Maghull Practice

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Maghull Practice. The practice is registered with the CQC to provide primary care services. We undertook a planned, comprehensive inspection on 20 November 2014 and we spoke with patients, relatives, staff and the practice management team.

The practice was rated as **Requires Improvement.**

Our key findings were as follows:

- There were aspects of the service that needed improvement. The practice had a good track record for maintaining patient safety. Incidents and significant events were identified, investigated and reported, though improvements were required for the reporting of incidents. Lessons learnt were disseminated to staff. Improvements were required to ensure staff were safely recruited and records were maintained.
- There were some systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. However, there was a lack of local clinical audits, peer review and support to monitor and improve patient outcomes and experience. The high use of locum GPs caused anxiety and concern for patients. Care and treatment was not always considered in line with recognised best practice standards and guidelines and in line with current legislation.
- The practice was caring, staff treated patients with dignity and compassion.
- The service was responsive. The practice provided good care to its population taking into account their health and socio economic needs. Patients were listened to and feedback was acted upon. Complaints were managed appropriately.
- Whilst there was good open and transparent leadership form the practice manager, improvements were required in terms of clinical leadership and support available to staff. Systems to monitor, evaluate and improve services required improving. Staff enjoyed working for the practice and felt supported and valued.

Summary of findings

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

Action the provider MUST take to improve:

- Ensure the practice has suitable arrangements in place for obtaining and acting in accordance with consent of patients in relation to their care and treatment. Some staff did not have sufficient knowledge of the Mental Health Act 2003, the Mental Capacity Act 2005 and the Children's Act 1989.

Action the provider SHOULD take to improve:

- Ensure full and complete required information relating to workers is obtained and held when recruiting staff. This must include a Disclosure and Barring Service (DBS) check for all staff with chaperoning responsibilities or a risk assessment to support their decision not to undertake this.
- Ensure that full and comprehensive records are made when serious events and incident occur to encourage learning and improvement.
- Staff should undertake chaperone training and records should be made when this is carried out for patients
- Ensure doctors have available emergency drugs for use in a patient's home or a risk assessment in place supporting their decision not to have this.
- Have available the use of equipment such as pulse oximeters, defibrillators and oxygen for emergency treatments or a risk assessment in place supporting
- Ensure staff have appropriate support from a practice safeguarding lead person.
- Ensure there is a systematic programme of clinical and internal audit and that action is taken when improvements are identified.
- Ensure that all clinical equipment is PAT tested annually.
- They should review the high use of locum GPs at the practice to ensure patients receive consistency and continuity of care when attending appointments.

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 requiring improvement for providing safe services. Information from NHS England and the Clinical Commissioning Group (CCG) indicated that the practice had a good track record for maintaining patient safety. Effective systems were in place to provide oversight of the safety of patients. Incidents and significant events were identified, investigated and reported, though improvements were needed to the reporting of incidents. Lessons learnt were disseminated to staff. Staff took action to safeguard patients and when appropriate, made safeguarding referrals. Improvements were needed to ensure staff were recruited appropriately and required information in respect of staff was obtained.

Are services effective?

Requires improvement

The practice is rated as requiring improvement for providing effective services. There were some systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. However, there was a lack of relevant local audits, national benchmarking, accreditation, peer review and activities to improve patient outcomes and experience. Care and treatment was not always delivered in line with recognised best practice standards and guidelines or in line with current legislation. The high use of locum GPs caused anxiety and concern for patients. The practice worked well with colleagues and other services, attending meetings and sharing information. Good health promotion and prevention support was available to patients.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients we spoke with and who completed the CQC comment cards were complimentary about the service. They all found the staff to be person-centred and felt they were treated with dignity and respect. We observed a person- centred culture and found evidence that staff were motivated and provided kind and compassionate care. Staff we spoke with were aware of the importance of providing patients with privacy and of confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing services responsive to patient's needs. We found they engaged with the locality team and the local Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Telephone triage and advice was available, appointments and home visits made where

Summary of findings

the need arose for vulnerable patients. However extended hours for weekend appointments were not available for working patients and patients we spoke with would welcome this. The practice responded appropriately to complaints about the service. There was an accessible complaints system.

Are services well-led?

Requires improvement

The practice is rated as requiring improvement for providing services that are well led. Staff were clear about the practice values and their responsibilities in relation to these. Staff felt supported by management. Regular team meetings were held. However improvements were needed for the systems in place to monitor and improve quality and identify risk and the clinical leadership of the practice. The practice sought feedback from staff and patients. Staff were well trained, received regular performance reviews and attended staff meetings.

