Central Park Medical Centre - SK Mukherjee (Senior Partner)

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Central Park Medical Centre - SK Mukherjee (Senior Partner) which is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on 07 January 2015 at the practice location in Victoria Health Centre. We spoke with patients, staff and the practice management team.

The practice was rated as Good. A safe, caring, effective, responsive and well- led service was provided that met the needs of the population it served.

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 cross infection.
- 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 overall happy with the care given by all staff. They felt listened to, treated with dignity and respect and had confidence in the GPs and nurses. Patients felt involved in decision making around their care and treatment.
- The practice planned its services to meet the differing needs of patients. The appointment system in place allowed good access to the service. The practice encouraged patients to give their views about the services offered and made changes as a consequence
- There was a clear leadership structure in place. Quality and performance were monitored, risks were identified and managed. The practice ensured that staff had access to learning and improvement opportunities.

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 safe. 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 cross infection. The staffing numbers and skill mix were reviewed to ensure that patients were safe and their care and treatment needs were met.

Are services effective?

Good

The practice is rated as good for effective. Patients care needs were assessed and care and treatment was being considered in line with best practice national guidelines. Staff were provided with the training needed to carry out their roles and they were 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.

Are services caring?

Good

The practice is rated as good for caring. We looked at 22 CQC comment cards that patients had completed prior to the inspection and spoke with four patients. Patients were positive about the care they received from the practice. They commented that they were treated with respect and dignity, 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.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. 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. The practice was accessible for people with a physical disability. Staff were knowledgeable about interpreter

Summary of findings

services for patients where English was their second language. Patients reported good access to the service. The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint.

Are services well-led?

Good

The practice is rated as good for well led. 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 using the service. A patient reference group (PRG) was in operation and members of the group told us how the practice had been improved following patient feedback.

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. 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. The practice had a record of carers and used this information to discuss any support needed and to refer carers on to other services if necessary. The practice offered extended hours appointments to enable working carers to accompany older patients to appointments. The practice ensured each person who was over the age of 75 had a named GP. The practice worked with other agencies and health providers to provide support and access specialist help when needed. The practice had identified all patients at risk of unplanned hospital admissions and a care plan had been developed to support them.

People with long term conditions

Good

The practice is rated as good for the population group 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), cardio vascular 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 from a nurse at the practice to review any long term conditions. Clinical staff kept up to update in specialist areas which helped them ensure best practice guidance was always being considered. The practice had identified all patients at risk of unplanned hospital admissions and a care plan had been developed to support them. The practice had achieved and implemented the gold standards framework for end of life care. One of the GPs took the lead for this group of patients. They had a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice provided medical advice to a local children's hospice and supported the training for the staff at the hospice.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Child health surveillance and immunisation clinics were run on a weekly basis. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns. The staff were very responsive to parents' concerns and ensured parents could readily bring children who appeared unwell into the practice to be seen. 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 meetings were held with the health visiting service to discuss any children who were at risk of abuse and to review if all necessary GP services had been provided.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age people (including those recently retired and students). The practice was open Monday to Friday from 08:00 – 20.00 which provided flexibility to working patients and those in full time education. We found the practice had a range of appointments available including pre-bookable, on the day and telephone consultations. Staff told us they would try to accommodate patients who were working to have early or late appointments wherever possible. Appointments could be booked and repeat prescriptions ordered on line. The practice monitored patient satisfaction with access to the service through patient feedback. Patient feedback indicated patients were satisfied with the range of appointments available. Health checks were being offered to patients who were 40 – 74 years of age to promote patient well-being and prevent any health concerns.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group 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. Staff were knowledgeable about interpreter services for patients where English was their second language. Patients' electronic records contained alerts for staff regarding patients requiring additional assistance in order to ensure the length of the appointment was appropriate. For example, if a patient required interpreting services or had a learning disability then a double appointment was offered

to the patient to ensure there was sufficient time for the consultation. Staff told us they would ensure homeless people received urgent and necessary care. They were aware of local support services for the homeless to which patients could be signposted. The practice was the medical advisor for a local homeless shelter. Staff were knowledgeable about safeguarding vulnerable adults. They had access to the practice's policy and procedures and had received training in this.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). 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. The practice referred patients to appropriate services such as psychiatry and counselling services. Referrals were made to Child and Adolescent Mental Health Services (CAHMS) to support younger patients. 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. One of the partners at the practice had developed the Patients Aid and Caring Team in 1991 which provided support to patients who had been bereaved, terminally ill or over 75. In 1999 a Beacon Award (an award given to highlight best practice and innovation in philanthropy) was given to this service and in 2006 this service was awarded the Queens Award for voluntary service.

