Kirkdale

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Kirkdale Medical Centre. Kirkdale Medical Centre is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on 8 October 2014 at the practice location. We spoke with patients, staff and the practice management team.

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.

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 the recruitment of staff. However, improvements were needed to the infection control systems in place to ensure patients and staffs were protected from the risks of health care associated infections.
- Patients care needs were assessed and care and treatment was being considered in line with best practice national guidelines. Staff promoted 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 that health issues were discussed with them and treatments were explained.
- The practice planned its services to meet the differing needs of patients. The appointment system had been reviewed to ensure better access to the service.
- The practice had a clear vision and set of values. The practice had systems to seek and act upon feedback from patients using the service. Quality and performance were monitored, risks were identified and managed.

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

Importantly, the provider must:

Summary of findings

- Take action to ensure patients and staff are protected against the risks of infection by having systems in place to assess the risk of and to prevent, detect and control the spread of a health care associated infection.

The provider should consider:

- Undertaking regular fire drills and ensuring the fire risk assessment is updated on an annual basis.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for 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 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. However, improvements were needed to the infection control systems in place to ensure patients and staff were protected from the risks of health care associated infections.

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.

Are services caring?

Good

The practice is rated as good for caring. We looked at four comment cards that patients had completed prior to the inspection and spoke with five patients on the day of the inspection. Patients were overall positive about the care they received from the practice. They commented that they were treated with respect and dignity. 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. The practice was accessible for people with a physical disability. Staff were knowledgeable about interpreter services for patients where English was their second language. The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. We saw documentation to record the details of concerns raised and action taken.

Summary of findings

Are services well-led?

Good

The practice is rated as good for well led. The practice had a vision and set of values which were understood by staff and publicised at the practice. 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 participation group (PPG) 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. Up to date registers of patients' health conditions were kept. 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.

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) and hypertension. This information was reflected in the services provided, for example, reviews of conditions and treatment, screening programmes and vaccination programmes. We found staff had a programme in place to make sure no patient missed their regular reviews for long term conditions.

Families, children and young people

The practice is rated as good for the population group of families, children and young people. Child health surveillance clinics were run on a weekly basis. The practice monitored any non-attendance of babies and children at these clinics and worked with the health visiting service to follow up any concerns. 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.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). 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. Patients unable to attend during the normal opening hours were able to book to be seen at the 'extended hours' service which ran until 7.30pm on Wednesdays.

Summary of findings

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 told us they would ensure homeless people received urgent and necessary care. They were also aware of the GP practice in the Clinical Commissioning Group (CCG) that took the lead for managing homeless patients' long term care and referred patients on appropriately. 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 and share care with specialist teams. The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. 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 four CQC comment cards that patients had completed prior to the inspection and we spoke with five patients on the day of the inspection. Patients were generally positive about the reception staff and described them as caring, and helpful. The patients spoken with said they were treated with respect and dignity, they told us they had enough time to discuss things fully with the GP and they felt listened to. They told us that health issues were discussed with them and treatments were explained. Four of the five patients we spoke with felt involved in decision making about the care and treatment they received. One comment card indicated that the waiting time to go in and see a GP for a booked appointment was long and that they had difficulty getting an appointment. Four of the five patients spoken with said they were generally able to get an appointment when they needed one. One patient said it could be difficult getting through on the telephone.

The National GP Patient Survey published in 2013 found that the number of patients who described the overall experience of their GP surgery as fairly good or very good was 90.3%. The number of patients who stated the last time they saw their GP or a nurse they were treated with care and concern was also in line with the national average responses from patients across the country. The National GP Patient Survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. The survey also showed that 87.4% of patients were very satisfied or fairly satisfied with the practice opening hours. 88.4% rated their ability to get through on the telephone easily and 64.2% stated they always or almost always see or speak to the GP they prefer. These responses were within the normal range of responses but higher than the national average responses from patients across the country. With regards to making an appointment patient responses placed the practice below the national average. Our discussions with the practice manager and GPs and talking with representatives from the PPG indicated the actions the practice had taken to improve accessibility to appointments.

