The Ash Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of The Ash Surgery.

We undertook a comprehensive inspection on 15th 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. However, improvements were needed to demonstrate the practice was recruiting staff safely and maintaining the safety of the premises and equipment.

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. Improvements were also needed to the systems in place to ensure the premises and equipment were safe.
- 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.

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.
- Protect patients against the risks associated with unsafe premises and equipment by ensuring that risk assessments are up to date and reviewed and that equipment is regularly checked to ensure it is operating safely.

The provider should:

- Ensure the serial numbers of all prescription pads and the clinical staff they are issued to are recorded.
- Improve the records of training to identify the training plans for individual staff and the training completed.

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. Improvements were also needed to the systems in place for ensuring risk assessments of the premises were up to date and reviewed and that equipment was regularly checked to ensure it was operating safely.

Are services effective?

Good

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

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. 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 providing responsive services. The practice planned its services to meet the differing needs of patients. They monitored the service to identify patient needs and service

Summary of findings

improvements that needed to be prioritised. Access to the service was monitored to ensure it met the needs of patients. The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint.

Are services well-led?

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 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 that it had a higher than average number of patients living in nursing homes, one of the GPs chaired a Frailty Working group and was working alongside other GP practices to improve standards of care for older people in the local area. A manager from a local care home was a member of the practice's Patient Participation Group which ensured that the views of this group of patients were represented.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. The practice held information about the prevalence of specific long term conditions within its patient population such as diabetes, chronic obstructive pulmonary disease (COPD), cardio vascular disease and hypertension. This information was reflected in the services provided, for example, reviews of conditions and treatment, screening programmes and vaccination programmes. The practice had a system in place to make sure no patient missed their regular reviews for long term conditions and to follow up unplanned hospital admissions in a timely manner. Varied appointments were offered to ensure long term conditions were adequately reviewed. For example, home visits were undertaken to housebound patients or those residing in residential care or nursing homes, longer appointments were offered depending on the number of conditions being reviewed. 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. In

response to patient need, the practice had developed a One Stop Diabetic Shop which enabled the majority of diabetic checks (apart from dietetic and retinopathy) to be carried out at the practice on the same day. This reduced the need for patients to attend for several appointments for different diabetic checks and increased the likelihood that patients would receive the care they needed. The Quality Outcomes Framework (QOF) data from April 2013 to April 2014 showed that patients were receiving their diabetes checks when they were needed.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. A weekly child health surveillance clinic and an immunisation programme were provided. The practice monitored any non-attendance of babies and children at child health and vaccination clinics and worked with the health visiting service to follow up any concerns. The practice hosted a Weaning Mum's Group, led by the health visitor once a month. 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 Monday evening allowed parents to bring children to appointments, preventing them from missing 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. The safeguarding lead met with the health visitor, school nurse and midwife every 4 – 6 months or more often if required to discuss any needs or concerns about children and young people registered with the practice.

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 and offered extended hours GP appointments until 19:45 on Mondays. 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.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice 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. Formal training in safeguarding adults was being arranged for staff who had not received this.

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). The practice had a mental health and dementia lead member of staff. GPs worked with specialist services to review care and implement new care pathways. 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 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 28 CQC comment cards that patients had completed prior to the inspection and spoke with eight 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 84% of practice respondents said the GPs were good or very good at involving them in decisions about their care and 85% felt the nurses were good or very good at involving them in decisions about their care. Seventy eight percent of patients described the overall experience of their GP surgery as fairly good or very good. Eighty six percent 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 89% 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. These responses were about average when compared to other practices nationally.

The National GP Patient Survey in March 2014 found that 75% of patients were very satisfied or fairly satisfied with opening hours. Seventy three percent rated their ability to get through on the telephone easy or very easy. These results were about average when compared to other practices nationally.

We looked at the last patient survey carried out by the practice in December 2014. This indicated that patients felt the GP involved them in decisions about their care, explained tests and treatments, listened and gave patients enough time to discuss their concerns. The majority of patients felt it was easy or usually easy to get an appointment at the practice. Comments made by patients indicated that a number felt improvements were needed to the telephone system as they had experienced problems getting through to the practice. Records and a discussion with representatives from the Patient Participation Group (PPG) indicated that an action plan had been put in place to address this issue.