Summary of findings

What people who use the service say

We looked at 22 CQC comment cards that patients had completed prior to the inspection and spoke with four patients. Patients were very positive about the care they received from the practice. They commented that they were treated with respect and dignity, 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, involved in decisions about their care and they were happy with the system for booking appointments.

The National GP Patient Survey in March 2014 found that 94% 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. Ninety eight 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. These responses were better than average responses when compared to other practices nationally. Ninety one percent of patients who responded to this survey described the overall experience of their GP surgery as fairly good or very good. Eighty nine percent of patients said the GPs were good or very good at involving them in decisions about their care and 94% felt the nurses were good or very good at involving them in decisions about their care.

We looked at the results of the last patient survey undertaken by the practice in February 2014. Three hundred and seventy three surveys were completed and the results showed that a high percentage were satisfied with the service provided. Patients indicated satisfaction with the appointment system with 98% being able to book a date and time that was suitable. Sixty seven percent of patients said they saw a GP/nurse of their choice. Thirty six percent said the phone was often engaged when they tried to book an appointment. The practice was aware of an on going issue with the telephone system and had taken steps to mitigate the impact of this on patients. The practice was working with Wirral NHS Community Trust to find a solution to this issue.

Central Park Medical Centre - SK Mukherjee (Senior Partner)

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and the team included a GP and a practice manager.

Background to Central Park Medical Centre - SK Mukherjee (Senior Partner)

Central Park Medical Centre - SK Mukherjee (Senior Partner) is based in Victoria Central Health Centre in the Wallasey area of Wirral. The practice merged with Mill Lane Surgery in 2013. The practice treats patients of all ages and provides a range of medical services. The staff team includes five GP partners and a non-clinical executive partner, a further seven GPs, a practice nurse manager, seven practice nurses, two healthcare assistants, a practice manager, an assistant practice manager, office and reception managers 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 also a location for clinical placement for medical students.

The practice is open Monday to Friday from 08:00 until 20:00. Patients can book appointments in person, by telephone or on-line. Patients can book urgent appointments, appointments for the next working day or up to weeks in advance for routine appointments. Telephone consultations are available and home visits are offered to patients whose condition means they cannot visit the practice. When the practice is closed patients access the GP out-of-hours provider operated by Wirral Community NHS Trust.

The practice is part of NHS Wirral Clinical Commissioning Group. It is responsible for providing primary care services to approximately 10,800 patients. The practice is situated in an economically mixed area with some areas of affluence and some deprived areas. The majority of the practice population are between the ages of 15 – 64 with 40.19% between the ages of 15 – 44 years. Seven percent of patients are from a black and minority ethnic population. The practice has a Primary Medical Services (PMS) contract.

The practice shares a building with a number of community services such as chiropody, physiotherapy, health trainer service and counselling 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.

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 07 January 2015.

We reviewed all areas of the practice, including the administration areas. We sought views from patients via comment cards, talking to patients at the practice and telephone interviews following the inspection. During our visit we spoke with five GPs, the non-clinical executive partner, the practice nurse manager, a practice nurse, the practice manager, four administrative/reception staff and with two members of the patient reference group.

Good

Are services safe?

Our findings

Safe Track Record

NHS Wirral Clinical Commissioning Group and NHS England reported no concerns to us about the safety of the service. GPs told us they completed incident reports and carried out significant event analysis as part of their on going professional development in order to reflect on their practice and identify any training or policy changes required. These were shared within the practice. We looked at a sample of significant event reports and saw that significant event were appropriately analysed, a plan of action had been formulated following analysis of the incidents and appropriate action taken.

Staff were able to describe the incident reporting process and were encouraged to report in an open, no blame culture. 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 operation of the practice as a result of reviewing significant events and complaints.

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.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring safety incidents. Staff told us and we saw evidence that significant events, incidents and complaints were investigated and reflected on by the clinical staff and non-clinical staff as appropriate. Records showed that significant events were discussed at weekly clinical meetings and at monthly governance meetings.

