Vauxhall Primary Health Care

Quality Report

Vauxhall Health Centre
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Date of inspection visit: 28th April 2015
Date of publication: 09/07/2015

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?	Outstanding
Are services caring?	Good
Are services responsive to people's needs?	Outstanding
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Vauxhall Primary Health Care.

We undertook a comprehensive inspection on 28th April 2015. We spoke with patients, staff and the practice management team.

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

Our key findings were as follows:

- There were systems in place to protect patients from avoidable harm, such as from the risks associated with medicines and infection control. However, improvements were needed to the recruitment of staff as the recruitment records did not demonstrate that all necessary checks were undertaken to demonstrate suitability for their roles.
- Patients care needs were assessed and care and treatment was being considered in line with best practice national guidelines. Staff were proactive in promoting good health and referrals were made to other agencies to ensure patients received the treatments they needed.
- Feedback from patients showed they were very happy with the care given by all staff. They felt listened to, treated with dignity and respect and involved in decision making around their care and treatment.
- The practice planned its services to meet the differing needs of patients. The practice encouraged patients to give their views about the services offered and made changes as a consequence.

Summary of findings

- Quality and performance were monitored, risks were identified and managed. Staff told us they could raise concerns, felt they were listened to, felt valued and well supported.

We saw areas of outstanding practice:-

- The practice carried out a range of clinical audits to evaluate the operation of the service. The findings from some audits had been shared outside the practice. For example, an audit of bariatric patients had led to changes in the practice protocols for monitoring the healthcare needs of these patients. This audit was presented to the Royal College of General Practitioners to disseminate the findings more widely and led to the GP who carried out the audit being invited to attend a nutritional panel that makes recommendations nationally.
- The practice looked after the health needs of the majority of Liverpool's travelling community. The practice worked closely with a multi-disciplinary team of health and social care professionals to ensure the health needs of the travelling community were met. For example, if follow up services were needed the traveller support workers (qualified nurses) hand delivered letters from the GPs and read them to the travellers as a number were illiterate. The GPs continued to monitor and prescribe medication when they moved to a site in another area in order to promote patient safety and continuity of care.
- A specialist service was provided to focus on the needs of patients with complex needs, those who were housebound (including those who lived in care homes), on polypharmacy (the use of four or more medications by a patient) and with multiple conditions. Home visits were undertaken by GPs and a comprehensive review of the patients' health care needs was undertaken. The patients identified were also discussed in multi-disciplinary meetings to ensure their needs were being effectively met. A review was carried out in May 2014 and found there had been changes to patient medication, including a reduction in the amount of prescribed medication compared to results of a review of this service in 2010.
- The practice was involved in a social work pilot. A social work team for adults was based at the practice. This pilot had been developed to encourage better communication and closer working relationships between health and social care services. This pilot had been in operation since February 2015 and although it had not been evaluated we spoke to staff from the practice, a social worker and the social work team leader who gave us many good examples of how admissions to hospital had been avoided and earlier hospital discharges facilitated due to better communication and faster reaction time from the practice and social services.
- We spoke to three members of the Patient Forum who had worked with the practice for over 20 years. They told us that many projects had been run at the practice to make patients' wait more enjoyable. For example, music was played, a patients' library had been established and a reading project was tried out. The most successful project had been "Nancy's Kitchen" where volunteers from the Patient Forum provided tea and toast. This continued to be provided at the practice every morning. Members of the Patient Forum told us how socially isolated patients benefitted from this service and how they were able to direct patients to sources of support if requested.

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

Importantly, the provider must:

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

The provider should:

- Ensure the serial numbers of all prescription pads and the clinical staff they are issued to are recorded.

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

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. The practice monitored its performance and had systems in place to improve outcomes for patients. The practice carried out a range of clinical audits to evaluate the operation of the service. The findings from some audits had been shared outside the practice. For example, an audit of bariatric patients had led to changes in the practice protocols for monitoring the healthcare needs of these patients. This audit was presented to the Royal College of General Practitioners to disseminate the findings more widely and led to the GP who carried out the audit being invited to attend a nutritional panel that makes recommendations nationally.

A specialist service was provided to focus on the needs of patients with complex needs, those who were housebound (including those who lived in care homes), on polypharmacy (the use of four or more medications by a patient) and with multiple conditions. Home visits were undertaken by GPs and a comprehensive review of the patients' health care needs was undertaken.

The practice worked effectively with health and social care services to promote patient care. For example, the practice was one of four practices involved in a social work pilot. This involved a social work team for adults being based at the practices. This pilot had been developed to encourage better communication and closer working relationships between health and social care services. The practice provided a service to the majority of Liverpool's travelling community and worked with other professionals to ensure the needs of this vulnerable group were met.

Summary of findings

Patients care needs were assessed and care and treatment was being considered in line with best practice national guidelines. There was good communication between staff and staff felt appropriately supported. Staff were proactive in promoting good health and referrals were made to other agencies to ensure patients received the treatments they needed.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients were very positive about the care they received from the practice. They commented that they were treated with respect and dignity and that staff were caring, supportive and helpful. Patients felt involved in planning and making decisions about their care and treatment. The National GP Patient Survey in March 2014 found that 98% of patients said the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care or concern. Ninety six percent of practice respondents said the GPs were good or very good at involving them in decisions about their care. These responses were better than average when compared to other practices nationally. We observed that all staff were kind, considerate and empathetic towards the needs of patients. Patients were provided with support to enable them to cope emotionally with care and treatment. For example, information about the support available to patients to help them to cope emotionally with care and treatment was on display in the waiting area. The Citizen's Advice Bureau held a weekly clinic at the practice for patients to get support and advice for a variety of issues.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. The practice planned its services to meet the differing needs of patients. For example, the practice opened on Saturday mornings to meet patients' needs. Some GPs had trained in complementary medicines such as acupuncture and one had trained in hypnotherapy as alternative ways to promote the health of patients experiencing conditions such as anxiety and panic attacks.