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

Requires improvement

There were aspects of the practice which required improvement in relation to all population groups. The practice had a high population of elderly patients. We saw that care was tailored to individual needs and circumstances, including those who resided in local care home setting. We saw that the Quality and Outcomes Framework (QOF) information indicated the percentage of patients aged 65 and older who had received a seasonal flu vaccination was similar to the national average. The practice was responsive to the needs of older people, they offered home visits and extended appointments for those with enhanced needs. The practice participated in the Virtual Ward programme for older vulnerable housebound patients.

The practice safeguarded older vulnerable patients from the risk of harm or abuse. There were policies in place, staff had been trained and were knowledgeable regarding vulnerable older people and how to safeguard them. However the practice did not have a safeguarding lead person. The practice nurse undertook some structured annual assessment of older people, including a review of their medicines. However we saw no evidence that the practice kept a register of all older people to help plan for the regular review of care and treatment. We found that all older patients had been assigned a named GP (as required nationally) but this was the registered provider and not their local GP. This was not practicable as the registered provider did not know the individual patients' and would have to travel some distance when needed.

Health promotional advice and support was given to patients and their carers if appropriate and leaflets were seen at the practice. These included signposting older patients and their carers to support services across the local community. Older patients were offered vaccines such as the flu vaccine each year

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People with long term conditions

Requires improvement

There were aspects of the practice which required improvement in relation to all population groups. The practice had processes in place for the referral of patients with long term conditions that had a sudden deterioration in health. The GP reviewed all unplanned admissions to hospital. We did not find that registers were kept for this patient group but the practice nurse showed us the work she undertook on a regular basis. Annual reviews of patients were

Summary of findings

carried out, or more regular if needed including a review of medications. All patients with an unplanned admission to hospital were reviewed by the GP on discharge. We saw health promotional advice, information and referral to support services for example smoking cessation.

Families, children and young people

Requires improvement

There were aspects of the practice which required improvement in relation to all population groups. The practice had systems in place for identifying children, young people and families living in disadvantaged and vulnerable circumstances. The practice monitored children and young people with a high number of A&E attendances. The GP had written reports for safeguarding and child protection meetings as required. The practice identified and reviewed newly pregnant women with ante and post natal referrals along with patients who experienced issues with their pregnancy. Regular meetings were held at the practice with midwives, health visitors and district nurses.

If required the GP would liaise with school nurses working locally. Not all staff we spoke with were aware of consent best practice for young people (Gillick competences). The practice nurse undertook children immunisation sessions and the practice and procedures were in place to follow up patients who did not attend their appointment.

We saw health promotional advice, information and signposting to support organisations and services for families, children and young people, including for sexual health clinics and mental health services.

Working age people (including those recently retired and students)

Requires improvement

There were aspects of the practice which required improvement in relation to all population groups. There was a lack of evidence to show that services for working age people including recently retired and students were good. There were no late night or weekend services available. There were no on-line arrangements for booking appointments or repeat prescriptions. We were told from patients within this population group that they had experienced delays in getting an appointment to see the GP.

People whose circumstances may make them vulnerable

Requires improvement

There were aspects of the practice which required improvement in relation to all population groups. Systems were in place for sharing information about patients at risk of abuse with other organisations where appropriate. The practice had a system in place for identifying patients living in vulnerable circumstances. Training for staff in

Summary of findings

children's and adult safeguarding matters was on offer but some staff required updating. A register was kept of patients with a learning disability to help with the planning of services and reviews. All such patients were offered an annual health check. We heard of the close links with community teams supporting this patient group. We saw health promotional advice and information available for patients.

People experiencing poor mental health (including people with dementia)

There were aspects of the practice which required improvement in relation to all population groups. The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. Clinicians routinely and appropriately referred patients to counselling and talking therapy services, as well as psychiatric provision.

Requires improvement

Summary of findings

What people who use the service say

We spoke with 10 patients on the day of our inspection and we received 25 completed CQC comment cards. Patients whom we spoke with varied in age and population group. They included older people, those with long term conditions, those of working age and mothers with babies. Patients told us the waiting times were usually good as well as contact made via telephone to make an appointment. Practice staff were kind, caring and professional and patients felt they were treated with dignity and respect by them. Whilst most patients were happy with the practice staff all of those we spoke with raised concerns about the high use of locum GPs and they were concerned about some aspects of their care.