Staff we spoke with told us they felt able to report significant events and that these incidents were analysed and learned from and changes to practice were made as a result. For example, following the analysis of an incident of a patient being verbally aggressive in the reception area, reception staff were reminded of the need to inform patients of possible delays in appointment times. Following the analysis of an incident where emergency medication was needed the system for accessing emergency medication had been reviewed.

A protocol around learning and improving from safety incidents was available for staff to refer to. A central log/ summary of significant events was maintained that would allow patterns and trends to be easily identified and enable a record to be made of actions undertaken and reviewed.

Reliable safety systems and processes including safeguarding

Staff had access to safeguarding procedures for both children and vulnerable adults. These provided staff with information about identifying, reporting and dealing with suspected abuse. We saw that staff had access to contact details for both child protection and adult local authority safeguarding teams.

Records and staff we spoke with confirmed they had received training in safeguarding at a level appropriate to their role. Staff we spoke with demonstrated good knowledge and understanding of safeguarding and its application.

One of the GPs took the lead for safeguarding. They attended regular meetings with the safeguarding lead from the commissioning organisation. This established link meant that advice and guidance could be easily sought as needed. Staff put alerts onto the patient's electronic record when safeguarding concerns were raised. Regular meetings were held with the health visiting service to discuss any children who were at risk of abuse and to review if all necessary GP services had been provided. 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.

We found that there were systems and processes in place to keep patients safe. This included systems and processes around infection prevention and control, medicines management, equipment and building maintenance. A chaperone policy was on display in the waiting area that advised patients that this service could be requested at reception.

Medicines Management

There were systems in place for medicine management. Annual reviews of medication for patients took place. The GPs re-authorised repeat medication on a six monthly basis

or more frequently if necessary. A system was in place to ensure that any changes made to medication by the out of hours service or following hospital discharge were actioned without a delay.

GPs worked with pharmacy support from the Clinical Commissioning Group (CCG) to review prescribing trends and medication audits. GPs reviewed their prescribing practices as and when medication alerts were received and in accordance with good practice guidelines.

We looked at how the practice stored and monitored emergency drugs and vaccines, to ensure patients received medicines that were in date and ready to use. Vaccines were securely stored and 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 use of the vaccines. 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 and a recent cold chain audit had been undertaken and identified no concerns.

Emergency drugs were listed and checked to ensure they were in date and ready to use. The emergency drugs were stored in a locked cupboard in an area which gave easy but secure access to staff. Prescription pads and repeat prescriptions were stored securely.

Cleanliness & Infection Control

There was a current infection control policy with supporting policies and guidance. We found that clinical staff had completed training in infection control relevant to their role. The reception/administrative staff were due to have this training refreshed and the practice manager had made arrangements to address this. Staff we spoke with were able to describe their own roles and responsibilities in relation to infection control. The practice nurse manager was the lead for infection control and had undertaken training to support her in this role.

The four 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 treatment rooms, waiting areas and toilets were in good condition and supported infection control practices. Surfaces were intact, easy to clean and the premises were uncluttered. 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 premises were leased from Wirral Community Trust who carried out an infection control audit in July 2014. This showed that overall the practice was providing effective infection control measures. An action plan had been put in place to address the shortfalls identified. We found that regular infection control audits were not undertaken by the practice. These should be undertaken to ensure that good infection control practices are continually promoted.

A cleaning schedule was in place and a log of cleaning works undertaken was maintained. We noted that a record had not been made of when some blinds and carpets had been cleaned. A plan was in place to replace carpets in GP consultation rooms to further promote good infection control practices.

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 gel 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.

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, vaccine fridge, thermometers and blood pressure machines had been tested and calibrated. All portable electrical equipment was routinely tested.

Staffing & Recruitment

The practice had a procedure for the safe recruitment of staff. This included guidelines about seeking references, checking qualifications/clinical registration, checking an applicants physical and mental fitness and obtaining Disclosure and Barring service (DBS), formerly Criminal

Good

Are services safe?

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 a sample of recruitment files for two GPs, the non clinical executive partner and three reception and administrative staff. We found that the recruitment procedure had in general been followed and the required checks had been undertaken to show the applicants were suitable for their posts. We noted that a record of the physical and mental fitness for one member of staff had not been carried out.