The practice provided very good access for the travelling community which included working closely with the social inclusion team which included the travellers' support workers, therapist from children's mental health services, school support workers, the city council site manager and social services. The practice worked closely with these professionals to ensure the health needs of the travelling community were met. For example, if follow up services were needed the traveller support workers (qualified nurses) hand

Summary of findings

delivered letters from the GPs and read them to the travellers as a number were illiterate. The GPs continued to monitor and prescribe medication when they moved to a site in another area in order to promote patient safety and continuity of care.

Reception staff told us that some patients were illiterate, they did not assume that patients were able to read and write and assisted patients who needed support discreetly and in private if this was needed. We spoke to three members of the Patient Forum who had worked with the practice for over 20 years. They told us that many projects had been run at the practice to make patients' wait more enjoyable. For example, music was played, a patients' library had been established and a reading project was tried out. The most successful project had been "Nancy's Kitchen" where volunteers from the Patient Forum provided tea and toast. This continued to be provided at the practice every morning. Members of the Patient Forum told us how socially isolated patients benefitted from this service and how they were able to direct patients to sources of support if requested.

The practice was involved in a social work pilot. This involved a social work team for adults being based at the practices. This pilot had been developed to encourage better communication and closer working relationships between health and social care services.

Are services well-led?

Good

The practice is rated as good for providing well led services. There was a clear leadership structure in place. Quality and performance were monitored. Staff told us they could raise concerns, felt they were listened to, felt valued and well supported.The practice had an active Patient Forum and Patient Participation Group and other systems to seek and act upon feedback from patients.

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. Home visits were made to housebound patients as requested and to carry out reviews of their health. The practice ensured each person who was over the age of 75 had a named GP and that a comprehensive geriatric assessment had been completed. The practice worked with other agencies and health providers to provide support and access specialist help when needed. Older patients with complex health needs were reviewed at multi-disciplinary meetings to ensure they were receiving all necessary GP services. The practice had identified older patients who were at risk of unplanned hospital admissions and developed a care plan to support them.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. An audit of bariatric patients had led to changes in the practice protocols for monitoring the healthcare needs of these patients. This audit was presented to the Royal College of General practitioners to disseminate the findings more widely and led to the GP who carried out the audit being invited to attend a nutritional panel that makes recommendations nationally. A specialist service was provided to focus on the needs of patients with complex needs, those who were housebound (including those who lived in care homes), on polypharmacy (the use of four or more medications by a patient) and with multiple conditions. Home visits were undertaken by GPs and a comprehensive review of the patients' health care needs was undertaken. The patients identified were also discussed in multi-disciplinary meetings to ensure their needs were being effectively met. A review of this service was carried out in May 2014 and found there had been changes to patient medication, including a reduction in the amount of prescribed medication compared to the results of a review of this service in 2010.

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

Summary of findings

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 had identified all patients at risk of unplanned hospital admissions and a care plan had been developed to support them. Clinical staff kept up to update in specialist areas which helped them ensure best practice guidance was always being considered. Multi-disciplinary team and palliative care meetings were held where patient care was reviewed to ensure patients were receiving the support they required. Patients receiving palliative care were allocated two GPs so there was always a GP available who knew the patients' needs.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. All new mothers were sent a letter advising them how to access services for mother and baby. The staff were responsive to parents' concerns about their child's health and prioritised appointments for children presenting with an acute illness. The extended hours service on a Saturday morning allowed parents to bring children to appointments, avoiding them having to miss school. Staff were knowledgeable about child protection and a GP took the lead for safeguarding. Staff put alerts onto the patient's electronic record when safeguarding concerns were raised. Regular liaison took place with the health visitor to discuss any children who were at risk of abuse and to review if an appropriate level of GP service had been provided.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice was open Monday to Friday 08:00 – 18:30 and offered extended hours GP appointments on Saturdays from 09:00 – 12:00. The practice offered pre- bookable appointments, on the day appointments for urgent medical conditions and telephone consultations. On line bookable appointments and on line prescription requests were available. The practice offered health promotion and screening that reflected the needs for this age group such as smoking cessation, sexual health screening and contraceptive services. Health checks were offered to patients who were over 45 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 care of people living in vulnerable circumstances. The practice looked after the health needs of the majority of Liverpool's travelling community. This patient group were vulnerable due to a number of risk factors such

as prevalence of domestic violence, alcohol consumption, child safeguarding concerns and low uptake of childhood immunisations. The practice met monthly with the social inclusion team which included the travellers' support workers, therapist from children's mental health services, school support workers, the city council site manager and social services. The practice worked closely with these professionals to ensure the health needs of the travelling community were met. For example, if follow up services were needed the traveller support workers (qualified nurses) hand delivered letters from the GPs and read them to the travellers as a number were illiterate. The GPs continued to monitor and prescribe medication when they moved to a site in another area in order to promote patient safety and continuity of care.

