Dr SS Sapre and Partners

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

We carried out an announced comprehensive inspection at Dr S S Sapre & Partners on 13 January 2016. Overall the practice is rated as requires improvement.

Our key findings across all the areas we inspected were as follows:

- The practice had a system in place for the management of Medicines and Healthcare Products Regulatory Agency (MHRA) alerts. However, there was a delay of up to one week before these were shared with clinicians. These alerts were not held for future reference.
- Arrangements for managing medicines kept patients safe.
- The practice had completed a number of clinical audits which evidenced safe prescribing.
- Assurances given by the provider in response to the findings of an infection control audit at the practice had not been acted upon.
- At the time of inspection, the practice was carrying vacancies for a health care assistant and a permanent GP.
- Staff recruitment checks were incomplete; a number of staff had not received an induction and some staff had not received the appropriate employment contracts.
- There was no oxygen available for use on site. The practice manager pointed to the availability of oxygen at neighbouring facilities but could not confirm or show there was an agreement in place for shared use of oxygen.
- No care plans were in place for patients aged over 75 who may be more vulnerable to ill health .

Summary of findings

- Dementia screening was being done opportunistically. There was no plan in place to show how all patients identified as being at risk of dementia, would be effectively screened in a timely manner.
- The practice did not have an efficient system in place to manage the health checks for patients aged 40-74 years.
- Complaints submitted to the NHS Choices website were not followed up and acted upon. All complaints were not recorded.
- The registration of the practice with the Care Quality Commission did not reflect the way in which the practice was run; the lead GP was present at the practice for two clinical sessions each week. Evidence from our inspection showed that this was insufficient to maintain overall direction and control of the practice.

There were areas were the provider MUST make improvements. The provider must:

- Ensure care plans are in place for patients aged 75 and over.
- Ensure there is access to oxygen for use in medical emergencies.
- Improve systems in place for the management and sharing of MHRA alerts.
- Effectively address points raised in the infection control audit by Liverpool Community Health.
- Record, investigate and respond to all complaints made about the practice, whether they are verbal or written, or registered on the NHS Choices website.
- Keep sufficient records in relation to staff recruitment.
- Keep sufficient records in relation to the management of regulated activities.
- Address issues around the registration of the practice.

There were areas were the provider SHOULD make improvements. The provider should:

- Provide a hearing loop facility for those patients with impaired or reduced hearing.
- Review all patient deaths (death audit) to ensure patients wishes around final place of care are observed.

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 the provision of safe care and treatment.

Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe.

- Medicines and Health Products Regulatory Agency (MHRA) alerts were shared with staff, but we noted delays of up to a week in doing this. These alerts were not held for future reference. We saw evidence that the practice was reliant on the medicines management team to recall and review patients medication in response to MHRA alerts.
- Arrangements for managing medicines kept patients safe.
- We found the practice premises to be clean and tidy. An infection control audit undertaken in July 2015 by Liverpool Community Health recommended that fabric curtains be laundered every six months and a spare pair kept to use in case of spillage, or that they be replaced with disposable ones. The practice had provided assurances that this would be addressed but had failed to act on this.
- Staff recruitment checks were incomplete; there were no references in place for key staff or health questionnaires and many staff had not received an induction.
- There was no oxygen on site. The provider said that oxygen was available in the community health centre next door and held at a dentist nearby. There was no evidence of a shared use agreement, or that staff knew the exact location of the oxygen.
- There were no spillage kits available to practice staff. The provider said these were available from the community health centre, linked to the practice building but staff did not know the exact location of these and could not find the key to the cupboard the items were stored in.

Are services effective?

Requires improvement

The practice is rated as requires improvement for the provision of effective services.

- There were no care plans in place for patients aged over 75, other than those in nursing homes, which the nursing home staff had produced.

Summary of findings

- There were no designated clinical leads within the practice other than for safeguarding. For example, there was no one GP who took the lead in the review and care of patients with learning disabilities or for patients with poor mental health.
- Although clinicians had all received recent training on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards, one GP had difficulty explaining the provisions of this legislation and on how it could impact on their daily work.
- Dementia screening was done opportunistically. There was no plan in place which demonstrated screening in line with expected prevalence, or showing that all patients at risk of dementia would be screened in a timely fashion.
- The systems in place to ensure all patients aged between 40 and 74 years received a health check were unclear as the figure given by the practice of 273 health checks delivered was in respect of patients from both practices.
- The GP on call each day reviewed discharge letters for patients who had been admitted to hospital unexpectedly. There was no discussion of unplanned admissions or coverage of this subject as a standard agenda item on practice clinical meetings. GPs decided whether to contact the patient by phone or face to face.
- We saw that some audits were conducted by the practice, for example, a methotrexate audit and an opiate prescribing audit which showed monitoring of high risk medicines.
- The provider had recruited a healthcare assistant who would assist the nurse at the practice on a part time basis. The practice was seeking to recruit a permanent GP for the practice but there was no live advertisement for this post either internally or externally. Few staff had received an appraisal. Staff files were incomplete, for example, some staff had not received an appraisal or induction.
- Not all staff had been given contracts of employment.