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

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. Reception and administrative staff were multi-skilled which meant they could cover each others duties if necessary. Clinical leads and the practice manager had an identified member of staff who could cover their absence. Duty rotas took into account planned absence such as holidays. Staff we spoke with felt staffing levels and the skill mix of staff were appropriate and met the needs of the service and patients. GPs and the practice manager told us that patient demand was monitored through the appointment system and staff and patient feedback to ensure that sufficient staffing levels were in place.

The practice had other systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the fire fighting equipment, medicines management, 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.

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 two automated external defibrillators(used to attempt to restart a person's heart in an emergency). Records showed that checks were made of the defibrillators to ensure they were working and ready to use.

Staff told us they had up to date training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). Samples of training certificates confirmed that this training was up to date. 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.

The building was leased from Wirral NHS Community Trust. The buildings manager ensured that checks were undertaken of the fire safety systems. Panic buttons were available for staff in the treatment rooms and in the reception area for staff to call for assistance.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

GPs and nurses attended weekly clinical meetings. These meetings provided the opportunity to discuss new clinical protocols, review complex patient needs and keep up to date with best practice guidelines and relevant legislation. GPs from other practices attended these meetings and consultants were invited to provide updates in their specialist areas. Clinical staff we spoke with told us how they accessed best practice guidelines to inform their practice, for example, they had access to National Institute for Health and Care Excellence (NICE) guidelines on their computers. GPs and nursing staff also attended training and educational events provided by the Clinical Commissioning Group.

GPs we spoke with 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. We found that audits of referrals were regularly undertaken to ensure that referrals were being completed in a timely manner that protected the welfare of patients.

GPs specialised and lead in clinical areas such as prescribing, terminal illness and anticoagulation. They also specialised and took the lead with different patient groups such as learning disability, dementia, child health and maternity. Staff meetings and other clinical meeting minutes demonstrated that staff discussed patient treatments and care and this supported staff to continually review and discuss new best practice guidelines. We observed a clinical multi-disciplinary meeting at which the needs of patients and their relatives were considered.

The practice nurses managed specialist clinical areas such as diabetes, heart disease and asthma. This meant they were able to focus on specific conditions and provide patients with regular support based on up to date information. Nurses met with nurses from other practices which assisted them in keeping up to date with best practice guidelines and current legislation.

The practice provided a service for all age groups. They provided services for patients in the local community with diverse cultural and ethnic needs, patients with learning disabilities, patients living in deprived areas and care homes and for patients experiencing poor mental health. We found GPs and nursing staff were familiar with the needs of patients and the impact of the socio-economic environment. For example, the practice had access to language translator services and provided health promotion services in accordance with the needs of patients.

Management, monitoring and improving outcomes for people

There were systems in place to evaluate the operation of the service and the care and treatment given. The practice had a system in place for completing clinical audit cycles. We saw that audits of clinical practice were regularly undertaken and that these were based on best practice national guidelines. Examples of clinical audits seen included an audit of anticoagulation of patients in atrial fibrillation, an audit of referral times for routine and urgent care, an audit of patients not attending appointments for child health surveillance and post natal reviews and audits relating to medication prescribing. The GPs told us clinical audits were often linked to medicines management information, safety alerts, clinical interest or as a result of Quality and Outcomes framework (QOF) performance. All the clinicians participated in clinical audits. We discussed audits with GPs and found evidence of a culture of communication, sharing of continuous learning and improvement. For example we found that as a result of one of the audits we looked at changes had been made to how the practice managed medication for anticoagulation of patients in atrial fibrillation and new guidelines around this had been introduced.

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.

The practice used the information they collected for the QOF and their performance against national and local screening programmes to monitor outcomes for patients. The practice identified what was working well and where improvements were needed. A development plan was in

Good

Are services effective?

(for example, treatment is effective)

place to address any areas where the outcomes for patients needed to be improved. The practice worked with the CCG to ensure prescribing practices promoted patient safety and met current clinical guidelines.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included managing long term conditions, safeguarding, unplanned admissions to hospital, education and training and information governance. The practice had achieved and implemented the gold standards framework for end of life care. One of the GPs took the lead for this group of patients. They had a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families. There was a clear process in place for informing the out of hours services of any particular needs of patients who were coming towards the end of their lives.