The practice was aware of patients in vulnerable circumstances and ensured they had appropriate access to health care to meet their needs. For example, a register was maintained of patients with a learning disability and annual health care reviews were provided to these patients. Patients' electronic records contained alerts for staff regarding patients requiring additional assistance in order to ensure the length of the appointment was appropriate. Staff were knowledgeable about safeguarding vulnerable adults. They had access to the practice's policy and procedures and had received guidance in this. 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. One of the GPs provided a weekly drop in surgery at the Whitechapel Centre for the homeless. GPs supported a twice weekly clinic held by Addaction (drug support service).

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia. GPs worked with specialist services to review care and to ensure patients received the support they needed. The practice maintained a register of patients who experienced poor mental health. The register supported clinical staff to offer patients experiencing poor mental health, including dementia, an annual health check and a medication review. The practice referred patients to appropriate services such as psychiatry and counselling services. An in-house counselling service was available for GPs to refer patients to. The Community Mental Health Team ran a clinic from the health centre which enabled good liaison with mental health professionals. One of

the GPs provided hypnosis to patients experiencing anxiety related ill health.The practice had information for patients in the waiting areas to inform them of other services available. For example, services for patients who may experience depression.	

Summary of findings

What people who use the service say

We looked at 31 CQC comment cards that patients had completed prior to the inspection and spoke with five patients. Patients were very positive about the care they received from the practice. They commented that they were treated with respect and dignity and that staff were caring, supportive and helpful. Patients we spoke with told us they had enough time to discuss things fully with the GP, treatments were explained, they felt listened to and they felt involved in decisions about their care.

The National GP Patient Survey in March 2014 found that 88% of practice respondents said the last time they saw or spoke to a GP, the GP was good or very good at treating them with care or concern and 95% described the overall experience of their GP surgery as fairly good or very good. These responses were about average when compared to other practices nationally. Ninety eight percent of patients said the last time they saw or spoke to a nurse the nurse was good or very good at treating them with care or concern. Ninety six percent of practice respondents said the GPs were good or very good at involving them in decisions about their care. These responses were better than average when compared to other practices nationally. Ninety three percent of patients felt the nurses were good or very good at involving them in decisions about their care. This was average when compared to other practices.

The National GP Patient Survey in March 2014 found that 91% of patients were very satisfied or fairly satisfied with opening hours. Ninety seven percent rated their ability to get through on the telephone easy or very easy. These results were above average when compared to other practices nationally.

The results from the National Patient Survey ranked the practice as 210 out of 7929 practices in England and seventh out of all the practices in Merseyside making them by comparison a high performing practice.

The patient survey for 2014 indicated that patients felt the GPs and nurses explained tests and treatments, treated them with care and concern and listened to them.

Areas for improvement

Action the service MUST take to improve

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

Action the service SHOULD take to improve

- Ensure the serial numbers of all prescription pads and the clinical staff they are issued to are recorded.

Outstanding practice

- The practice carried out a range of clinical audits to evaluate the operation of the service. The findings from some audits had been shared outside the practice. For example, an audit of bariatric patients had led to changes in the practice protocols for monitoring the healthcare needs of these patients. This audit was presented to the Royal College of General Practitioners to disseminate the findings more widely and led to the GP who carried out the audit being invited to attend a nutritional panel that makes recommendations nationally.
- The practice looked after the health needs of the majority of Liverpool's travelling community. The practice worked closely with a multi-disciplinary team of health and social care professionals to ensure the health needs of the travelling community were met. For example, if follow up services were needed the

traveller support workers (qualified nurses) hand delivered letters from the GPs and read them to the travellers as a number were illiterate. The GPs continued to monitor and prescribe medication when they moved to a site in another area in order to promote patient safety and continuity of care.

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- The practice was involved in a social work pilot. A social work team for adults was based at the practice. This pilot had been developed to encourage better communication and closer working relationships between health and social care services. This pilot had been in operation since February 2015 and although it had not been evaluated we spoke to staff from the practice, a social worker and the social work team leader who gave us many good examples of how admissions to hospital had been avoided and earlier hospital discharges facilitated due to better communication and faster reaction time from the practice and social services.
- We spoke to three members of the Patient Forum who had worked with the practice for over 20 years. They told us that many projects had been run at the practice to make patients' wait more enjoyable. For example, music was played, a patients' library had been established and a reading project was tried out. The most successful project had been "Nancy's Kitchen" where volunteers from the Patient Forum provided tea and toast. This continued to be provided at the practice every morning. Members of the Patient Forum told us how socially isolated patients benefitted from this service and how they were able to direct patients to sources of support if requested.

Vauxhall Primary Health Care

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, specialist advisors.

Background to Vauxhall Primary Health Care

Vauxhall Primary Health Care is based in an inner city area of Liverpool. The practice has been operating for 23 years and was established by the then, health authority working alongside local residents to establish what they wanted and needed from a GP practice. Patients have continued to have an active voice in the operation of the service.

The practice treats patients of all ages and provides a range of medical services. The staff team includes five GP partners, four salaried GPs, two practice nurses, a healthcare assistant, a practice manager, information manager, reception manager, practice development lead and administrative and reception staff. The practice has GP registrars working for them as part of their training and development in general practice.

The practice is open Monday to Friday from 08.00 to 18.30 Monday to Friday and from 09:00 to 12:00 on Saturdays. Patients can book appointments in person, on-line or via the telephone. The practice provides telephone consultations, pre bookable consultations, urgent same day appointments and home visits to patients who are housebound or too ill to attend the practice. The practice closes one afternoon per month for staff training. When the practice is closed patients access Urgent Care 24 for out of hours services.