We looked at the last patient surveys carried out by the practice and completed by 28 patients in March 2014 and 50 patients in January 2013. These showed that patients who responded rated the helpfulness of the reception and nursing staff as either good, very good or excellent and they rated the length of time waited for an appointment, speed at which phone was answered and convenience of appointment as predominantly good, very good or excellent.

Areas for improvement

Action the service MUST take to improve

Take action to ensure patients and staff are protected against the risks of infection by having systems in place to assess the risk of and to prevent, detect and control the spread of a health care associated infection.

Action the service SHOULD take to improve

The provider should consider:

- Undertaking regular fire drills and ensuring the fire risk assessment is updated on an annual basis.

Kirkdale

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 Kirkdale

Kirkdale Medical Centre is a small inner city practice in the Kirkdale area of Liverpool. The practice is registered with the Care Quality Commission (CQC) to provide primary care services, which includes access to GPs, maternity and midwifery services and treatment of diseases and injuries. The practice treats patients of all ages and provides a range of medical services. The staff team includes two GP partners, one part-time locum GP, a practice manager, a part time practice nurse and healthcare assistant and administrative and reception staff.

The practice is open Monday to Friday from 8.30am until 6.30pm. Extended hours consultations are provided daily until 6.30pm and on Wednesdays until 7.30pm. Patients can book appointments in person and by telephone. Patients can book on the day or in advance, home visits are offered to housebound patients and telephone consultations are available. When the practice is closed patients access the GP out-of-hours provider Urgent Care 24 (UC24).

The practice is part of NHS Liverpool Clinical Commissioning Group. It is responsible for providing primary care services to approximately 3303 patients. The practice is situated in an economically deprived area of the city. 19.4% of the practice population are over 65 years of age. 66.7% of the practice population have a long standing health condition which are slightly higher than national average. The practice has a General Medical Services (GMS) contract.

The practice works closely with visiting health professionals including a health visitor, community matron, district nurses, midwife and a health trainer.

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.

This provider had not been inspected before and that was why we included them.

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?

Detailed findings

- 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 carried out an analysis of the data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas. We carried out an announced inspection on 08 October 2014.

We reviewed all areas of the practice, including the administration areas. We sought views from patients both face-to-face and via comment cards. During our visit we spoke with staff including: two GPs, a practice nurse, a practice manager and three reception and administration staff. We spoke with patients who were using the service on the day of the inspection and with members of the patient participation group.

Requires improvement

Are services safe?

Our findings

Safe Track Record

NHS Liverpool 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 a plan of action had been formulated following analysis of the incidents.

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. For example, the analysis of a significant incident indicated a patient who had symptoms that may be caused by cancer had not been referred to hospital within the timescale of two weeks (as indicated by National Institute of Clinical Excellence Guidelines (NICE)) because the referral had been faxed and not received. Changes were made to the system for making these referrals to ensure an electronic and paper copy of the referral were sent and a check was made to ensure the referral had been received.

Alerts and safety notifications from national safety bodies were dealt with by the GPs and the practice manager. Staff confirmed that they were informed 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. We saw evidence that significant events, incidents and complaints were investigated and reflected on by the clinical staff and non-clinical staff as appropriate.

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, as a result of the analysis of one incident changes were made to repeat prescriptions for medication where the dosage may fluctuate, such as warfarin. All repeat prescriptions for warfarin were now provided by the GPs following a review of the patients records. Records showed that changes had been made to the practice as a result of patient complaints. For example, examination equipment suitable for patients with allergies had been made available.

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

Reliable safety systems and processes including safeguarding

A sample of training records looked at and staff spoken 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. The practice manager had identified that some staff were due for training updates in this area and there was a plan in place to address this.

One of the GPs took the lead for safeguarding. They had attended meetings with the safeguarding lead from the commissioning organisation. This established link meant that advice and guidance could be easily sought as needed.