Effective staffing

An induction protocol and check list were in place which identified the essential knowledge and skills needed for new employees. We spoke to a new member of staff who confirmed that they had received an induction. Records of induction were in place on a sample of staff records looked at, however, we noted that on one staff file the induction had not been fully recorded.

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

We looked at the records relating to three nurse which indicated they had received an annual appraisal. We spoke to GP and nursing staff 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 of GPs had either taken place or were due. 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, GPs and nursing staff met weekly to look at new protocols, to review complex patient needs and keep up to date with best practice guidelines and relevant legislation. A clinical governance meeting was held every two weeks.

The practice manager kept a record of training carried out by clinical and administration staff. This did not contain an up to date record of all clinical training undertaken. The GPs and nurses kept a record of their own training. The practice manager told us that they were developing a system to enable them to maintain more detailed information about clinical training that would help them to plan for future training needs. Clinical and non clinical staff told us they had the training they needed to support them in their roles and in any specialist roles. For example, the lead GP for palliative care had undertaken a Diploma in Palliative care.

Working with colleagues and other services

The practice worked with other agencies and professionals to support continuity of care for patients. The GPs described how the practice provided the 'out of hours' service with information, to support, for example 'end of life care.' Information received from other agencies, for example A&E or hospital outpatient departments were read and actioned by the GPs 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 within 72 hours.

The practice shared a building with a number of community services which assisted multi-professional working. The registered manager told us how they worked with the Community Matron, district nursing team, social workers and health visitors to support patients and promote their welfare.

Good

Are services effective?

(for example, treatment is effective)

Multi-professional working took place to support patients and promote their welfare. Clinical staff met with health visitors on a monthly basis with the main focus being reviewing the health care needs of children subject to a child protection plan. Gold Standards Framework meetings were held monthly with district and palliative care nurses to review the needs of patients on the palliative care register. GPs were invited to attend reviews of patients with mental health needs and where they were unable to attend they supplied a report about their involvement with the patient.

Information Sharing

There was a confidentiality policy and data sharing policy which gave clear guidance to staff. Information about access to records and data protection was available for patients to refer to. Staff spoken with confirmed they had undertaken on-line training around promoting patient confidentiality.

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).

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 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 systems were also in place for making referrals.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. They gave examples in their practice of when best interest decisions were made and mental capacity was assessed prior to consent being obtained for a surgical 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, for all minor surgical procedures, a patient's written consent was obtained and documented in the electronic 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.

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.

Health promotion advice was provided to patients. This included smoking cessation, obesity management and travel advice.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We looked at 22 CQC comment cards that patients had completed prior to the inspection and spoke with four patients. Patients were very positive about the care they received from the practice. They commented that they were treated with respect and dignity, 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 94% 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. Ninety eight 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. These responses were better than average responses when compared to other practices nationally. Ninety one percent of patients who responded to this survey described the overall experience of their GP surgery as fairly good or very good.

We looked at the results of the last patient survey undertaken by the practice in February 2014. Three hundred and seventy three surveys were completed and the results showed that a high percentage were generally satisfied with the service provided.

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 a room available if patients wished to discuss something with them away from the reception area. We observed that a notice advising patients of this was on display. The telephones were answered away from the reception area which promoted patient privacy and confidentiality.

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

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 89% of practice respondents said the GPs were good or very good at involving them in decisions about their care and 94% felt the nurses were good or very good at involving them in decisions about their care.

Patients we spoke 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. Patient feedback on the comment cards we received indicated they felt listened to and supported.

Patient/carer support to cope emotionally with care and treatment

Information was on display in the waiting area and on the practice website about the support available to patients to help them to cope emotionally with care and treatment. Information available included, information about the Citizen's Advice Bureau, advocacy services, mental health support services, carer services and services to support patients experiencing domestic violence. GPs and nursing staff were able to refer patients on to counselling services. There was written information available for carers to ensure they understood the various avenues of support available to them. One of the partners at the practice had developed the Patients Aid and Caring Team in 1991 which provided support to patients who had been bereaved, terminally ill or over 75. In 1999 a Beacon Award (an award given to highlight best practice and innovation in philanthropy) was given to this service and in 2006 this service was awarded the Queens Award for voluntary service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the practice population were understood and systems were in place to address identified needs. The practice engaged with NHS Wirral Clinical Commissioning Group (CCG) to address local needs and service improvements that needed to be prioritised.