Areas for improvement

Action the service MUST take to improve

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.
- Protect patients against the risks associated with unsafe premises and equipment by ensuring that risk assessments are up to date and reviewed and that equipment is regularly checked to ensure it is operating safely.

Action the service SHOULD take to improve

The provider should:

- Ensure the serial numbers of all prescription pads and the clinical staff they are issued to are recorded.
- Improve the records of training to identify the training plans for individual staff and the training completed.

The Ash Surgery

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 The Ash Surgery

The Ash Surgery is based in the Aigburth area of Liverpool. The practice treats patients of all ages and provides a range of medical services. The staff team includes four GP partners, three salaried GPs, three practice nurses, a healthcare assistant, a practice manager, an assistant practice manager 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 Tuesday to Friday from 08.30 to 18.30 and on Mondays from 08:30 to 19:45. Patients can book appointments in person, on-line or via the telephone. The practice provides telephone consultations, pre bookable consultations, same day (advanced access) 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 Unplanned 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 6,500 patients. The practice is situated in one of the more affluent suburbs of Liverpool and caters for a population that has more nursing homes than average. The practice has a General Medical Services (GMS) contract.

The practice shares a building with a counselling service and community services such as health training and the podiatry service operate from the practice.

An improvement grant had been applied for to enable the practice to extend the premises and make more room for clinics and other services.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Detailed findings

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 15th 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, 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.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring safety incidents. A protocol around learning and improving from safety incidents was available for staff to refer to. We looked at a sample of records of significant events that had occurred in the last 12 months. There was evidence that appropriate learning had taken place and that findings were disseminated to relevant staff. We saw that protocols had been revised and were told that training had been provided to staff as a result of the investigation into significant events to improve practice and ensure patient safety.

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. There was a central log/summary of significant events that would allow patterns and trends to be identified.

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 guidance flow charts and contact details for both child protection and adult safeguarding teams.

Staff we spoke with confirmed they had received training in safeguarding at a level appropriate to their role and they demonstrated good knowledge and understanding of safeguarding and its application. Some staff had received informal training around safeguarding adults at practice meetings where the policy and procedure was discussed. The safeguarding lead had identified this and was organising a formal training session to address this.

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

Regular liaison took place with the health visitor to discuss any children who were at risk of abuse and to review if an appropriate level of GP service had been provided. The safeguarding lead met with the health visitor, school nurse and midwife every 4 – 6 months or more often if required to discuss any needs or concerns about children and young people registered with the practice. 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. GPs worked with pharmacy support from the Clinical Commissioning Group (CCG) to review prescribing trends and medication audits.

Requires improvement

Are services safe?

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 spoke to staff who managed the vaccines and they told us that a cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was in place for the safe management of vaccines. They had a clear understanding of the actions they needed to take to keep vaccines safe. We noted that the vaccine fridges did not have a thermometer that was independent of mains power. We were informed that thermometers that were independent of the power supply had been ordered.

Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients or their representatives who attended the practice to collect them. 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 are issued to the GP and having the GP sign for the receipt of the pad.

Cleanliness & Infection Control

There was a current infection control policy with supporting processes and guidance which staff were able to easily access. There was a lead member of staff for infection control who had completed training relevant to this role and who attended regular infection control meetings with the Clinical Commissioning Group. Non-clinical staff had received in-house training in infection control that included training around handling samples and hand washing.

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 generally supported effective infection control practices. Surfaces were intact, easy to clean and the premises were uncluttered. Some consulting rooms were carpeted and these were regularly cleaned. Treatment rooms and some 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.

Liverpool Community Health carried out infection control audits with the last one undertaken in November 2014. This audit indicated that overall the practice was meeting effective infection control standards. An action plan had been put in place to address the shortfalls identified. A cleaning schedule was 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.

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

A Legionella risk assessment had been recently carried out. This identified actions that needed to be taken to ensure the safety of the water supply. We noted that one action was reported as being immediate. A date to address this was provided to CQC and following the inspection the registered manager confirmed that this work had been carried out.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly. We were shown a certificate to demonstrate that equipment such as the weighing scales, spirometer and blood pressure machines had been tested and calibrated. All portable electrical equipment was routinely tested. We noted that some of the labels applied to electrical equipment following testing were not showing the most recent date of inspection.