The main concerns from speaking to patients, comment cards received on the day and from the practice patient survey was a lack of continuity of care from GPs at the practice. This indicated they were not always satisfied with the level of care they received from locum GPs and some had reported this to the practice manager and senior members of the organisation. One patient was disappointed that they had not had a response to concerns raised. Patients told us staff listened to them and nothing was too much trouble. Patients told us the environment appeared clean and hygienic.

Areas for improvement

Action the service MUST take to improve

Ensure the practice has suitable arrangements in place for obtaining and acting in accordance with consent of patients in relation to their care and treatment. Some staff did not have sufficient knowledge of the Mental Health Act 2003, the Mental Capacity Act 2005 and the Children's Act 1989.

Action the service SHOULD take to improve

Ensure full and complete required information relating to workers is obtained and held when recruiting staff. This must include a Disclosure and Barring Service (DBS) check for all staff with chaperoning responsibilities or a risk assessment to support their decision not to undertake this.

Ensure that full and comprehensive records are made when serious events and incident occur to encourage learning and improvement.

Staff should undertake chaperone training and records should be made when this is carried out for patients

Ensure doctors have available emergency drugs for use in a patient's home or a risk assessment in place supporting their decision not to have this.

Have available the use of equipment such as pulse oximeters, defibrillators and oxygen for emergency treatments or a risk assessment in place supporting

Ensure staff have appropriate support from a practice safeguarding lead person.

Ensure there is a systematic programme of clinical and internal audit and that action is taken when improvements are identified.

Ensure that all clinical equipment is PAT tested annually.

They should review the high use of locum GPs at the practice to ensure patients receive consistency and continuity of care when attending appointments.

Maghull Practice

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. The team was also accompanied by an Expert by Experience.

Background to Maghull Practice

Maghull Practice is registered with CQC to provide primary care services, which include access to GPs, family planning, ante and post natal care. The practice is situated within the Maghull ward area of Sefton. The practice has a higher than average population in full or part time employment and over 75 year olds. At 84.6 years, life expectancy in the Maghull area is higher than the national average.

The practice provides GP services for 3500 patients. They have one self-employed doctor working on a regular basis with all other sessions covered by locum GPs. The practice also has a practice nurse, practice manager and a number of administration and reception staff. The practice is part of South Sefton Clinical Commissioning Group (CCG).

GP consultation times are Monday to Friday 08.00 to 18.30. Patients can book appointments in person or via the telephone. Appointments can be booked for up to a week in advance for the doctors and a month in advance for the nursing clinics. The practice treats patients of all ages and provides a range of medical services. The practice does not deliver out-of-hours services. These are delivered by Go To Doc (GTD), a private provider of out of hour's services commissioned by South Sefton CCG.

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.

How we carried out this inspection

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

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Detailed findings

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

We carried out an announced inspection on 20 November 2014. We reviewed all areas of the practice including the administrative areas. We sought views from patients both face-to-face and via comment cards. We spoke with the practice manager, the doctor in attendance, a practice nurse, a number of administrative staff and the receptionists on duty.

We observed how staff treated patients visiting and ringing the practice. We reviewed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service. We also talked with carers and family members of patients visiting the practice at the time of our inspection.

Requires improvement

Are services safe?

Our findings

Safe track record

Reports from NHS England indicated that the practice had a good track record for maintaining patient safety. Information from the Quality and Outcomes Framework (QOF), which is a national performance measurement tool, showed that the provider was appropriately identifying and reporting significant events. GPs told us they completed incident reports and carried out significant event analysis routinely and as part of their on-going professional development.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events. We looked at the records of significant events that had occurred in the last 12 months. There was evidence that some learning had taken place where necessary however we found the records made of each incident were too brief. They lacked sufficient information for what actions staff had taken after the incident had been analysed and what learning or improvements had been made. We were told that feedback to staff was good. They told us they received feedback verbally either at one to one meetings or on occasion at team meetings if the events were relevant to all staff.

The practice had a process for monitoring serious events called serious event analysis (SEA) and when required these were reported to the local Clinical Commissioning Group (CCG). The practice received alert notifications from national safety bodies and a system was in place for cascading these to relevant staff. We saw evidence that staff were reflective when incidents occurred. The previous week to our inspection there had been a medicines incident and staff were keen to ensure firstly, that patients were safe and secondly that all agencies required had been notified.

From the review of complaint investigations information, we saw that the practice ensured complainants were given full feedback and they were asked for detailed information about their concerns. We saw how complaints made were used by the service to learn and improve patient safety and experience.