Are services caring?

Good

The practice is rated as good for providing caring services.

Our findings were:

- We received 32 CQC comment cards, completed by patients before our inspection. Of these, 29 gave positive feedback.

Summary of findings

Three gave negative feedback which was around waiting times when patients had arrived for their appointment, errors in repeat prescribing and about lack of onward referral for treatment of more persistent health problems.

- There was no routine review of patient deaths (death audit); the practice did not send sympathy cards but said sometimes they would make a phone call to bereaved carers or family members.
- In the last GP Patient Survey 56% of respondents would recommend the practice to people new to the area, compared with an average score for the same question amongst other practices locally of 69% and 78% nationally; and
- 84% of respondents said they had confidence and trust in the last GP they spoke to, compared with an average score for the same question amongst other practices locally of 94% locally and 95% nationally.

Are services responsive to people's needs?

Good

The practice is rated as good for the provision of responsive services.

The practice provides an extended hours surgery on a Tuesday evening.

Due to the way in which the practice was run, it was not possible to determine how staff were allocated to each practice patient list, in terms of availability of GPs and number of appointments available and whether this was truly sufficient to meet patients needs.

There were longer appointments available for patients with a learning disability. Same day appointments were available for children and those with serious medical conditions. Patients were able to receive travel vaccinations available on the NHS.

There was no induction hearing loop available at the practice for patients with limited hearing.

A Patient Participation Group (PPG) had recently been set-up and had met for the first time in the last three months.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for providing well-led services.

- The registration of the practice with the Care Quality Commission did not reflect the way in which the practice was being run. The provider was unable to demonstrate that they were in overall direction and control of the practice on a day to day basis.

Summary of findings

- We saw a lack of clear, direct leadership which could guide staff through changes which had been made at the practice since its acquisition by Dr Sapre in 2012.
- Although an administrator had been appointed to support the practice manager, the division of duties was unclear. This hindered the practice in moving forward.
- An IT problem had not been dealt with effectively and had not been brought to a resolution by practice leaders.

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

The practice is rated as requires improvement for the care of older people. The ratings of requires improvement in the domains of safe, effective and well-led impacted on all population groups.

The older patient population was slightly higher at the practice, than that of other practices in England. The practice offered pre-bookable appointments up to seven days in advance and appointments could be booked on-line. We were told that the ordering of repeat prescriptions on-line had been problematic, and the practice had not effectively addressed this issue. There were no care plans in place for patients aged over 75 who may have required more support.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long term conditions. The ratings of requires improvement in the domains of safe, effective and well-led impacted on all population groups.

The nurse had a lead role in chronic disease management. Longer appointments were available to those that needed them and home visits were available for housebound patients. The practice recognised that they needed a health care assistant to support the work of the nurse.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care and treatment of families, children and young people. The ratings of requires improvement in the domains of safe, effective and well-led impacted on all population groups.

The practice had a policy to see any child under five on the day, when this was required. The practice has access to Food Vouchers for use at a local foodbank, for those patients deemed to be classed as in urgent need.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care and treatment of working age people, including those recently retired and students. The ratings of requires improvement in the domains of safe, effective and well-led impacted on all population groups.

Summary of findings

The practice did not have an efficient system in place to manage the health checks for patients aged 40-74 years. At the time of inspection, the practice had completed 273 health checks on patients aged 40-74 years but could not say whether these were patients of the practice we were inspecting, or of a practice based in the same building which is also owned by Dr Sapre & Partners. The practice gave the figure of 273 health checks completed on patients between 40-74 years, out of a total patient list for the two practices of approximately 4,800 patients.

Immunisation rates were high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice took part in a number of screening programmes; we saw that the rate of screening for bowel cancer at the practice was slightly higher than the local CCG and England average. The numbers of women between the ages of 50 and 70 who had been screened for breast cancer in the last three years was in line with rates for the local CCG and England average.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care and treatment of people whose circumstances may make them vulnerable. The ratings of requires improvement in the domains of safe, effective and well-led impacted on all population groups.