Staffing & Recruitment

Staffing levels were reviewed to ensure patients were kept safe and their needs were met. In the event of unplanned absences staff covered from within the service. 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. We were told by staff that in the event of extremely busy periods of activity, changes were made to the service to ensure patient safety. For example, the practice had opened on a Saturday to meet the demands of high numbers of patients requiring flu vaccination.

The practice had a recruitment procedure 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 administrative, who were employed within the last 4 years. We found that these records lacked organisation and some records were held electronically and some were in paper format. None of the records we looked at contained evidence of physical and mental fitness. No references were found in one of the clinical member of staff's records. Staff spoken with told us that DBS checks were carried out. The recruitment records showed that DBS checks had been requested. The practice manager told us that in accordance with data protection the DBS certificates had been destroyed. The DBS numbers and dates the checks had been carried out had not been retained as evidence of safe recruitment practices. The professional registration of clinical staff was checked prior to appointment, however, there was no system in place to record checks of on going professional registration with the General Medical Council (GMC), Nursing Midwifery Council (NMC) and the National Performers List. We also found no system in place to ensure clinicians had up to date professional indemnity insurance.

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 and infection control. The practice used electronic record systems that were protected by passwords and smart cards on the computer system. Health and safety information was displayed for staff. Fire drills took place and some staff had been trained as fire wardens.

Improvements were needed to the systems in place for monitoring the safety of the premises and equipment. A health and safety audit had been carried out in 2011 and made a number of recommendations that had not been implemented. A fire risk assessment was not available. An up to date electrical wiring test inspection had not been carried out. Emergency lighting was not serviced and in-house checks to record that they were functioning were not recorded. The fire alarm was regularly serviced but in-house checks were recorded as taking place monthly and not on a weekly basis. Environmental risk assessments of the premises had not been regularly reviewed. Several fire extinguishers had been replaced following a service visit, the new extinguishers were not labelled and were awaiting a check from the company that services the extinguishers to certify they were suitable for use. Following our visit the registered manager confirmed that a plan had been put in place to address the issues identified.

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). The defibrillator was serviced annually and we were told 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. 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. We noted that this did not include a plan for the risks presented by unplanned staff absence.

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

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

The GPs specialised and lead in clinical areas such as diabetes, dermatology, orthopaedics, vestibular problems and sexual health. They also specialised and took the lead with different patient groups such as women's health and older people. The practice nurses managed specialist clinical areas such as diabetes, chronic obstructive pulmonary disease (COPD) and hypertension. This meant that the clinicians were able to focus on specific conditions and provide patients with regular support based on up to date information.

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

Management, monitoring and improving outcomes for people

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

We looked at a sample of clinical audits and found that the results either confirmed no changes were needed to practice or where necessary changes had been made to practice to improve patient care. There were systems in place to ensure the outcomes from clinical audits were shared amongst all clinical staff. The Clinical Commissioning Group (CCG) pharmacist worked with clinical staff to ensure medication was effectively managed. This included carrying out audits of medication to ensure prescribing met patients' needs.

The practice worked with the Clinical Commissioning Group (CCG) to monitor and improve outcomes for patients. The 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 achieving targets in relation to mental health, urgent care, cancer screening and patient experience and had a development plan that highlighted areas where they wanted to make improvements.

The GPs told us about how they worked with neighbouring practices and the CCG to identify patient needs and to work on solutions to address them. For example, one GP who was the lead for integrated care within the neighbourhood group told us, that as a result of identifying high admission rates of older people to hospital within the locality a Frailty Working Group was established which was looking at how to best support older people and avoid hospital admissions.

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

The GPs and nurses had key roles in monitoring and improving outcomes for patients. These roles included managing long term conditions, safeguarding and

Good

Are services effective?

(for example, treatment is effective)

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

Effective staffing

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

The staff we spoke with told us they felt well supported in their roles. They said they had undertaken the training needed for their roles. The records of staff training did not reflect the training that staff told us they had completed. Improvements were needed to these records to identify the training plans for individual staff and the training completed. This would assist in planning for future training needs. The practice manager had identified that some staff needed refresher training in mandatory areas such as health and safety and they had a plan in place to address this.

Clinical and non-clinical staff told us they worked well as a team and had good access to support from each other. Regular developmental and governance meetings took place to share information, look at what was working well and where any improvements needed to be made. For example, the practice closed one afternoon per month for in-house developmental meetings. A variety of external educators had attended these meetings, such as local consultants and community support services. The clinical staff met to discuss new protocols, to review complex patient needs and keep up to date with best practice guidelines. The GPs met informally every morning to discuss patient needs and provide peer support. Partners and managers meetings took place weekly to look at the overall operation of the service.