The lead GP kept the NHS adult and child protection procedures in their treatment room. Staff had day to day access to a shortened version of the procedures and contact details for significant agencies were on display in the reception and treatment rooms. The child protection policy available for staff did not contain sufficient information. The forms of abuse, possible indicators of abuse and the action to be taken if abuse was suspected were not recorded.

Following the installation of a new computer system staff had begun to put alerts onto the patient's electronic record when safeguarding concerns were raised. The lead GP told us that they met weekly with the health visitor for the practice and discussed any safeguarding concerns about children.

Requires improvement

Are services safe?

We found that there were systems and processes in place to keep patients safe. This included systems and processes around medicines management, equipment and building maintenance and staff recruitment checks.

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. The GPs re-authorised medication for patients on an annual basis or more frequently if necessary. A system was in place to highlight patients requiring medication reviews through electronic alerts on the practice computers. 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 to ensure patient safety. Emergency drugs were listed and checked to ensure they were in date and ready to use. 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. The vaccine fridge had one thermometer. All fridges should ideally have two thermometers, one of which is independent of mains power. If only one thermometer is used, then a monthly check should be considered to confirm that the calibration is accurate. Following our visit the practice manager told us that a second thermometer independent of the mains power would be obtained. The policy for the safe storage of vaccine was last reviewed in March 2010 and contained little guidance around incident reporting, for example should the fridge breakdown or a failure in the power supply. Prescription pads and repeat prescriptions were stored securely.

Cleanliness & Infection Control

The five patients we spoke with commented that the practice was clean and appeared hygienic. We looked around the premises and found that in general, the waiting areas, toilets and treatment rooms were clean. The surfaces in the treatment rooms, flooring and examination couches could be easily cleaned and the areas seen were clutter free. We found that the ledge behind an examination couch and an extractor fan were covered in dust. The practice manager told us that a cleaner was employed for one hour per day. No assessment had been made of the number of cleaning hours needed to effectively clean premises of this size. Following our visit the practice manager wrote to us and told us that the cleaning hours would be increased to two hours per day.

There was no up to date evidence to show that the cleaner worked to a cleaning schedule. There was no evidence to show that audits of the cleaning had taken place and completed checks of the cleaning undertaken. For example, toys were available in the waiting area for children to play with and although they appeared clean there was no record of when they were last cleaned. At the time of our visit a contract cleaning company was providing one hour of cleaning to the practice each working day. The contact cleaner was completing a schedule of cleaning. The practice manager told us that they carried out a weekly check to ensure the premises were clean and that daily visual checks were undertaken by all staff and any issues reported. These checks were not recorded. We found that regular infection control audits were not undertaken by the practice.

There was a current infection control policy, however, this was not a detailed policy and did not provide sufficient guidance for staff. The policy did not contain information referred to in The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. For example, it did not contain information around standard infection control and prevention precautions, safe handling and disposal of sharps or steps to take if an outbreak of a communicable infection is identified. The clinical and non-clinical staff spoken with said they had received infection control training, however, there was no record to indicate when this had been undertaken. The practice manager said that she had identified that the majority of staff needed this training updating. The reception and administrative staff spoken with were aware of their responsibilities in relation to infection control.

There was appropriate segregated waste disposal systems for clinical and non-clinical waste.

We were told the practice did not use any instruments which required decontamination between patients and that all instruments were for single use only. We found that examination gloves were available and in date and staff had access to hand washing facilities. Hand wash signs

were in the staff and patient toilets and waiting area. However, we found there was no hand gel in the dispensers outside the GP treatment rooms or in the waiting area. No spillage kits were available to safely manage bodily waste.

Legionella testing was carried out by the company that managed the premises.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. The blood pressure machines were new and not due for calibration, however, the weighing scales and fridge were calibrated in March 2013 and a further test had been scheduled for 30 October 2014.

Staffing & Recruitment

The practice had a procedure for the safe recruitment of staff including guidelines about seeking references, proof of identity and checking qualifications/clinical registration. We looked at two staff files and found the recruitment procedure had been followed. Checks had been carried out to show the applicants were suitable for the posts. We also found that suitable checks were carried out prior to the use of any locum GPs.