Reliable safety systems and processes including safeguarding

The practice had up to date child protection and protection of vulnerable adult policies and procedures. 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 and they had easy access to contact details for both child protection and adult safeguarding teams. We saw evidence of such information displayed in clinical, reception and administrative areas. All staff had received relevant training to their role on safeguarding. Staff we spoke with were knowledgeable about the types of abuse to look out for and how to raise concerns. However, because of the high use of locum GPs the practice did not have a GP safeguarding lead to whom staff could approach for advice and support. The GP did not routinely attend case conferences but instead they provided a written report when required. The practice had a system on their computers to flag up patients and children at risk.

The practice had a current chaperone policy. A chaperone policy notice was displayed in the reception area. Non clinical staff who may be asked to act as a chaperone had not received appropriate training for this role. Some staff we spoke with were unsure of their responsibilities in respect of chaperoning. Non clinical staff acting as chaperones had not had a Criminal Records Bureau (CRB) or Disclosure and Barring Service (DBS) check undertaken.

Medicines management

We checked medicines stored in the treatment rooms and fridges. We found that they were stored appropriately. There was a current policy and procedures in place for medicines management including cold storage of vaccinations and other drugs requiring this. We saw the checklist that was completed daily to ensure the fridge remained at a safe temperature and staff could tell us of the procedure in place for action to take in the event of a potential failure of the cold chain. The previous week to our inspection the practice had a cold chain incident. Daily records of fridge temperatures were taken but they were recorded as high for a number of days before the incident was escalated to the practice manager. When known the practice manager initiated a serious incident investigation and appropriate actions were taken. All vaccines at this time were quarantined until assurance from the vaccine providers was given to continue with their use.

Medicines for use in medical emergencies were kept securely in a cupboard in one of the practice rooms. We

saw evidence that stock levels and expiry dates were checked and recorded on a regular basis. The practice nurse had good systems in place for checking this. Staff knew where these were held and how to access them. We reviewed the bags available for doctors when undertaking home visits and found they did not routinely hold medicines. There was no oxygen kept by the practice for use in case of an emergency and no risk assessment in place to support this decision.

The practice worked with pharmacy support from the Clinical Commissioning Group (CCG) to support the clinical staff in keeping up to date with medication and prescribing trends. The CCG pharmacy support visited the practice and regular meetings were held with them to discuss medicines optimisation plans. We saw evidence of good working with the pharmacy support and recorded notes of meetings.

Stock prescription pads were stored securely and a paper record of when they were received into the practice and taken for use by GPs was maintained.

GPs reviewed their prescribing practices as and when medication alerts were received. Patient medicine reviews were undertaken on a regular basis depending on the nature and stability of their condition.

Cleanliness and infection control

Patients commented that the practice was clean and tidy. The practice had an infection control audit undertaken by the community trust infection control team in July 2014. The practice had obtained 95% compliance with the audit. Internal infection control audits were also undertaken and action plans were seen for July 2014. Cleaning was undertaken by a contracted cleaning company, the practice manager and cleaning company monitored the schedule and standard of cleaning.

The practice nurse was the lead for infection control although we found some staff were not aware of this when we spoke with them. They had received appropriate training in infection control and this was updated annually. They linked closely with the community trust infection control team. We saw evidence of support given to the practice nurse from the community infection control nurse.

There was an up-to-date infection control policy and associated procedures in place. A needle stick injury policy was in place, which outlined what to do and who to contact in the event of accidental injury. Needle stick injury flow charts were displayed in all treatment and consultation rooms. We saw current protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance and were in line with current best practice.

We inspected the treatment and clinical rooms. We saw that all areas of the practice were clean and processes were in place to manage the risk of infection. Consultation and treatment rooms had adequate hand washing facilities. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms. We found protective equipment such as gloves and aprons were available in the treatment/consulting rooms.

We were told the practice did not use any instruments which required decontamination between patients and that all instruments were for single use only. Procedures for the safe storage and disposal of needles and waste products were evident in order to protect the staff and patients from harm.

The practice undertook regular testing and investigation of legionella (bacteria found in the environment which can contaminate water systems in buildings).

Equipment

The practice had systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment. Suitable equipment which included medical and non-medical equipment, furniture, fixtures and fittings were in place. Staff confirmed they had completed training appropriate to their role in using medical devices. We saw evidence that clinical equipment was regularly maintained and cleaned but there was no evidence that an annual PAT test had taken place for all electrical equipment in use.