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, 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, school nurse and midwife 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.

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.

Good

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). The practice had a consent policy, however we noted that information around best interest decision making needed to be more detailed in order to give clear guidance to staff.

Health Promotion & Prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, children's immunisations, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets in the waiting area about the services available. 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.

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

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

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We looked at 28 CQC comment cards that patients had completed prior to the inspection and spoke with eight 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 86% 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 89% 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. Seventy eight percent of patients who responded to this survey described the overall experience of their GP surgery as fairly good or very good. These responses were about average when compared to other practices nationally.

We looked at the last patient survey carried out in December 2014. This indicated that patients felt the GPs and nurses explained tests and treatments, treated them with care and concern, listened to them, took their problems seriously and gave patients enough time to discuss their concerns.

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

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.

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 84% of practice respondents said the GPs were good or very good at involving them in decisions about their care and 85% felt the nurses were good or very good at involving them in decisions about their care.

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

We looked at the last patient survey carried out in December 2014. This indicated that patients felt the GPs and nurses involved them in decisions about their care.

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, mental health support services and relationship 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 counselling services for emotional support, for example, following bereavement. A counselling service was available within the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The clinical staff told us how they engaged with Liverpool Clinical Commissioning Group (CCG) to address local needs and service improvements that needed to be prioritised. For example, one GP who was the lead for integrated care within the neighbourhood group told us, that as a result of identifying high admission rates of older people to hospital within the locality a Frailty Working Group was established which was looking at how to best support older people and avoid hospital admissions.

The practice had assessed the needs of its patient population and had tailored the services provided to meet these needs. As a result of identifying a high number of referrals to different clinical services, the GPs had decided to each specialise in clinical areas and undertake further training so as to ensure that unnecessary referrals were not being made. A system of directing patients to the most appropriate GP to assess their condition was put in place, for example to a GP specialising in dermatology, vertigo/ dizziness or sexual health. Referrals were also peer reviewed by another GP to ensure they were appropriate. The GPs told us that as a result of this system referrals to hospital for some conditions had been reduced. For example, there had been a reduction for referrals related to vertigo and dizziness.

In response to patient need, the practice had developed a One Stop Diabetic Shop which enabled the majority of diabetic checks (apart from dietetic and retinopathy) to be carried out at the practice on the same day. This reduced the need for patients to attend for several appointments for different diabetic checks and increased the likelihood that patients would receive the care they needed. The Quality Outcomes Framework (QOF) data from April 2013 to March 2014 showed that patients were receiving their diabetes checks when they were needed. A comparison with other practices that belonged to the neighbourhood quality improvement scheme operated by NHS Liverpool Clinical Commissioning Group (CCG) indicated that the practice was performing well in relation to care for patients with diabetes.

In order to increase the number of patients attending smoking cessation clinics and therefore improve their health, the practice had carried out an audit of smokers over the age of 50 and invited them to attend smoking cessation clinics. This had resulted in a good uptake of this service.

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, 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 an 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 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

A disability access assessment had been carried out in 2011. A number of the identified actions had been addressed, however we noted that a re-assessment had not taken place to identify if the measures taken had been

Good

Are services responsive to people's needs?

(for example, to feedback?)

effective and to ascertain if there were any further matters that needed attention. The practice provided disabled access in the reception and waiting areas, as well as to the consulting and treatment rooms. There was disabled car parking available, however, the car parking area had become uneven since it was last tarmacked and a longer term solution was being sought. A disabled toilet was available. An audio induction loop was available for patients with reduced ranges of hearing.

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

Access to the service

The practice was open Monday to Friday from 08.30 to 18.30 Tuesday to Friday and from 08:30 to 19:45 on Mondays. Patients could book appointments in person, on-line or via the telephone. The practice provided telephone consultations, pre bookable consultations, same day (advanced access) 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 Unplanned Care 24 for out of hours services.

The National GP Patient Survey in March 2014 found that 75% of patients were very satisfied or fairly satisfied with opening hours. Seventy three percent rated their ability to get through on the telephone easy or very easy. These results were about average when compared to other practices nationally. We looked at the last patient survey carried out in December 2014. This indicated that the majority of patients felt it was easy or usually easy to get an appointment at the practice. Comments made by patients indicated that a number felt improvements were needed to the telephone system as they had experienced problems getting through to the practice.

