements

Meetings took place to share information, look at what was working well and where any improvements needed to be made. The clinical staff and practice manager met weekly to discuss new protocols, to review complex patient needs and keep up to date with best practice guidelines. The practice manager met with the reception/administrative staff every 6-8 weeks and had a plan to introduce more regular meetings. The partners and the practice manager met once a month to discuss the operation of the practice and any actions needed to improve the operation of the service.

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically or in a paper format. Staff told us that they each had an individual folder with policies and procedures and useful telephone numbers. The practice manager had reviewed a number of policies and procedures since coming in to post and she was working on any further reviews needed. We looked at a sample of policies and procedures and found that they were up to date.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The GPs spoken with told us that QOF data was regularly discussed and action plans were produced to maintain or improve outcomes.

The practice had completed clinical audits to evaluate the operation of the service and the care and treatment given. A discussion with the GPs showed improvements had been made to the operation of the service and to patient care as a result of the audits undertaken.

The practice had systems in place for identifying, recording and managing risks. We looked at examples of significant incident reporting and actions taken as a consequence. Staff told us that the outcome of significant incidents and complaints and how they were to be learned from were discussed at staff meetings to ensure that any actions were implemented by all necessary staff.

### Leadership, openness and transparency

There was a leadership structure in place and clear lines of accountability. Staff had specific roles within the practice, for example, safeguarding and infection control and clinical staff took the lead for different patient groups, for example, mental health and long term conditions. We spoke with 10 members of staff and they were all clear about their own roles and responsibilities. They all told us that they felt valued and well supported.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings or as they occurred with the practice manager or one of the GPs. Staff told us they felt the practice was well managed with clear leadership from clinical staff and the practice manager. Staff told us they could raise concerns and felt they were listened to. Regular governance meetings took place to share information, look at what was working well and where any improvements needed to be made.

We reviewed a number of human resource policies and procedures that were available for staff to refer to, for example, the induction, sickness and absence and disciplinary procedures. These procedures were available for staff in a handbook. A whistle blowing policy and procedure was available and staff spoken with were aware of the process to follow.

### Practice seeks and acts on feedback from users, public and staff

Patient feedback was obtained through carrying out surveys, reviewing the results of national surveys, comments and suggestions forms located in the patient waiting area and through the complaint procedure.

# Are services well-led?

Good 

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

The practice had a Patient Forum. The purpose of the Patient Forum was to meet with practice staff to review the services provided and help determine the commissioning of future services in the neighbourhood. Surveys sent by the practice were discussed and agreed with the Patient Forum and an action plan devised with them. The last patient survey was carried out in March 2014 and focussed on access and communication with the practice. Records showed that an action plan had been put in place to improve patient access and communication following the results of the survey, for example by increasing the number of mobile telephone numbers held to allow reminders to be sent and to decrease the amount of DNA (did not attend) appointments.

We met with representatives of the Patient Forum who told us they met every three months. They told us that a number of improvements had been identified for the practice such as upgrading the telephone system, introducing TV screens in the waiting area and improving the appointment system. They said they felt they were listened to and that their opinions mattered.

A leaflet was on reception and handed out to patients encouraging them to access and participate in the NHS friends and family test. The NHS friends and family test (FFT) is an opportunity for patients to provide feedback on the services that provide their care and treatment. It was available in GP practices from 1 December 2014. Results for

January 2015 showed that 181 out of 211 patients were “extremely likely” or “likely” to recommend the practice. Results for February 2015 showed that 16 out of 19 patients were “extremely likely” or “likely” to recommend the practice.

Staff told us they felt able to give their views at practice meetings. Staff told us they could raise concerns and felt they were listened to.

## **Management lead through learning & improvement**

Clinical and non-clinical staff told us they worked well as a team and had good access to support from each other. Regular developmental and governance meetings took place to share information, look at what was working well and where any improvements needed to be made. Staff told us the practice was supportive of their learning and development needs and that they felt well supported in their roles. Staff were offered annual appraisals to review performance and identify development needs for the coming year. Procedures were in place to record incidents, accidents and significant events and to identify risks to patient and staff safety. There was evidence that appropriate learning had taken place, that findings were disseminated to relevant staff and that generally appropriate action had been taken to respond to any safety concerns.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed  Patients were not protected against the risks associated with unsuitable staff because the provider did not ensure that information specified in Schedule 3 was available for all staff employed.
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	