The locum GP at the practice (who had been working for the practice for a considerable time) said registers were in place for vulnerable patients. The practice had a lead for safeguarding of children and vulnerable adults and all staff knew who this was. Safeguarding registers were kept by the practice.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care and treatment of people experiencing poor mental health (including people with dementia). The ratings of requires improvement in the domains of safe, effective and well-led impacted on all population groups.

The practice was screening patients at risk of dementia on an opportunistic basis. There was no plan in place that showed how all patients would have access to this screening in a timely manner. The practice had a mental health register and care plans were in place for these patients.

Summary of findings

What people who use the service say

The national GP patient survey results were published in 2015. We were unable to establish what proportion of the practice population, the results were representative of as no record had been kept of how many questionnaires were distributed.

The results showed the practice performed well in response to five of the 22 questions asked, when compared with local and national averages. The practice performed at a rate below the local and national average in relation to 16 of the questions asked. One question asked gave a response rate, indicating performance of the same level as local and national averages. For example:

- 89% of respondents found it easy to get through to this surgery by phone compared to a CCG average of 66%% and a national average of 73%.
- 96% were able to get an appointment to see or speak to someone the last time they tried (CCG average 82%, national average 85%).
- 97% said the last appointment they got was convenient (CCG average 93%, national average 92%)
- 89% described their experience of making an appointment as good (CCG average 68%, national average 73%).
- 87% said they found the receptionists at this surgery helpful (CCG average 84%, national average 87%).
- 79% described the overall experience of their GP surgery as fairly good or very good (CCG average 80%, national average 85%).
- 56% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 69%, national average 78%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 32 comment cards, the majority of which were positive about the standard of care received. Three negative comments made were about waiting times when patients had arrived for their appointment, and incorrect medicines being sent to the chemist for patients to collect.

We spoke with two patients during the inspection. Both patients said they were happy with the care they received and thought staff were approachable, committed and caring.

Areas for improvement

Action the service MUST take to improve

- Ensure care plans are in place for patients aged 75 and over.
- Ensure there is access to oxygen for use in medical emergencies.
- Improve systems in place for the management and sharing of MHRA alerts.
- Effectively address points raised in the infection control audit by Liverpool Community Health.
- Record, investigate and respond to all complaints made about the practice, whether they are verbal or written, or registered on the NHS Choices website.
- Keep sufficient records in relation to staff recruitment.
- Keep sufficient records in relation to the management of regulated activities.
- Address issues around the registration of the practice.

Action the service SHOULD take to improve

- Provide a hearing loop facility for those patients with impaired or reduced hearing.
- Review all patient deaths (death audit) to ensure patients wishes around final place of care are observed.

Dr SS Sapre and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and practice manager specialist adviser.

Background to Dr SS Sapre and Partners

Dr S S Sapre and Partners (the practice) is located in Maghull, Merseyside and falls within South Sefton Clinical Commissioning Group. All services for this practice are delivered under a General Medical Services (GMS) contract. The practice serves approximately 1,300 patients and is located in a building with a second practice, also owned by Dr Sapre. We did not inspect this second practice as it is registered as a separate location.

The practice clinical team consists of two GP partners (male) and one none clinical partner, supported by two long term locum GPs, (one male and one female). A further (male) locum GP is available on an ad hoc basis for additional cover as and when required. These GPs provide services to both practices in the building. The service has a practice nurse who works four days a week at the practice, although this time is split between the two surgeries on this site. The clinical team is supported by a practice manager, a practice administrator and seven administrative and reception staff. All staff support the second practice located in the same building which is also owned by Dr Sapre.

The practice is open between 8am and 6.30pm Monday to Friday. Appointments are from 9am to 11.30am every morning and from 3.30pm to 6pm daily. Extended surgery hours are offered at the practice on Tuesday of each week, from 6.30pm to 8pm.

The practice is in a facility shared with Maghull Community Health Centre. Community midwives, health visitors and nurses are based in this building. The practice has a slightly higher than average population of older patients, with 9.7% of the practice register being made up of patients over 75 years of age, compared to the England average of 7.6%. Patients over 65 years of age make up 19.9% of the patient register, compared to the England average of 16.7%.

Throughout our inspection the practice leaders presented the practice as a partnership. This does not reflect the registration of the practice with CQC. Dr Sapre has stated that he will apply to update his registration with CQC and ensure that all partners are accurately registered.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

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. The 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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 13 January 2016.

During our visit we:

- Spoke with a range of staff including the two GP partners, the non-clinical partner who was the practice manager, a practice administrator and a locum GP. We also spent time with several administrative support staff. We spoke to two patients who used the service.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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

- 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 were provided for specific groups of people and what good care looked like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

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. The data about this practice that we had access to was limited.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice computer system.
- The practice carried out investigation and analysis of significant events.