We looked at 28 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. One comment card indicated that it could be difficult to get through to the practice by phone. We spoke with eight patients. They all said they were able to get an appointment when one was needed, one said that they had experienced problems with getting through to the practice by telephone. Patients said they were generally satisfied with arrangements for repeat prescriptions and that if a referral to another service was needed this had been done in a timely manner.

Patient demand was monitored through the appointment system and staff and patient feedback.

The GP partners told us there was an issue with the phone line and that they were working with the Patient Participation Group to improve the system. Changes were being introduced to the appointment system to increase capacity. An improvement grant had been applied for to enable the practice to extend the premises and make more room for further consulting rooms and other services.

Listening and learning from concerns & complaints

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

One of the GP partners was responsible for the management of complaints, with the practice manager being the designated contact person. We looked at the record of complaints and found documentation to record the details of the concerns raised and the action taken. Staff we spoke with were knowledgeable about the policy and the procedures for patients to make a complaint.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision and its aims and objectives were to:-

"Provide the best possible quality of service to our patients and a service that we are proud of.

We will provide this by combining traditional General Practice which is family-based, cradle to grave, with continuity of care and familiarity. We will do this in an organisation that is forward thinking, integrated, technologically engaged and enabled to deliver the modern agenda. We will at all times respect our patients, treat them with courtesy and involve them in the decision making process. We will engage with a variety of other health professionals and care-givers in order to achieve the best possible outcomes for our patients."

The aims and objectives were displayed for staff and patients to see. Staff we spoke with were able to articulate the vision and values of the practice.

Governance Arrangements

Meetings took place to share information, look at what was working well and where any improvements needed to be made. The practice closed one afternoon per month which allowed for learning events and practice meetings. The clinical staff met to discuss new protocols, to review complex patient needs and keep up to date with best practice guidelines. The GPs met informally every morning to discuss patient needs and provide peer support. Partners and managers meetings took place weekly 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 they were generally up to date. We identified that the health and safety and the bullying at work policies and procedures were due for review.

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

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

The practice had systems in place for identifying, recording and managing risks. We looked at examples of significant incident reporting and actions taken as a consequence. Staff 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, for example, safeguarding and infection control and clinical staff took the lead for different clinical areas, for example, diabetes, dermatology, sexual health and gynaecology. We spoke with nine members of staff and they were all clear about their own roles and responsibilities. They all told us that they felt valued and well supported.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings or as they occurred with the practice manager or one of the GPs. Staff told us they felt the practice was well managed. 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, sickness and absence, equality and bullying policy. 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 Patient Participation Group. The purpose of the Patient Participation Group was to meet with practice staff to review the services provided and help determine the commissioning of future services in the neighbourhood. Surveys sent by the practice were discussed and agreed with the Patient Participation Group

Are services well-led?

Good

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

and an action plan devised with them. The last patient survey was carried out in December 2014 and the results were made available for patients to view on the practice website. The results indicated that patients wanted improvements to be made to communication, including the telephone system, time waiting for appointments and the practice website. Records showed that an action plan had been put in place to address these issues, for example by commissioning a web designer to improve the website, introducing catch up slots to decrease patient waiting times and informing patients via the waiting room screens of any delays to appointments. We noted that the action plan was not displayed on the practice website for patients to view.

We met with representatives of the Patient Participation Group who told us they met twice a year and also communicated via email. They told us that a number of improvements had been made to the practice as a result of their involvement, such as redecoration of the premises and missed appointments were reduced following the introduction of text reminders. They said they felt they were listened to and that their opinions mattered.

A leaflet was on reception and handed out to patients encouraging them to access and participate in the NHS friends and family test. The NHS friends and family test (FFT) is an opportunity for patients to provide feedback on the services that provide their care and treatment. It was available in GP practices from 1 December 2014. Results for January to March 2015 showed that 77 out of 79 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. Improvements were needed to the records of training to identify the training plans for individual staff and the training completed. This would assist in planning for future training needs.

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

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 Family planning services 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.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Patients were not protected against the risks associated with unsafe premises and equipment because the provider did not ensure that risk assessments were up to date and reviewed and that equipment was regularly checked to ensure it was operating safely.**