The Practice Manager checked the professional registration for clinical staff. We saw that the practice carried out Disclosure and Barring service (DBS) checks for GPs, nurses and administrative staff. These checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post.

Monitoring Safety & Responding to Risk

The practice reviewed staffing levels and were in the process of recruiting to a number of positions. At the time of our visit the practice manager told us that they were advertising for a part-time salaried GP and a part-time administrator. Following a nurse leaving the practice the practice manager was also looking at the existing nurse increasing their hours or advertising externally.

In the event of unplanned absences amongst the administrative staff, staff covered from within the service. A locum GP was currently covering the vacant GP post and the CCG were providing staff to cover some nursing hours.

Duty rotas took into account planned absence such as holidays. GPs and the practice manager told us that patient demand was monitored through the appointment system to ensure that sufficient staffing levels were in place and to identify shortfalls.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff told us they had training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). Samples of training certificates confirmed that this training was up to date. The practice did not have access to emergency equipment.

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.

A disaster recovery and business continuity plan was in place, which was reviewed in August 2014. The plan covered loss of building, power supply, loss of medical records and loss of electronic systems. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system. We noted that the plan did not contain a plan for the risks presented by unplanned staff absence. The Practice Manager described two occasions when the plan was put into operation recently due to lack of access to computers and the telephone systems.

Records showed that the fire alarm, emergency lighting and fire fighting equipment were regularly checked to ensure they were operating safely. A fire risk assessment had been undertaken that included actions required to maintain fire safety. This had been last reviewed in February 2012 and was due for an annual review. The last recorded fire drill was May 2012.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

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

The practice provided a service for all age groups. The local community provided services for people with learning disabilities, patients living in deprived areas and care homes and for people with mental health needs. We found GPs were familiar with the needs of patients and the impact of the socio-economic environment.

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 used the information it collected for the Quality Outcomes Framework (QOF) and their performance compared against national and local screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided**.** The report from 2012-2013 showed the practice was meeting national targets and performing well in relation to registers maintained for adult patients with a learning disability, patients in need of palliative care, carrying out regular multi-disciplinary reviews of patients on the palliative care register, the treatment of patients with atrial fibrillation and for monitoring alcohol consumption for patients with a diagnosis of schizophrenia, bi-polar affective disorder and other psychoses.

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 diabetes, asthma and chronic obstructive pulmonary disease (COPD), 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 belonged to a neighbourhood quality improvement scheme operated by NHS Liverpool Clinical Commissioning Group (CCG). The CCG worked on quality indicators with the practices in each neighbourhood. The GPs told us that the practice regularly monitored these indicators to identify where they were achieving well and where improvements were needed. The registered manager and the CCG provided us with information that indicated that the practice was performing well in areas including recording levels of BMI 40+ and weight management advice, breast and cervical screening. The practice had a development plan that highlighted areas where they wanted to make improvements including reducing children's attendance at accident and emergency, improve flu vaccination uptake and health checks for patients with diabetes. Representatives from the practice attended regular meetings to look at their practice development plan with the CCG.

We looked at a sample of two clinical audits completed in the last five years. The audits undertaken included an audit of preferred place of care for terminally ill patients and an audit of dermatology referrals. The audit on preferred place of care for terminally ill patients showed with improved communication and support from a multi-disciplinary team more patients were choosing home as their preferred place of care. The audit of dermatology referrals indicated high referral rates to hospital and as a consequence both GPs attended training and obtained a dermatoscope (used for the examination of the skin using skin surface microscopy). A further audit indicated that dermatology referrals to hospital had decreased. We found that although the GP described how they had reflected and acted on the clinical audit the record of this audit did not

Good

Are services effective?

(for example, treatment is effective)

fully record this information. This information is needed to provide a full analysis An audit of cancer referrals was in the process of being completed following the analysis of a significant event.