The practice is part of Liverpool Clinical Commissioning Group. It is responsible for providing primary care services to approximately 6,576 patients. The practice is situated in an area of high economic deprivation. Income deprivation affecting children and older people is significantly higher than the national average. The number of unemployed patients and patients claiming disability allowance is also higher than the national average. The practice has a Primary Medical Services (PMS) contract.

Health and community services such as counselling, chiropody, phlebotomy and health training operate from the health centre premises.

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:

Detailed findings

- 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 28th April 2015.

We reviewed the operation of the practice, both clinical and non-clinical. We observed how staff handled patient information, spoke to patients face to face and talked to those patients telephoning the practice. We discussed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service. We sought views from patients, looked at survey results and reviewed comment cards left for us on the day of our inspection. We spoke with the practice manager, registered manager, GPs, practice nurse, practice development lead, information manager, reception manager, administrative staff and reception staff on duty.

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. Clinical staff told us they completed incident reports and carried out significant event analysis in order to reflect on their practice and identify any training or policy changes required. We looked at a sample of significant event reports and saw that a plan of action had been formulated following analysis of the incidents. Every two months clinical staff attended meetings to review significant events and any actions taken. Significant events were also discussed at practice meetings which took place monthly.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring safety incidents. A protocol around learning and improving from safety incidents was available for staff to refer to. We looked at a sample of records of significant events that had occurred in the last 12 months. There was evidence that appropriate learning had taken place and that findings were disseminated to relevant staff.

Staff we spoke with, both clinical and non-clinical told us they felt able to report significant events and that these incidents were analysed, learning points identified and changes to practice were made as a result. Staff were able to describe the incident reporting process and told us they were encouraged to report incidents. They told us they felt confident in reporting and raising concerns and felt they would be dealt with appropriately and professionally. Staff were able to describe how changes had been made to the practice as a result of reviewing significant events. For example, as a result of a patient not attending a hospital appointment when a referral had been made by the practice for suspected cancer, the systems for checking patient attendance at these appointments had been reviewed. Discussions had also taken place with the hospital in order to improve communication from the hospital with the practice when these appointments were missed. We noted that a central log/summary of significant events that would allow patterns and trends to be identified and actions taken to be reviewed was not in place.

Reliable safety systems and processes including safeguarding

Staff had access to safeguarding policies and procedures for both children and vulnerable adults. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were available to staff on their computers and in hard copy. Staff had access to contact details for both child protection and adult safeguarding teams. A safeguarding audit had been completed to ensure there were appropriate safeguarding systems in place.

Staff we spoke with confirmed they had received training in safeguarding at a level appropriate to their role and they demonstrated good knowledge and understanding of safeguarding and its application. We looked at a sample of training records that confirmed staff had attended this training. Training to update all staff had been planned and was being provided by the practice safeguarding lead.

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

The safeguarding lead met with the health visitor every two months to discuss any children who were at risk of abuse and to review if an appropriate level of GP service had been provided. Codes and alerts were applied to the electronic case management system to ensure identified risks to children, young people and vulnerable adults were clearly flagged and reviewed.

Medicines Management

The GPs told us they re-authorised medicines in accordance with the needs of patients and a system was in place to highlight patients requiring medicine reviews. The

practice employed a pharmacist one day a week who provided support with medication reviews and prescribing. The practice had a good working relationship with the local pharmacist who attended some monthly practice meetings and liaised with the practice when there were any issues of concern.

All GPs had undertaken Level 1 drug misuse Royal College of General Practitioners training. A clinic for patients withdrawing from illegal drugs was held twice a week at the practice. This was run by a community health service with support from GPs at the practice if needed.

We looked at how the practice stored and monitored emergency drugs and vaccines. Emergency drugs and vaccines were held securely and routinely checked by a designated nurse to ensure they were in date and suitable for use. We saw the vaccine fridges were checked daily to ensure the temperature was within the required range for the safe storage of the vaccines. We noted that a cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was not in place for clinical staff to refer to. We spoke to staff who managed the vaccines and they had a clear understanding of the actions they need to take to keep vaccines safe.

We noted that the serial numbers of prescription pads and the clinical staff the prescription pads were issued to were not recorded which would minimise the risk of misappropriation. Recent guidance from NHS Protect included recording the first and last serial numbers of the pads when they were issued to the GP and having the GP sign for the receipt of the pad. Prescription pads were generally held securely, we noted that additional security was needed for the management of some blank prescriptions that were in a lockable room, but not in a lockable cabinet. Following the inspection the practice manager reported that this had been attended to.

Cleanliness & Infection Control

There was a current infection control policy with supporting processes and guidance which staff were able to easily access. There was a lead member of staff for infection control who had completed training relevant to this role. Clinical and non-clinical staff generally had up to date training in infection control. The practice manager had identified several staff who needed training updates and they had taken steps to address this.

The patients we spoke with commented that the practice was clean and appeared hygienic. We looked around the premises and found all areas seen to be clean and tidy. The treatment and consulting rooms, waiting areas and toilets seen supported effective infection control practices. Surfaces were intact, easy to clean and the premises were uncluttered. Treatment rooms and consulting rooms had easy clean flooring. Staff had access to gloves and aprons and there were appropriate segregated waste disposal systems for clinical and non-clinical waste. Hand washing facilities and instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms.

The premises were leased from Liverpool Community Health who carried out legionella testing to ensure the safety of the water supply.