Staffing and recruitment

Staff told us there was a recruitment policy in place but they were unaware if this included the requirement that all staff should have a Disclosure and Barring (DBS) check in place. We looked at a sample of recruitment files for doctors, reception and administrative staff, practice manager and nurses. The practice employed locum GPs. We were told they independently checked the suitability of locum doctors as well as reviewing the NHS performer's lists.

Requires improvement

Are services safe?

We found gaps in the required information relating to workers in the staff files that we looked at. We looked at four staff records. There were appropriate CRB or DBS checks for the clinical staff (including practice nurses and GPs). There was not a policy in place to identify which roles required which level of DBS check and at what frequency these would be undertaken. Non clinical staff such as reception and administration staff did not have an appropriate CRB or DBS check. These staff were occasionally asked to undertake chaperone duties and therefore they must have the required checks undertaken.

There was a system in place to record professional registration such as for the General Medical Council (GMC) and the Nursing Midwifery Council (NMC). We saw evidence that demonstrated professional registration for clinical staff was up to date and valid.

Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The staff worked well as a team and as such supported each other in times of absence and unexpected increased need and demand.

Monitoring safety and 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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff. A basic risk assessment log was seen. Risks were assessed, rated and control measure recorded to reduce and manage the risk. Staff confirmed they had received regular cardiopulmonary resuscitation (CPR) training and training associated with the treatment of anaphylactic shock. Formal risk assessments for the environment and premises were in place; this included a fire risk assessment and a completed legionella test for the building.

Arrangements to deal with emergencies and major incidents

Comprehensive plans to deal with any emergencies that may occur, which could disrupt the safe and smooth running of the practice, were available. A detailed business continuity plan was in place. The plan covered business continuity, staffing, records/electronic systems, clinical and environmental events. Reception staff we spoke with were knowledgeable about the business continuity plans and described how they had used the plan when telephone and IT systems failed. We found there was no oxygen cylinder, nebuliser or automated external defibrillator available at the practice. We were not assured that the practice was able to immediately respond to the needs of a person who becomes seriously ill because they did not have this equipment and there was no risk assessment in place to support this.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

There were a number of systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. Staff had access to corporate guidance and current guidance from the National Institute for Health and Care Excellence (NICE). These guidelines were available on the practice IT system and staff were familiar with them. Despite this we considered that some staff did not have a good enough awareness of safe and effective current practice. This included the requirements of the Mental Capacity Act 2005 and the assessment of Gillick competencies for children when gaining their consent. Some GPs lacked the knowledge and awareness and were not following this guidance. The GP did not attend practice or peer group meetings so we were unclear how they would be updated when new guidance was developed.

Each patient attending the practice had their needs assessed by either the GP or the practice nurse. We reviewed a number of patient's records in consultation with the GP and found assessments were comprehensive and treatments were appropriate. However we found that some GPs were not clear about the rationale for some of the medications they were prescribing and what new medicines were now available. We found also that the monitoring systems the provider had in place, identified poor practice for some GPs in terms of each patient having a completed patient assessments and this was discussed at regular monthly locality manager meetings.

Consistency and continuity of planned care was achieved between the day and out-of-hour's service for patients with complex and end of life care needs. The practice nurse managed specialist clinical areas such as diabetes, heart disease and asthma. This meant they were able to focus on specific conditions and provide patients with regular support based on up to date information.

The practice referred patients appropriately to secondary care and other services. We saw that the practice's referral rates for healthcare conditions reflected the national standards for referral rates. All GPs we spoke with used national standards for referral, for example suspected cancers. There was an electronic audit trail for acting on test results and hospital consultation letters. However practice staff routinely passed patient discharge information to the GP without first scanning it onto the IT system.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients' care and treatment. It used the Quality and Outcomes Framework (QOF) to assess its performance and undertook regular local clinical audit. However we found that the GPs working at the practice were not aware of the practice results for QOF and not engaged with how the practice monitored performance in general. Discussion of audits, performance indicators and quality initiatives was evident in practice meetings but the GPs did not attend these meetings.

Examples of clinical audits included data quality and a variety of medicines management audits. Whilst local audits were undertaken we found that actions identified when completed had not always taken place. We did not find a systematic programme of clinical and internal audit, which was used to monitor quality and patient outcomes. National audits had been carried out however these were not available or known during the inspection and there was no evidence of national benchmarking, accreditation or peer review to provide assurance that care and treatments were effective. We found that GPs were not involved in any of this work at the practice.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice had achieved and implemented the gold standards framework for end of life care. There was no designated GP but locum GPs had attended meetings for this. The practice had a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw evidence of these meetings and saw evidence of patients

and families identified as having these particular needs. Special notes were used to inform out of hours services of any particular needs of patients who were coming towards the end of their lives.