Effective staffing

An induction was provided to new staff. We looked at the records for two new staff and spoke with the practice manager about their induction. The induction programme included time to read the practice's policies and procedures, role specific training, risk assessment, and health and safety guidance and shadowing colleagues. Staff told us they had easy access to a range of policies and procedures to refer to and support them in their work.

The practice manager began working for the service in February 2014 and they had identified improvements that were needed to ensure an effective staff team. The practice manager told us that appraisals for reception, administrative staff and the health care assistant were due to be undertaken and that these had been planned. The practice nurse had received an appraisal within the last 12 months and they had a personal development plan. We saw the practice manager's appraisal and saw that a personal development plan had been agreed. The practice manager told us they felt well supported in their role. GPs had an annual appraisal, one GP had been revalidated and one was due in 2015.

Clinical and administrative staff told us they felt well supported to carry out their work. Two formal practice meetings had taken place this year and the practice manager informed us that monthly practice meetings were being introduced as well as regular meetings for administrative and reception staff. GPs met informally to discuss clinical issues and changes to practice. The practice nurse and GPs told us that the clinical staff worked well as a team.

The practice manager was in the process of developing an up to date record of all training carried out by clinical and administrative staff to identify training needs and develop a training plan. The practice manager had already identified that some staff needed training updates and she had taken steps to address this. Clinical staff told us they had access to training opportunities to keep their clinical practice up to date. GPs told us they ensured they had protected learning time and met with their external appraisers to reflect on their practice, review training needs and identify areas for development. Reception and administrative staff told us that they had undertaken all mandatory training but needed refreshers in some areas.

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 on the same day. Information was scanned onto electronic patient records in a timely manner. GPs described how blood result information would be sent through to them electronically and the system in place to respond to any concerns identified.

The practice kept up to date disease registers for patients with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD), 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. Multi-disciplinary team meetings for patients on the palliative care register took place on a regular basis to ensure patients had sufficient levels of support and equipment and drugs were in place in a timely manner.

Multi-professional working took place to support patients and promote their welfare. Clinical staff met with health visitors, district nurses and Macmillan nurses to discuss any concerns about patient welfare and where further support may be required. GPs were invited to attend reviews of patients with mental health needs and child and vulnerable adult safeguarding conferences, where they were unable to attend they said they supplied a report about their involvement with the patient.

Information Sharing

The practice identified people who needed on-going support with their health. 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. The practice also kept registers of vulnerable people such as those with mental health needs and learning disabilities and used these to plan annual health checks.

Good

Are services effective?

(for example, treatment is effective)

New patients were offered a consultation to ascertain details of their past medical and family histories, social factors including occupation and lifestyle, medications and measurements of risk factors such as smoking and alcohol intake.

Information to support patients to lead healthier lives was available to them in the waiting area and information was also provided by the GPs and nurses following consultations. For example, this included information around smoking cessation schemes and sexual health.

Information around data sharing, data protection and patient access to records was available for patients to refer to in the waiting area.

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 included consent to treatment by children and young people and referred to Gillick competency in children (Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.) The GPs we spoke with understood the principles of gaining consent including issues relating to capacity. We saw that systems were in place to ensure that consent was recorded in accordance with the policy of the practice.

Health Promotion & Ill-health Prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, long term condition reviews and provided health promotion clinics to patients.

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 flu vaccinations, providing physical health checks for patients with severe mental health conditions and diabetes.

The practice also provided patients with information about other health and social care services such as carers' support. We saw a range of information posters and leaflets in the practice. The practice website had some telephone numbers of health and social care organisations for patients to go to for further information and support such as Alcoholics Anonymous, Victim Support, Relate Marriage Guidance and The Samaritans. Further information around health promotion and ill-health prevention should be made available on the practice website.

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

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We looked at four CQC comment cards that patients had completed prior to the inspection and spoke with five patients on the day of the inspection. Patients were generally positive about the reception staff and described them as caring, and helpful. The patients spoken with said they were treated with respect and dignity, they told us they had enough time to discuss things fully with the GP and that they felt listened to. Three of the patients spoken with felt their conversations may be overheard at reception, however they said they would ask to speak to the receptionist away from the reception if they had an issue they wanted to discuss in private. The patients spoken with were aware that they could ask for a chaperone if they felt this was needed.