Liverpool Community Health carried out infection control audits with the last one undertaken in September 2013. This audit indicated that overall the practice was meeting effective infection control standards. We noted that the practice did not undertake its own infection control audits. These should be undertaken to ensure that good infection control practices are continuously promoted and where any shortfalls are identified an action plan is put in place to address them. A cleaning schedule was in place and we were told that the cleaners completed a log of cleaning works undertaken. Practice staff made checks of the premises to ensure cleaning was carried out to a satisfactory standard.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly. We were shown a certificate to demonstrate that equipment such as the weighing scales, spirometer and blood pressure machines had been tested and calibrated. All portable electrical equipment was routinely tested.

Staffing & Recruitment

Staffing levels were reviewed to ensure patients were kept safe and their needs were met. Duty rotas took into account planned absence such as holidays. In the event of unplanned absences staff from within the service covered non-clinical roles. Locum GPs were used that were known to the practice in order to promote continuity for patients.

Requires improvement

Are services safe?

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 a recruitment procedure that outlined the checks that were needed prior to the employment of staff, for example, obtaining references, checking qualifications and professional registrations and carrying out Disclosure and Barring service (DBS), formerly Criminal Records Bureau (CRB) checks (these checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post).

We looked at the recruitment records of three staff (two clinical and one non-clinical) who were amongst the last staff to be employed at the service. We found that improvements were needed to these records. None of the records we looked at contained evidence of physical and mental fitness. One contained no references. Two contained no evidence of identity and one contained no evidence of a DBS check. We were told that some administrative/reception staff had acted as chaperones, however, they were not carrying out this role until satisfactory DBS checks had been received. Staff spoken with confirmed this.

The professional registration of clinical staff was checked prior to appointment and we saw an up to date record of on going professional registration with the General Medical Council (GMC) and the Nursing Midwifery Council (NMC). We did not see evidence of up to date checks of the National Performers List or evidence that this had been checked prior to the employment of a GP whose records we looked at. The practice manager told us that these checks were undertaken but that a record had not been made.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included medicines management, infection control, dealing with emergencies and monitoring the safety of equipment. A health and safety policy and procedure was available. The practice manager was the lead for health and safety and these issues were discussed at staff meetings. The building was leased from Liverpool Community Health. The buildings manager ensured that checks were undertaken of the fire safety systems.

Arrangements to deal with emergencies and major incidents

Emergency medicines were held securely and routinely checked by a designated nurse to ensure they were in date and suitable for use. The practice had access to oxygen in the event of an emergency and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). We were told that the defibrillator was serviced annually and we saw records to confirm that regular checks of the batteries were carried out to ensure it was fit for use in the event of an emergency.

Staff told us they had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). We saw a sample of training certificates that confirmed this. Training to update all staff had been booked for May 2015. 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 computer and electrical equipment and loss of utilities. Key contact numbers were included for staff to refer to.

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

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

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

A specialist service was provided to focus on the needs of patients with complex needs, those who were housebound (including those who lived in care homes), on polypharmacy (the use of four or more medications by a patient) and with multiple conditions. Home visits were undertaken by GPs and a comprehensive review of the patients' health care needs was undertaken. The patients identified were also discussed in multi-disciplinary meetings to ensure their needs were being effectively met. A review of this service was carried out in May 2014 and found there had been changes to patient medication, including a reduction in the amount of prescribed medication compared to the results of a review of this service in 2010.

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

The GPs specialised in clinical areas such as diabetes, high risk medication monitoring, heart disease and sexual health. They also specialised and took the lead with different patient groups such as patients living in vulnerable circumstances, patients experiencing poor mental health and patients with cancer and those receiving palliative care. The practice nurses managed specialist clinical areas such as diabetes, chronic obstructive pulmonary disease (COPD), childhood immunisations and cervical screening. This meant that the clinicians were able to focus on specific conditions and provide patients with regular support based on up to date information.

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

Management, monitoring and improving outcomes for people

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 patients with chronic obstructive pulmonary disease (COPD) on steroid inhalers and an audit of healthcare provided to bariatric patients. Both audits led to changes to how the practice operated to meet patients' health care needs. For example, the initial audit of bariatric patients led to changes in the practice protocol for recalling patients for annual blood tests. The second cycle of this audit showed that all patients were now having the correct health care monitoring and it had been identified that several patients needed further intervention, such as the prescribing of supplementary vitamins. This audit was presented to the Royal College of General practitioners to disseminate the findings more widely and led to the GP who carried out the audit being invited to attend a nutritional panel that makes recommendations nationally.

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.

One of the GPs was involved in clinical research and trials in order to improve patient care. For example, they had carried out a TIME trial study to see if what time antihypertensive medication was taken made a difference. Some GPs had trained in complementary medicines such as acupuncture and one had trained in hypnotherapy as alternative ways to promote the health of patients experiencing conditions such as anxiety and panic attacks.

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 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 worked with the Clinical Commissioning Group (CCG) to monitor and improve outcomes for patients. The practice was one of several practices that 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. Information provided by the CCG showed that representatives from the practice attended regular meetings, the practice was meeting targets, for example, in relation to cervical screening, accident and emergency attendances, mental health, patient experience and recording smoking status. The practice had a development plan that highlighted areas where they wanted to make improvements.

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system for the performance management of GPs intended to improve the quality of general practice and reward good practice. QOF data from 2013/2014 showed the practice was performing about average when compared to other practices nationally. The practice performed better than average in maintaining a register for patients with a learning disability, a register of all patients in need of palliative care/support, having regular multidisciplinary reviews of patients on the palliative care register and ensuring women aged 25 – 65 had cervical screening within the last 5 years.