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 health care support. Administrative staff monitored referrals to ensure all referral letters were completed in a timely manner. Records indicated this system worked well with all referrals receiving prompt attention.

The practice worked to the National Gold Standard Framework in end of life care (The National Gold Standards Framework (GSF) Centre in End of Life Care provides training to enable generalist frontline staff to provide a gold standard of care for people nearing the end of life). The practice had a palliative care register and had monthly multidisciplinary meetings to discuss patient's and their families' care and support needs. They regularly updated shared information to ensure good communication of changes in care and treatment. The practice was the medical advisor for a local children's hospice. Daily visits were made to the hospice and the lead GP for palliative care supported the training provided to staff at the hospice.

The practice had a mix of male and female GPs so that patients were able to choose to see a GP of the gender of their choice.

The practice offered patients a chaperone prior to any examination or procedure. Staff we spoke with said they had received sufficient guidance around carrying out this role. Records demonstrated that staff who acted as chaperones had received training in this.

The practice had a long established Patient Reference Group (PRG). The purpose of the PRG 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 the changes made to the practice as a result of feedback from surveys and meeting with the PRG, for example, improving access to the service, the arrangements for collecting prescriptions and making improvements to the waiting area.

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. An audio induction loop was available to support patients with reduced ranges of hearing. There were comfortable waiting areas for patients attending an appointment and car parking was available nearby. There were disabled toilet facilities.

Seven percent of patients were from a black and minority ethnic population. Staff were knowledgeable about interpreter services for patients where English was their second language. Information about interpreting services was available in the waiting area. We noted that this information may not be accessible to patients as it was written in English. Information about interpreting services was also available on the practice website. The website could be translated into a number of different languages.

Patients' electronic records contained alerts for staff regarding patients requiring additional assistance in order to ensure the length of the appointment was appropriate. For example, if a patient required interpreting services or had a learning disability then a double appointment was offered to the patient to ensure there was sufficient time for the consultation.

Staff we spoke with told us there was a low incidence of homeless people accessing the practice. They told us they would ensure that patients received urgent and necessary care whatever their housing status. They were also aware of local support services for the homeless to which patients could be signposted. The practice was the medical advisor for ARK, a local homeless shelter.

Staff spoken with indicated they had received training around equality, diversity and human rights.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

The practice was open form 08:00 to 20:00 Monday to Friday. Patients were able to make appointments in person, telephone and on-line. Patients were able to book urgent same day appointments, appointments for the next working day or up to two weeks in advance for routine appointments. Telephone consultations were available and home visits were offered to patients whose condition meant they were not able to visit the practice. Out of hours medical assistance was provided by Wirral Community NHS Trust.

The appointment system was monitored to ensure that any issues around access to appointments were identified. Access to appointments was also monitored through the systems for patient feedback and from feedback from staff. As a result of patient feedback from the last patient survey carried out by the practice more extended access was provided for patients. Two practices merged to form Central Park Medical Centre in 2013. As a result there were two reception areas. In order to improve the reception area for patients the practice had a plan in place to provide a single reception.

The National GP Patient Survey in March 2014 found that patients were overall happy with access to the service. Eighty nine percent were very satisfied or fairly satisfied with opening hours and 85% rated their ability to get through on the telephone easy or very easy.

We looked at the results of the last patient survey undertaken by the practice in February 2014. Three hundred and seventy three surveys were completed and the results indicated patient satisfaction with the appointment system with 98% being able to book a date and time that was suitable. Sixty seven percent of patients said they saw a GP/nurse of their choice. Thirty six percent said the phone was often engaged when they tried to book an appointment. The practice was aware of an on going issue with the telephone system and had taken steps to mitigate the impact of this on patients. The practice was working with Wirral NHS Community Trust to find a solution to this issue. The practice had notified patients of the problems being encountered and the action being taken to resolve them.

We looked at 22 CQC comment cards that patients had completed prior to the inspection. A number of the comments indicated that patients were happy with the system for booking appointments and that they could get an appointment when one was needed. We spoke with four patients who said they were able to get appointment when they needed one. They said they were satisfied with arrangements for repeat prescriptions and that if a referral to another service was needed this had been done in a timely manner. One patient said that it could be difficult to get through to the practice to make an appointment by telephone.