The National GP Patient Survey published in 2013 found that the number of patients who described the overall experience of their GP surgery as fairly good or very good was 90.3%. The number of patients who stated the last time they saw their GP or a nurse they were treated with care and concern was also in line with the national average responses from patients across the country.

We looked at the last patient surveys carried out by the practice and completed by 28 patients in March 2014 and 50 patients in January 2013. These showed that patients who responded rated the helpfulness of the reception and nursing staff as either good, very good or excellent.

Staff we spoke with were aware of the importance of providing patients with privacy. They told us there was a private area at the side of the reception desk if patients wished to discuss something with them away from the reception area. A notice advising patients of this was not on display. We observed that overall privacy and confidentiality were maintained for patients using the service on the day of the visit.

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.

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. The practice manager said that a clinical member of staff provided guidance to staff around being a chaperone, that further guidance was being discussed at the next practice meeting and more formal training was being looked into.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the most recent National GP Patient Survey showed 83.8% of practice respondents said the GP involved them in care decisions and 89.5% felt the nurse involved them in decisions about their care. These responses were slightly higher than the national average responses from patients across the country.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them, treatments were explained and they generally felt listened to. Four of the five patients we spoke with felt involved in decision making about the care and treatment they received.

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

Patient/carer support to cope emotionally with care and treatment

Information was on display in the waiting area 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, debt management and domestic violence. The five patients

Good

Are services caring?

we spoke with said that they had been referred to or given information about support groups if they were needed. Further information about support services should be made available on the practice website.

Staff spoken with told us that bereaved relatives known to the practice were offered support following bereavement.

GPs and nursing staff were able to refer patients on to counselling services. The practice was requesting that carers who would like support complete a referral form to allow their details to be passed to the Carers Service, a national organisation providing information and advice for carers.

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. NHS Liverpool Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We discussed with the GPs actions agreed to implement service improvements and manage delivery challenges to its population. For example, the practice development plan included making improvements to patient experience, services offered to children and management of long term conditions.

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. Immunisations for children were being carried out by a community service. The registered manager told us that health visitor clinics were being established at the practice which would enable the GP and health visitor to work together closely around the monitoring of children's health. The registered manager told us that the health visitor would be providing an immunisation clinic that would improve immunisation uptake as children could be vaccinated while they attended for child health surveillance.

The practice was proactive in contacting patients who failed to attend vaccination and screening programmes. They worked with other health providers to support patients who were unable to attend the practice. For example patients who were housebound were identified and referred to the district nursing team to receive their flu vaccinations.

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 had a palliative care register and had regular internal meetings as well as monthly multidisciplinary meetings to discuss patient and their families care and support needs. The practice worked collaboratively with other agencies, regularly updated shared information to ensure communication of changes in care and treatment.

The GPs attended integrated care meetings on a six weekly basis. This multi-professional team looked at the needs of high risk patients, for example those prescribed a number of medications and patients who were repeatedly admitted to hospital. Patients' needs were discussed with their consent and the meetings focused on looking at the best ways to support patients with their health and social care needs. The GPs told us about how individual patients had benefitted as a result of these meetings.

A Patient Participation Group (PPG) had been established for approximately 2 years. We saw the minutes from the last meeting in March 2014 and saw that discussion had taken place to inform the group of the actions taken to improve the service following feedback from PPG. For example, the number of telephone consultations had been increased and extended hours surgeries had been made available. New services and improvements were also discussed and the views of the PPG obtained.

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 a waiting area with seating for patients attending an appointment and car parking was available nearby. There were disabled toilet facilities.

Information about interpreting services was on display in the waiting area. 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. If a patient had a learning disability then a longer appointment was offered to the patient to ensure there was sufficient time for the consultation.