Effective staffing

An appraisal policy was in place. Staff were generally offered annual appraisals to review performance and identify development needs for the coming year. The practice manager told us that some staff reception/ administrative staff and nurses were overdue for an appraisal and that a plan had been put in place to address this. We spoke to four reception/administrative staff and a nurse who told us the practice was supportive of their learning and development needs. The GPs we spoke with told us they had annual appraisals. 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 most of the GPs had taken place. Revalidation is the process by which all registered doctors have to demonstrate to the General Medical Council (GMC) that their knowledge is up to date, they are fit to practise and are complying with the relevant professional standards.

Clinical and non-clinical staff told us they worked well as a team and had good access to support from each other. Regular developmental and governance meetings took place to share information, look at what was working well and where any improvements needed to be made. For example, the practice closed one afternoon per month for in-house meetings and to provide time for staff development. The clinical staff met to discuss new protocols, to review complex patient needs and keep up to date with best practice guidelines. The reception and administrative staff met to discuss their roles and responsibilities and share information. GPs met informally to discuss patient needs and provide peer support. Partners and managers meetings took place to look at the overall operation of the service.

The practice manager maintained a record of mandatory training carried out by all staff and role specific training for reception/administration staff, nurses and the health care assistant. This showed that they had completed mandatory training such as safeguarding adults and children and training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). They had also undertaken role specific training, such as chaperone

training, fire warden training and information governance. Some records showed that training updates were due and the practice manager had a plan in place to address this. The GPs kept a record of their own clinical training. On discussion with the GPs it was evident that they kept their skills and knowledge up to date. Clinical and non-clinical staff told us they had the training they needed to support them in their roles.

Working with colleagues and other services

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

Multi-disciplinary team and palliative care meetings were held on a regular basis. Clinical staff met with health visitors, social workers, district nurses, community matrons and Macmillan nurses to discuss any concerns about patient welfare and identify 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, when they were unable to attend these meetings they provided a report detailing their involvement with the patient. The safeguarding lead met with the health visitor to discuss any needs or concerns about children and young people registered with the practice. The practice worked with mental health services to review care and share care with specialist teams.

The GPs told us about how they worked with neighbouring practices and the CCG to share information, identify patient needs and to work on solutions to address them. The practice was one of four practices involved in a social work pilot. This involved a social work team for adults being based at the practices. This pilot had been developed to encourage better communication and closer working relationships between health and social care services. This pilot had been in operation since February 2015 and although it had not been evaluated we spoke to staff from the practice, a social worker and the social work team leader who gave us many good examples of how admissions to hospital had been avoided and earlier hospital discharges facilitated due to better communication and faster reaction time from the practice and social services. Clinical staff and social workers made joint visits to housebound patients to co-ordinate a review of health and social care needs. Social workers attended the multi-disciplinary team and palliative care meetings which enabled a more holistic approach to reviewing a patient's needs.

The practice looked after the health needs of the majority of Liverpool's travelling community. This patient group were vulnerable due to a number of risk factors such as prevalence of domestic violence, alcohol consumption, child safeguarding concerns and low uptake of childhood immunisations. The practice met monthly with the social inclusion team which included the travellers support workers, therapist from children's mental health services, school support workers, the city council site manager and social services. The practice worked closely with these professionals to ensure the health needs of the travelling community were met. For example, if follow up services were needed the traveller support workers (qualified nurses) hand delivered letters from the GPs and read them to the travellers as a number were illiterate. The GPs continued to monitor and prescribe medication when they moved to a site in another area in order to promote patient safety and continuity of care.

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the computer system for future reference. Staff we spoke with had been trained on the system, and could demonstrate how information was shared.

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

Outstanding ☆

Are services effective?

(for example, treatment is effective)

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

Consent to care and treatment

We spoke with clinical staff about their understanding of the Mental Capacity Act 2005. They provided us with examples of their understanding around consent and mental capacity issues. They were aware of the circumstances in which best interest decisions may need to be made in line with the Mental Capacity Act when someone may lack capacity to make their own decisions. 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). A procedure was in place for gaining verbal and written consent from patients, for example, when providing joint injections and minor surgical procedures.

Health Promotion & 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 information to patients. They provided information to patients via their website and in leaflets in the waiting area about the services available. A health trainer was linked to the practice. They were accessible to all patients who wanted support to improve their lifestyle.

The practice monitored how it performed in relation to health promotion. It used the information from Quality and Outcomes Framework (QOF) and other sources to identify where improvements were needed and to take action. Quality and Outcomes Framework (QOF) information showed the practice was meeting its targets regarding health promotion and ill health prevention initiatives. For example, in providing diabetes checks, flu vaccinations to high risk patients and providing other preventative health checks/screening of patients with physical and/or mental health conditions. The practice performed better than average in ensuring women aged 25 – 65 had cervical screening within the last 5 years.

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.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We looked at 31 CQC comment cards that patients had completed prior to the inspection and spoke with five patients. Patients were very positive about the care they received from the practice. They commented that they were treated with respect and dignity and that staff were caring, supportive and helpful. Patients we spoke with told us they had enough time to discuss things fully with the GP, treatments were explained and that they felt listened to.

The National GP Patient Survey in March 2014 found that 88% of practice respondents said the last time they saw or spoke to a GP, the GP was good or very good at treating them with care or concern and 95% described the overall experience of their GP surgery as fairly good or very good. These responses were about average when compared to other practices nationally. Ninety eight percent of patients said the last time they saw or spoke to a nurse the nurse was good or very good at treating them with care or concern. This response was better than average when compared to other practices.

The patient survey for 2014 indicated that patients felt the GPs and nurses explained tests and treatments, treated them with care and concern and listened to them.