Effective staffing

The induction programme covered a wide range of topics including policies and procedures, confidentiality, staff training, organisational induction and job specific induction. We saw in individual staff records that mandatory training had been undertaken by all staff according to their roles. These topics included for example annual basic life support, infection control, health and safety, information governance and safeguarding of vulnerable adults and children. Staff also had access to additional training related to their role. Staff we spoke with told us they felt they were well trained and received good support to undertake training including that which was required by the practice and for training and development personal to their role. The new practice nurse in particular had been well supported in her induction. We confirmed that staff had the knowledge and skills required to carry out their roles.

The staff files we reviewed showed that staff of all disciplines had received an annual appraisal. Nursing staff had access to regular formal peer supervision sessions. The administrative staff told us they were well-supported and regularly had conversations about their performance with their line manager. The practice nurse performed defined duties and extended roles. They were able to demonstrate that they were appropriately trained to fulfil these duties. For example, on administration of vaccines and cervical cytology.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or were progressing towards revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council). All doctors were on the national GP performers list and this was monitored by the local Clinical Commissioning Group. We found that the practice was covered by a large number of locum GPs and for many patients we spoke with during our inspection this caused them considerable concern. We found that because of the high use of GP locums in place the practice was unable to achieve continuity of care by doctors. Patients were unable to make appointments with a named doctor and they were not always able to have a choice over being seen by a male or female doctor if required. Many patients we spoke with were concerned by this model fearing the GP might not know their medical history, they had to go over this at each visit and some were concerns that mistakes might occur because of this.

The practice demonstrated that they were managing poor or variable performance of staff. Systems were in place for the practice manager to discuss concerns about poor performance and actions were taken in response to this. Concerns had been escalated to senior managers across the organisation. It was agreed that following the inspection CQC would be notified of what actions the provider had taken for concerns raised relating to this.

Working with colleagues and other services

The practice worked with other agencies and professionals to support continuity of care for patients. We were shown how the practice provided the 'out of hours' service with information, to support, for example, end of life care. The practice worked closely with other health care providers in the local area. The GPs and the practice manager attended various meetings for management and clinical staff involving practices across South Sefton CCG. South Sefton CCG organised themselves into localities and the practice met regularly with the CCG and other practices. These meetings shared information, good practice and national developments and guidelines for implementation and consideration.

The practice held multi-disciplinary team meetings three monthly to discuss the needs of complex patients with end of life care needs. We saw good communications with the out of hours services to ensure patient care was transferred safely when the practice was closed.

Information sharing

We found that staff had all the information they needed to deliver effective care and treatment to patients. All new patients were assessed and patients' records were set up, this routinely included paper and electronic records with assessments, case notes and blood test results. We saw that all letters relating to blood results and patient hospital discharge letters were reviewed on a daily basis by doctors in the practice. However they were not routinely scanned

Are services effective?

(for example, treatment is effective)

on the IT system before being given to the GP. We found that when patients moved between teams and services, including at referral stage, this was done in a prompt and timely way.

Consent to care and treatment

There was a practice policy for documenting consent for specific interventions. For example, for invasive implantations, a patient's written consent was obtained and documented.

The practice had systems in place to seek patients consent for certain procedures, for instance for vaccinations. A written policy was available and we saw that consent was sought for procedures such as childhood immunisations. However we found some staff were not aware of their responsibilities for this and why written consent was required in line with legislation and national guidance. We considered some lacked awareness of the requirements of the Mental Capacity Act 2005 and the Children Act 1989 and 2004 and therefore may not be following this.

Health promotion and 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 and information in the waiting area about the services available. The practice also provided patients with information about other health and social care services such as carers' support. Staff we spoke with were knowledgeable about other services, how to access them and how to direct patients to relevant services.

The practice offered a health check and assessment to all new patients registering with the practice and also offered NHS Health Checks to all its patients aged 40-75. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was average for the CCG.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Consultations took place in purposely designed rooms with an appropriate couch for examinations and screens to maintain privacy and dignity. Staff we spoke with were aware of the importance of providing patients with privacy and of confidentiality. There was a separate room available if patients wanted to speak in private when they presented at reception. We observed staff were discreet and respectful to patients. Reception staff had received customer care training.

The practice offered patients a chaperone prior to any examination or procedure. Information about having a chaperone was seen displayed in the reception area. Patients we spoke with told us they were always treated with dignity and respect and that staff were caring and compassionate. We found that staff knew the majority of their patients well and patients told us the practice had a family feel to it, the staff were all welcoming, caring and compassionate.