We reviewed safety records, incident reports and national patient safety alerts. Alerts from the Medicines and Health Care Products Regulatory Agency (MHRA) were received into the practice by the practice manager. However, we saw that the sharing of these was not immediate. Some examples we reviewed showed there was approximately a one week delay before each alert was shared with staff at the practice. In the alert document received by the practice are instructions on how the alert should be shared and actioned within the practice, and how a record of these alerts should be kept for reference purposes. There was no file, electronic or otherwise of these alerts kept at the practice. Staff we spoke with said they relied on the CCG medicines management team to action these (MHRA) alerts. We were able to speak with the CCG pharmacist who was on site on the day of our inspection. We could see that alerts for example, involving a blood glucose monitoring system had been actioned immediately by the medicines management team. However, staff at the practice should be able to action alerts and manage the recall of any patients affected by them. When we reviewed minutes of clinical meetings, we saw that these alerts and updates were not discussed as a matter of routine at each clinical meeting.

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse.

Arrangements in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs did not attend safeguarding meetings but provided reports where necessary for other agencies. Administrative staff said they had received training relevant to their role but could not evidence this. GPs were trained to Safeguarding level 3.

The practice did not hold a register of vulnerable adult patients and did not have a system in place to follow up reported attendances of children at local A&E departments. We were told the reason for this was that there was insufficient resource to complete this work.

A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones had been trained for the role by the practice manager. Not all staff who performed chaperone duties had undergone a Disclosure and Barring Service check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). A risk assessment had been applied to the role to assess the need for a DBS check. All risk assessments concluded that administrative staff did not require a DBS check as they were not left alone with patients.

We observed the premises to be clean and tidy. However following an infection control audit by Liverpool Community Health in July 2015, recommendations were made in relation to the laundering of privacy curtains around examination couches. These curtains were to be laundered at least every six months and spare curtains should be available for use in the case of spillage or staining. The practice had given assurances following the infection control audit that the curtains were being replaced by disposable ones, and this was recorded in the practice action plan. On inspection we found the curtains around examination couches were not disposable, so should have been laundered at least every six months, and a spare set of curtains should have been available in the case of any spillage. This was not the case.

The practice manager was the infection control clinical lead. There was an infection control protocol in place. We were told staff had received up to date training and this was confirmed by staff records.

The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice carried out

regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use.

We reviewed 10 personnel files and found recruitment checks were incomplete and did not cover all items as required by Schedule 3. For example, the required level DBS check for the practice nurse had only been completed on 18 December 2015, although they had worked for the practice since July 2013. There were no references taken in respect of the recently recruited practice administrator, who acted as a deputy practice manager. The provider was able to provide evidence after the inspection of mandatory training completed for all staff, for example updates to safeguarding training, infection control, information governance, health and safety and fire risk and prevention.

Monitoring risks to patients

Risks to patients were assessed and managed.

There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available to all staff on the practice computer system. The practice had fire risk assessments held regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. The practice retained two regular locums directly and was able to call on a third regular locum to cover planned absences such as annual leave. The practice nurse had recently started working four days a week at the practice, which GPs felt was sufficient to meet the needs of patients. The practice had recruited a healthcare assistant to support the work of the nurse on a part time basis.

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Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to respond to emergencies and major incidents.

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.

We were told that all staff received annual basic life support training. The provider was able to evidence this following the inspection. There were emergency medicines available in the treatment room. We saw that these were in date and suitable for use.

The practice did not have oxygen available for use in an emergency. The practice manager told us oxygen was available in the community health centre but could not show any evidence of agreement to shared use of these items.

The practice manager said that spillage kits were available from the community health centre which was linked to the practice building but could not say where they were kept. However, staff were unable to find the key to the store room where these were kept and could not point to the appropriate kits for use in the event of spills.

The provider was requested to submit, as part of the provider information return prior to inspection, a business continuity plan for the practice. The has not been supplied as requested and could not be located by staff on the day of the inspection.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs. We did note that updates to NICE guidance was not listed as a standard agenda item for all clinical meetings at the practice.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed the practice achieved 97 % of the total number of points available, with 6% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014-15 showed;

- Performance for several of the diabetes related indicators was similar to the national average. For example:
- The percentage of diabetes patients on the register in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 or less was 77.7% (national average 78.03%).
- The percentage of patients with diabetes on the register who have had influenza immunisation in the preceding 1 August to 31 March was 91.7% (national average 94.45%).
- The percentage of diabetes patients on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5mmol/l or less was 77.9% (national average 80.53%) and;
- The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification within the preceding 12 months was 91.1% (national average 88.3%).