We observed that all staff were kind, considerate and empathetic towards the needs of patients.

Reception staff we spoke with were aware of the importance of providing patients with privacy. They told us there was an area available if patients wished to discuss something with them away from the reception. We observed that a notice advising patients of this was on display. Reception staff told us that some patients were illiterate, they did not assume that patients were able to read and write and assisted patients who needed support in private if this was needed. They told us how they made every effort to communicate with patients who did not speak English when trying to arrange for an interpreter, for example, they had sung happy birthday to patients to establish their date of birth.

We observed that privacy and confidentiality were maintained for patients using the service on the day of the visit. We observed that consultation / treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity were maintained during examinations, investigations and treatments.

We spoke to three members of the Patient Forum who had worked with the practice for over 20 years. They told us that they had been involved in many projects that had been run at the practice to make patients' wait more enjoyable. For example, music was played, a patient's library had been established and a reading project was tried out. The most successful project had been "Nancy's Kitchen" where volunteers from the Patient Forum provided tea and toast. This continued to be provided at the practice every morning. Members of the Patient Forum told us how socially isolated patients benefitted from this service and how they were able to direct patients to sources of support if requested.

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 96.3% of practice respondents said the GPs were good or very good at involving them in decisions about their care. This was better than average when compared to other practices nationally. Ninety three percent of patients felt the nurses were good or very good at involving them in decisions about their care. This was average when compared to other practices.

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

Patient/carer support to cope emotionally with care and treatment

Information about the support available to patients to help them to cope emotionally with care and treatment was on display in the waiting area. This included, information for carers, information about the Citizen's Advice Bureau, advocacy services and mental health support services. Staff spoken with told us that bereaved relatives known to the practice were offered support following bereavement. GPs and the practice nurse were able to refer patients on to

Good

Are services caring?

counselling services for emotional support, for example, following bereavement. A counselling service was based at the practice. The Citizen's Advice Bureau held a weekly clinic at the practice for patients to get support and advice for a variety of issues. Some GPs had trained in complementary medicines such as acupuncture and one had trained in hypnotherapy as alternative ways to promote the health of patients experiencing conditions such as anxiety and panic attacks.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had assessed the needs of its patient population and had ensured that services were available to address these needs. The practice provided very good access for the travelling community which included working closely with the social inclusion team which included the travellers' support workers, therapist from children's mental health services, school support workers, the city council site manager and social services. The practice worked closely with these professionals to ensure the health needs of the travelling community were met. For example, if follow up services were needed the traveller support workers (qualified nurses) hand delivered letters from the GPs and read them to the travellers as a number were illiterate. The GPs continued to monitor and prescribe medication when they moved to a site in another area in order to promote patient safety and continuity of care.

The practice was involved in a social work pilot. This involved a social work team for adults being based at the practices. This pilot had been developed to encourage better communication and closer working relationships between health and social care services.

Some GPs had trained in complementary medicines such as acupuncture and one had trained in hypnotherapy as alternative ways to promote the health of patients experiencing conditions such as anxiety and panic attacks.

Clinical staff told us how they engaged with Liverpool Clinical Commissioning Group (CCG), health and social care services to address local needs and service improvements that needed to be prioritised. For example, The practice was one of four practices involved in a social work pilot. This involved a social work team for adults being based at the practices. This pilot had been developed to encourage better communication and closer working relationships between health and social care services.

Staff we spoke with told us how they responded to the differing needs of patients. For example, reception staff told us that some patients were illiterate, they did not assume that patients were able to read and write and assisted patients who needed support discreetly and in private if this was needed. We spoke to three members of the Patient Forum who had worked with the practice for over 20 years. They told us that many projects had been run at the practice to make patients' wait more enjoyable. For example, music was played, a patients' library had been established and a reading project was tried out. The most successful project had been "Nancy's Kitchen" where volunteers from the Patient Forum provided tea and toast. This continued to be provided at the practice every morning. Members of the Patient Forum told us how socially isolated patients benefitted from this service and how they were able to direct patients to sources of support if requested.

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

Referrals for investigations or treatment were mostly done through the "Choose and Book" system which gave patients the opportunity to decide where they would like to go for further treatment. Administrative staff monitored referrals to ensure all referral letters were completed in a timely manner.

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

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

The practice had a long-standing, active Patient Participation Group. The purpose of the Patient Participation Group was to meet with practice staff to review the services provided, develop a practice action plan, and help determine the commissioning of future services in the neighbourhood. Records showed how the Patient Participation Group had been consulted over the type of questions to include in the patients survey. Records

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

and a discussion with representatives from the Patient Participation Group indicated how they had worked with the practice to make improvements to access to services and communication with patients.

Tackling inequity and promoting equality

The practice provided disabled access in the reception and waiting areas, as well as to the consulting and treatment rooms. There were comfortable waiting areas for patients attending an appointment and car parking was available nearby. There were disabled parking spaces and toilet facilities.

Staff were knowledgeable about interpreter services for patients where English was not their first language. Information about interpreting services was available in the waiting area.

Patients' electronic records contained alerts for staff regarding, for example patients requiring additional assistance in order to ensure the length of the appointment was appropriate. If a patient required interpreting services then a double 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 access this service. In addition, one of the GPs provided a weekly drop in surgery at the Whitechapel Centre for the homeless.

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

Access to the service

The practice was open Monday to Friday from 08.00 to 18.30 Monday to Friday and from 09:00 to 12:00 on Saturdays. Patients could book appointments in person, on-line or via the telephone. The practice provided telephone consultations, pre bookable consultations, urgent same day appointments and home visits to patients who were housebound or too ill to attend the practice. The practice closed one afternoon per month for staff training. When the practice was closed patients accessed Urgent Care 24 for out of hours services.