Staff we spoke with were knowledgeable about how to support patients who were homeless. The staff told us they made sure the patient received urgent and necessary care whatever their housing status. They were also aware of the GP practice in the Clinical Commissioning Group (CCG) that took the lead for managing homeless patients' long term care. They told us they would ensure patients knew how to

Good

Are services responsive to people's needs?

(for example, to feedback?)

access this service. Asylum seekers were registered with the practice and there was information for staff to refer to around initial screening examinations that were undertaken by another service provider.

A mental health liaison support worker visited the practice each month to discuss patient well-being. They worked with the GPs to identify any patients who were not accessing the service to have their health care needs monitored and worked with other mental health professionals to facilitate this.

Some staff had received training around equality, diversity and human rights and the practice manager had a plan in place to ensure all staff attended this training. Staff told us that equality and diversity issues were discussed at practice meetings.

Access to the service

Patients were able to make appointments in person or by telephone. Pre-bookable appointments could be made two weeks in advance. Appointments could be booked on the day and each GP reserved some appointments each day to see patients who needed urgent attention. Telephone consultations were also available and home visits were made to patients who were housebound or too ill to attend the practice. Patients unable to attend during the normal opening hours were able to book to be seen at the 'extended hours' service run until 7.30pm on Wednesdays. The patient information leaflet and the practice website contained details of different appointments available. However, we observed the extended hours service was not advertised as being specifically for patients unable to attend normal opening hours. Two week in advance appointments were also not clearly indicated and contact details for out of hours services were not clearly indicated.

The National GP survey results published in 2013 showed that 87.4% of patients were very satisfied or fairly satisfied with the practice opening hours. 88.4% rated their ability to get through on the telephone easily and 64.2% stated they always or almost always see or speak to the GP they prefer. These responses were within the normal range of responses but higher than the national average responses from patients across the country.

With regards to making an appointment patient responses placed the practice below the national average for patients indicating the last time they wanted to see or speak to a GP or nurse they were able to get an appointment.

We looked at four CQC comment cards that patients had completed prior to the inspection and spoke with five patients on the day of the inspection. One comment card indicated that the waiting time to go in and see a GP for a booked appointment was long and that they had difficulty getting an appointment. Four of the five patients spoken with said they were generally able to get an appointment when they needed one. One patient said it could be difficult getting through on the telephone.

We looked at the last patient surveys carried out by the practice and completed by 28 patients in March 2014 and 50 patients in January 2013. These showed that patients who responded rated the length of time waited for an appointment, speed at which phone was answered and convenience of appointment as predominantly good, very good or excellent.

Our discussions with the practice manager and GPs and talking with representatives from the PPG indicated the actions the practice had taken to improve accessibility to appointments. A new computer system had been installed within the last six months that unlike the previous system allowed different types of appointments to be made, for example, emergency, routine and 48 hour appointments. Extended hours appointments and telephone consultations had also been made available. The practice was also working on providing information to patients to ensure they booked an appointment appropriately, for example, some patients had booked an urgent appointment when they needed a repeat prescription or a Statement of Fitness for Work. Letters were also being sent to patients who failed to attend an appointment to advise them of the consequences of this for other patients.

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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at a sample of complaints. We saw 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.

We saw that the complaint policy was displayed in the waiting area and leaflets detailing the procedure were accessible to patients. The patient complaint procedure contained information about the Patient Advisory Liaison Service (PALS) and the Health Service Ombudsman, should patients wish to take their concerns outside of the practice. The website did not contain full details of the complaint procedure. The website directed patients to the practice manager if they had a complaint and also advised that details around the procedure could be obtained from reception staff.

Staff we spoke with were knowledgeable about the policy and the procedures for patients to make a complaint and confirmed complaints were discussed at practice meetings. Records showed that changes had been made to the practice as a result of patient complaints. For example, examination equipment suitable for patients with allergies had been made available.

Are services well-led?

(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 set of values which were understood by staff and publicised at the practice. The practice's mission statement included a commitment to expanding the range of services available, providing holistic, patient centred consultations and involving patients in decision making about their care and the future development of the practice.

The staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically or in paper format. We spoke with staff who knew how to access these policies and procedures. We looked at a sample of policies and procedures, generally the policies had been recently reviewed and contained the required information, however, the infection control, child protection policy, policy for the safe storage of vaccines and the consent to treatment policy did not provide sufficient guidance for staff.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was overall performing in line with 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 GPs spoken with told us about a local peer review system they took part in with neighbouring GP practices and the Clinical Commissioning Group (CCG). This enabled the practice to measure their service against others and identify areas for improvement.

The practice had completed clinical audits to evaluate the operation of the service and the care and treatment given. Examples of clinical audits included preferred place of care for terminally ill patients and an audit of dermatology referrals.

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. Minutes from team meetings showed that significant incidents and how they were to be learned from where discussed.

Leadership, openness and transparency

There was a clear leadership structure in place and clear lines of accountability. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

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 registered manager. 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.

There were no formal clinician only meetings, however, the GPs and nurse spoken with said they felt supported by their informal meetings and knew they could approach a clinician from the practice if they needed support or guidance.

We reviewed a sample of human resource policies and procedures, for example, induction policy, equal opportunities/anti-discrimination policy and procedure for the management of harassment and bullying at work which were in place to support staff. Staff we spoke with knew where to find these policies if required.

We saw evidence that showed the practice worked with the Clinical Commissioning Group (CCG) to share information, monitor performance and implement new methods of working to meet the needs of local people. GPs attended prescribing and medicines management and shared information within the practice.

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

Patient feedback was obtained through comments/ suggestion boxes in the waiting areas and by carrying out surveys. We looked at the last patient surveys carried out by the practice and completed by 28 patients in March 2014

Are services well-led?

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

and 50 patients in January 2013. These showed that patients who responded rated the appointment system, prescription service, obtaining test results and helpfulness of staff as predominantly good, very good or excellent.

We looked at patient feedback left on the NHS Choices website. During 2013 and 2014 five comments were left. One comment indicated that the patient was happy with the service provided. The other four comments showed patients were not satisfied with the opening hours, level of interest displayed by the GP in their health concerns and ability to get through to the practice on the phone. The practice manager had responded to each comment made providing where possible information to help the patient, for example, about extended hours appointments. The practice manager had also invited the patients to contact the practice to discuss their concerns further so that they could be fully investigated.

A Patient Participation Group (PPG) had been established for approximately two years. We saw the minutes from the last meeting in March 2014 and saw that discussion had taken place to inform the group of the actions taken to improve the service following feedback from PPG. For example, the number of telephone consultations had been increased and extended hours surgeries been made available. New services and improvements were also discussed and the views of the PPG obtained. We met with three members of the PPG. They told us they met twice a year and they felt listened to and improvements had been made to the practice as a result of their suggestions. They said the practice had been redecorated and new seating provided in the waiting area, notices had been removed from the reception windows, exterior lighting had been improved and patients were asked to collect repeat prescriptions in the afternoon if possible to allow staff to concentrate on answering phone calls and booking patients in for appointments in the busier morning periods.

The last PPG survey results were displayed on the practice website. The minutes from PPG meetings were not available on the website. This information was also not displayed in the waiting area to advertise the PPG, encourage new members and demonstrate the actions taken to improve the practice as a result of patient's feedback.

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

Management lead through learning & improvement

The practice had an understanding of the need to ensure staff had access to learning and improvement opportunities. The practice manager told us that appraisals for reception, administrative staff, practice nurse and the health care assistant were due to be undertaken and that these had been planned to review performance at work and identify development needs for the coming year. Staff told us that the practice was supportive of training and that they had regular training including in-house training sessions where guest speakers and trainers attended. GP appraisals were up to date, one GP had been revalidated and was planned for 2015. 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 practice manager was in the process of developing an up to date record of all training carried out by clinical and administrative staff to identify training needs and develop a training plan

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.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **People who use the service were not protected against the identifiable risks of acquiring a health care associated infection because the provider did not have effective systems in place to assess the risk of and to prevent, detect and control the spread of a health care associated infection.**