The practice provided a quarterly newsletter for patients. This provided information around services available, any changes to services, for example, the appointment system and signposted patients to helpful services and organisations.

Listening and learning from concerns & complaints

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

We saw that the complaint policy was displayed in the waiting area and reference was made to the policy on the practice's website. The policy included contact details for NHS England and the Health Service Ombudsman, should patients wish to take their concerns outside of the practice.

We looked at the record of complaints and found documentation to record the details of the concerns raised and the action taken. There was a central log/summary of complaints to monitor trends and ensure any changes made were effective. Staff we spoke with were knowledgeable about the policy and the procedures for patients to make a complaint. We found that changes to the service had been made as a result of patient complaints.

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 mission statement "to provide high quality primary health care to our registered patients and to be an organisation with a high performing reputation." Staff were able to articulate the values of the practice. We noted that the mission statement was not displayed for patients to refer to.

Governance Arrangements

There were clear systems in place to direct and monitor the performance and operation of the practice. There were regular meetings of the executive management board, senior management team and clinical governance group to look at what was working well and where any improvements were needed.

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. Policies and procedures were regularly reviewed and the sample we looked at were up to date. We spoke to staff who were aware of how to access policies and procedures.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was either performing in line with or exceeded national standards. 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. Examples of clinical audits seen included an audit of anticoagulation of patients in atrial fibrillation, an audit of referral times for routine and urgent care, an audit of patients not attending appointments for child health surveillance and post natal reviews and audits relating to medication prescribing.

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 and minutes from clinical meetings indicated that the outcome of significant incidents and complaints and how they were to be learned from where discussed.

Leadership, openness and transparency

There was a clear leadership structure in place which had named members of staff in lead roles. For example, one GP was the lead for prescribing medication and another was the lead for education and training. We spoke with 13 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. They all told us there was a friendly, open culture within the practice and they felt very much part of a team. They all felt valued, well supported and knew who to go to in the practice with any concerns. They felt any concerns raised would be dealt with appropriately.

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, there was a weekly clinical forum meeting to look at new protocols, to review complex patient needs and keep up to date with best practice guidelines and relevant legislation. There were also developmental team meetings for the nursing team and administrative/reception staff.

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 in a staff handbook which was updated on an annual basis.

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 available on-line and through the complaint procedure. We looked at the results of the last patient survey undertaken by the practice in February 2014. Three hundred and seventy three surveys were completed and the results showed that patients were overall satisfied with the system to book appointments, their experience of the practice and GP and nurse consultations.

The practice had a long established Patient Reference Group (PRG). The purpose of the PRG is 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. We saw that information about the PRG meetings, survey results and the action plan were available on the practice website. Surveys sent by the practice were agreed with the

Are services well-led?

Good

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

PRG prior to distribution. The results were discussed at PRG meetings and an action plan devised. Records showed the changes made to the practice as a result of feedback from surveys and meeting with the PRG, for example, the results of the last patient survey in February 2014 indicated that patients wanted improvements to be made to the arrangements for picking up prescriptions and more extended hours appointments. As a result the practice had promoted the electronic delivery of prescriptions to the chemist, had two dedicated prescription clerks to manage queries around prescriptions and the practice now opened late every Friday evening.

We met with two members of the PRG who told us they met monthly, they felt listened to and improvements had been made to the practice as a result of their suggestions. For example, the appointment system had been improved and improvements had been made to the waiting area. They said that new services and improvements were also discussed and the views of the PRG obtained.

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.

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. A whistle blowing policy and procedure was available for staff to refer to in the staff handbook. We noted that the policy and procedure did not contain details of organisations that staff could refer their concerns to, such as NHS England.

Management lead through learning & improvement

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Staff were offered annual appraisals to review performance and identify development needs for the coming year. Staff told us the practice was supportive of their learning and development needs and that 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.

The practice manager monitored staff training to ensure essential training was completed each year. They were developing their training records to give a better overall view of clinical training received and training needed.

Procedures were in place to record incidents, accidents and significant events and to identify risks to patient and staff safety. The results were discussed at practice meetings and if necessary changes were made to the practice's procedures and staff training.