The National GP Patient Survey in March 2014 found that 91% of patients were very satisfied or fairly satisfied with opening hours. Ninety seven percent rated their ability to get through on the telephone easy or very easy. These results were above average when compared to other practices nationally.

We looked at 31 CQC comment cards that patients had completed prior to the inspection. All comments indicated patients were very happy with the standard of care provided and a number mentioned being able to get an appointment when they needed one. Two people commented they would like more urgent access appointments. We spoke with five patients. They all said they were able to get an appointment when one was needed, one said that there could sometimes be a longer wait to see a GP of their choice. Patients 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.

The practice development lead monitored appointments to ensure there were enough available to meet the needs of patients. They had carried out a recent survey to find out patient views about an extra appointments scheme that had been introduced following funding from Liverpool Clinical Commissioning Group. Access to appointments was also monitored through staff and patient feedback.

The practice was encouraging patients to make use of on-line services such as arranging appointments and ordering repeat medication. A prize draw was being held to encourage uptake.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The complaint policy and procedure were available in the reception area. A television screen in the waiting area also provided details of how to make a complaint. The practice was planning to update it's website with this information. The policy included contact details for the Health Service Ombudsman, should patients wish to take their concerns outside of the practice and for Healthwatch Liverpool. We noted that contact details for NHS England were not included.

We looked at the record of complaints and found documentation to record the details of the concerns raised and the action taken. Staff we spoke with were

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

knowledgeable about the policy and the procedures for patients to make a complaint. A log was made of complaints to allow patterns and trends to be identified and acted upon.

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 clear aims and objectives which included, providing a high-quality, patient-led primary health-care service, involving patients in all aspects of their health care, providing a timely response to both acute and long-term conditions, ensuring patients saw the most appropriate clinical member of staff and communicating effectively with other health-care providers from both primary, secondary and community care settings and to participate.

The aims and objectives were available in the statement of purpose for the practice which was available on request. Staff we spoke with were able to articulate the vision and values of the practice. The practice had a charter which summarised its aims and objectives and was displayed at the practice and on the website for patients to see.

Governance Arrangements

Meetings took place to share information, look at what was working well and where any improvements needed to be made. The practice closed one afternoon per month which allowed for learning events and practice meetings. Clinical staff met to discuss new protocols, to review complex patient needs, keep up to date with best practice guidelines and review significant events. The reception and administrative staff met to discuss their roles and responsibilities and share information. Partners and managers meetings took place to look at the overall operation of the service.

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically or in a paper format. We looked at a sample of policies and procedures and found that the policies and procedures required were generally available and up to date. We noted that a cold chain policy and a staff sickness policy were not available.

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

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

The practice had systems in place for identifying, recording and managing risks. We looked at examples of significant incident reporting and actions taken as a consequence. Staff were able to describe how changes had been made to the practice as a result of reviewing significant events.

Leadership, openness and transparency

There was a leadership structure in place and clear lines of accountability. Staff had specific roles within the practice, and clinical and managerial staff took the lead for different areas, for example, Quality Outcomes Framework, infection control, information governance and clinical audits. We spoke with thirteen members of staff and they were all clear about their own roles and responsibilities. They all told us that they felt valued and well supported.

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

We reviewed a number of human resource policies and procedures that were available for staff to refer to, for example, disciplinary, grievance and capability and the equality and diversity policies and procedures. A whistle blowing policy and procedure was available and staff spoken with were aware of the process to follow.

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

Patient feedback was obtained through carrying out surveys, reviewing the results of national surveys and through the complaint procedure.

The practice had a well-established Patient Forum that had been in operation for over 30 years. Members of the group had been involved in the initial set up of the practice which included interviewing clinical staff for the practice and being involved in the design of the premises. We met with members of the Patient Forum who told us how they had

Are services well-led?

Good

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

worked with the practice over the years to make improvements to the services provided. Members of the Patient Forum worked alongside the Patient Participation Group. The purpose of this group was to meet with practice staff to review the services provided and help determine the commissioning of future services in the neighbourhood. Annual surveys sent by the practice were discussed and agreed with the Patient Participation Group and following the outcome an action plan devised with them. The results of the last patient survey indicated that patients wanted improvements to be made to the length of wait at reception, to the practice website and to the patient information leaflet. Records showed that an action plan had been put in place and action taken to address these issues. For example, to reduce waiting time at reception step by step instructions had been made available for patients on how to use the auto-arrivals screen. This was publicised through the practice website, newsletter and in reception. .

A leaflet was on reception and handed out to patients encouraging them to access and participate in the NHS friends and family test. The NHS friends and family test (FFT) is an opportunity for patients to provide feedback on the services that provide their care and treatment. It was available in GP practices from 1 December 2014. Results for February 2015 showed that 25 out of 25 patients were "extremely likely" or "likely" to recommend the practice.

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

Management lead through learning & improvement

Clinical and non-clinical staff told us they worked well as a team and had good access to support from each other. Regular developmental and governance meetings took place to share information, look at what was working well and where any improvements needed to be made. Staff told us the practice was supportive of their learning and development needs and that they felt well supported in their roles. Staff were offered annual appraisals to review performance and identify development needs for the coming year. The practice manager had identified that some staff needed training updates and some were overdue for an appraisal and they had put a plan in place to address this.

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 clinical and practice meetings and if necessary changes were made to the practice's procedures and staff training.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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