Care planning and involvement in decisions about care and treatment

The Quality Outcomes Framework (QOF) showed adequate results for patients who had a comprehensive care plan documented in their records which had been agreed between individuals, their family and/or carers as appropriate. During our inspection patients told us they felt involved in their care. However many of the patients reported a lack of consistency and continuity when attending appointments and they were frustrated they were not able to see the same doctor at each appointment.

We found that staff were at time unclear about how to ensure patients were involved in making decisions and the requirements of the Mental Capacity Act 2005 and the Children's Act 1989 and 2005. Some of the answers given to our questions suggested staff were not aware of the legislation so may not take account of it when involving patients in decisions about their care and treatment.

The practice had an 'access to records' policy that informed patients how their information was used, who may have access to that information, and their own rights to see and obtain copies of their records.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the care they received from the practice. They commented that they were treated with respect and dignity. Patients we spoke with told us they had enough time to discuss things fully with the GP but they were concerned by the high use of locums. They told us all the staff were compassionate and caring.

We observed that the reception staff treated people with respect and tried to ensure conversations were conducted in a confidential manner. We observed that privacy and confidentiality were maintained for patients using the service on the day of the visit.

Clinical staff had various ad hoc methods of supporting bereaved patients. Some would contact them personally, the reception staff were knowledgeable in support for bereaved patients. They were familiar with support services and knew how to direct patients to these. However the practice did not have a consistent protocol for communication and care of bereaved patients.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and they were aware of the different needs of the local population groups. We saw that home visits and patient reviews were undertaken in local care homes, the practice had a higher than average age group for patients over 75 years and a number of these lived locally in care homes. The practice held information about the prevalence of specific diseases and population groups. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions and mental health conditions.

We found that the practice was mostly responsive in terms of seeking and acting upon patients views. A patient questionnaire had recently been sent out in August 2014. We were told the results of these were discussed at practice meetings held monthly. The practice had an active Patient Participation Group (PPG) and we spoke with one of the members during our inspection. They told us the practice was engaged with the group, interested in their views and willing to take their advice. They did however show us a letter identifying the groups concerns about the high use of locum GPs which they had sent to senior manager of the provider organisation. This letter was sent in August 2014 and the group had still not had a reply. We saw in reception there were publicised comments forms and a box for patients and public to contribute views. We were told that patient experience feedback was discussed at staff meetings.

Tackling inequity and promoting equality

The practice ethos strived to provide quality and responsive care to all patients. The practice analysed its activity and monitored patient population groups, this enabled them to direct support and information at different groups needing different support. The practice had a majority population of English speaking patients though it could cater for other languages as it had access to translation services.

The premises and services had been adapted to meet the needs of people with disabilities. All treatment and consultation rooms were located on the ground floor with doorways wide enough for wheelchair access. There were disabled parking and toilet facilities available.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The practice manager dealt with complaints in the practice and liaised with all relevant staff in dealing with the complaints on an individual basis.

We looked at the complaints records for the last 12 months and found that complaints had been dealt with and responded to appropriately. The practice took action in response to complaints to help improve the service. Complaints were investigated thoroughly. A summary and overview log was recorded which broke down the complaints into subjects and themes. We found however, that senior managers within the provider organisation had not made a written response to concerns raised by a member of the practice PPG.

Patients we spoke with were all aware of the complaints procedure. An information leaflet detailing the process for making complaints or comments about the practice was available to take away at the reception desk. Staff we spoke with were able to tell us how they would handle initial complaints made at reception or by telephone and what information they would give to patients wishing to make a complaint.

Access to the service

Patients told us they experienced good access to the service but they were frustrated they could not see the same GP at each appointment. We saw that initial assessments by the GPs and the practice nurse were carried out in a timely manner. Patients generally reported they could access an appointment at a time that suited them. However the practice has a high number of working patients and late night or weekend appointments were not available. We were told that these appointments were due to commence shortly after our inspection. We found that internet booking of appointments was not in use at the practice but time was made for GPs to undertake telephone patient consultation when needed.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

We saw evidence of how practice staff worked with out-of-hours services and other agencies to make sure patients' needs were met when they moved between services. Monthly multi-disciplinary Gold Standard Framework (GSF) meetings took place to monitor the needs of palliative care patients. We saw that when needed a patient appointment with other providers such as a hospital referral would be made during the patient's consultation with the GP. This was undertaken after the appropriate tests and examinations had been completed by the practice. We heard from patients that following discharge from hospital the GP and practice staff had been very supportive.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

Staff were able to articulate the values of the practice. The lead GP told us how they aimed to deliver high quality care that was responsive to needs. However the practice did not have and could not articulate a strategy for the future or for future developments in service provision.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computer and in hard copy in the offices. Staff confirmed they had read them and were aware of how to access them. We found that the organisational structure was not clearly defined or written down. Staff did have identified lead roles, for example there was a lead nurse for infection control however there was no lead GP for safeguarding at the practice. We spoke with staff of varying roles and they were all clear about their own roles and responsibilities. They all told us there was a friendly, open culture within the practice and they felt very much part of a team. They all felt valued, well supported and knew who to go to in the practice with any concerns. They felt any concerns raised would be dealt with appropriately. Staff attended a number of meetings both internally and externally and with multi-disciplinary teams. They met regularly with the Clinical Commission Group (CCG) and other local practices for benchmarking and service developments.

We found some processes were in place for the practice to monitor the care and treatment that was given. Staff meetings took place on a monthly basis. Monthly support and monitoring meetings were held between the practice and locality manager. We saw records of these meetings and could see that patient safety and experience, performance and poor performance of staff was reviewed at this time. Patients had been asked their views in a recent patient satisfaction survey.

National audits were undertaken. The practice took account of data such as the Quality Outcomes Framework (QOF) data to monitor performance. However, we found only evidence of clinical audits which were generally medicines management audits. We found that whilst they had been completed there was little evidence that actions identified when completed had taken place. We did not find a systematic programme of clinical and internal audit, which was used to monitor quality and patient outcomes. National audits had been carried out however these were not available or known during the inspection and there was no evidence of national benchmarking, accreditation or peer review to provide assurance that care and treatments were effective. We found that GPs were not involved in any of this work at the practice and they were not providing effective leadership to the team.

The practice had arrangements in place for identifying and managing risks. Risk assessments had been carried out where risks were identified and control measures were in place.

Leadership, openness and transparency

The management structure was clearly identified and staff knew who their leader was and understood the lines of responsibility. Reception and administration staff felt well supported in their role. They felt confident in the practice managers ability to deal with any issues, including serious incidents and concerns regarding clinical practice. Staff reported an open and no-blame culture where they felt safe to report incidents and mistakes. All the staff we spoke with told us they felt they were valued and their views about how to develop the service acted upon.

Examples of various practice meeting minutes demonstrated information exchange, improvements to service, practice developments and learning from significant events. Regular monthly team meetings were held at which time practice staff, but not the GPs, had the opportunity and were happy to raise any suggestions or concerns they had. We found the locum GP and the recent changes to this meant the practice did not have effective clinical leadership and support at all times.

The practice manager was responsible for human resource policies and procedures at a local level but support was available from across the organisation. We saw that when needed actions had been taken when concerns were raised about poor practice and staff competence.

Practice seeks and acts on feedback from its patients, the public and staff

The practice recognised the importance of gaining the views of patients, carers and the public to build on and improve services. They had an active Patient Participation Group (PPG) which met regularly to share their views of the

Are services well-led?

Requires improvement

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

practice. During our inspection we met with one of the members who was positive about the practice engagement but was disappointed that concerns raised about the high use of locum GPs had not been responded to.

The practice regularly reviewed the results of the patient survey and we saw actions taken in response. We found they had undertaken their own patient survey in August and actions had been taken for negative comments made by patients.

We looked at complaints and found that the practice investigated and responded to them in a timely manner, and complainants were satisfied with the outcomes. They were discussed at staff meetings and were used to ensure staff learned from the event.

There was a whistleblowing policy in place. Staff told us they had no concerns about reporting any issues internally. The practice gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

Staff told us they had annual appraisals which included a review of their performance and development needs. We saw these were up to date. The practice had an induction programme and a mandatory training programme to ensure staff were equipped with the knowledge and skills needed for their specific l roles. Mandatory training was up to date for all staff. Staff told us they had good access to training and were well supported to undertake further development in relation to their role. The practice manager knew the training status of the staff.

The practice had completed reviews of significant events, complaints and other incidents and shared these with staff at meetings. There was a half day each month when the practice closed and this time was used for learning, development and staff meetings.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person must ensure the practice has suitable arrangements in place for obtaining and acting in accordance with consent of patients in relation to their care and treatment. Some staff did not have sufficient knowledge of the Mental Health Act 2003, the Mental Capacity Act 2005 and the Children's Act 1989. Regulation 18