However, we noted there was a higher rate of exception reporting in some of the key tests for diabetes patients, namely tests on the IFCC-HbAc1 levels of patients (tests which show how well controlled a patient's blood glucose has been in the preceding 8 weeks).For example:

- The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c was 64mmol/mol or less in the preceding 12 months was 80.7%, with an exception reporting rate of 13.5%.
- The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c was 59mmol/mol or less in the preceding 12 months was 73.8%, with an exception reporting rate of 16.7%. And
- The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75mmol/mol or less in the preceding 12 months was 86.5% with an exception reporting rate of 7.3%.

It was not clear why exception reporting for these tests was raised.

The practice performance for management of patients with hypertension was in line with national averages:

- The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months0 was 150/90 or less was 82.7% (national average 83.65%)

  The practice performance for mental health related indicators was slightly better than the national average scores:

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 100% (national average 88.47%).
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was 100% (national average 89.5%).

Requires improvement

Are services effective?

(for example, treatment is effective)

- The percentage of patients diagnosed with dementia whose care has been reviewed in a face to face review in the preceding 12 months was 90.9% (national average 84.01%).

Clinical audits demonstrated improvement. There had been three clinical audits undertaken in the last two years, two of these were completed audits where improvements were implemented and monitored. The practice participated in local audits, many of which were performed by the CCG medicines management team. Findings were used by the practice to improve services. For example, to ensure antibiotic prescribing follows national and local guidelines and that the appropriate antibiotics are used in each patient.

The practice nurse delivered health checks for patients aged between 40-75 years old. The practice was unable to tell us whether the 273 health checks completed on patients were from the practice we were inspecting, or from the practice based in the same building which is also owned by Dr Sapre and Partners. Out of a total patient list for the two practices of approximately 4,800 patients, 273 health checks had been completed. There was no plan in place that confirmed what percentage of patients from the practice were covered by this work, and how checks were planned to ensure all patients had been offered this service.

There were no care plans in place for patients aged over 75 years, other than those in nursing homes, which the nursing home staff had produced. MDT assessments were compiled by the virtual ward team, ran by the community matron. (A virtual ward is a list of patients who the community health teams provide care and support to, along with a GP).

Dementia screening was done opportunistically. There was no plan in place which demonstrated screening in line with expected prevalence, or showing that all patients at risk of dementia would be screened in a timely fashion.

Effective staffing

The practice said it had an induction programme for all newly appointed staff however checks of staff records showed some staff did not receive this induction. In the case of a recently recruited member of staff we saw that their staff file contained a confidentiality agreement, but no contract, no appraisal, no references and no record of induction. With regard to staff training, the provider had submitted a spreadsheet prior to inspection as part of its information return with a statement saying all staff had received mandatory training.

Records submitted showed the practice nurse had received regular training updates and that they had the skills, experience and knowledge to support and treat patients. Staff administering vaccinations and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. The nurse had received annual appraisals.

We did not see that the learning needs of support staff were identified through a system of appraisals, meetings and reviews of practice development needs. We were told staff had access to appropriate training to meet their learning needs and to cover the scope of their work through various training events held by the CCG, or by delivery of training through e-learning. We were unable to confirm that all support staff had received annual appraisal.

Coordinating patient care and information sharing

The GP on call each day reviewed patients who had been admitted to hospital unexpectedly by checking discharge letters. Cases were not discussed as a standard agenda item at clinical meetings. GPs decided whether to contact the patient by phone or face to face. This was not done as a matter of routine. GPs told us that sometimes they would refer these patients to the community matron for inclusion on the virtual ward system within the area.

The practice held multi-disciplinary team meetings although minutes of these were limited. We were told that the practice GPs attended meetings which covered patients on the virtual ward system and patients on the Gold Standard Framework of palliative care, held at Maghull Town Hall.

The practice showed us that patients experiencing poor mental health were identified in the electronic patient record system. When we asked about interventions for these patients we were told by GPs we spoke to that they gave advice and encouraged self referral, for example, for various types of counselling.

Requires improvement

Are services effective?

(for example, treatment is effective)

There were no designated clinical leads within the practice other than for safeguarding. For example, there was no one GP who took the lead in the review and care of patients with learning disabilities or for patients with poor mental health.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff had received the relevant training on consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 although the senior partner at the practice had problems explaining this clearly.
  When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment. Although clinicians had all received recent training on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards, one GP had difficulty explaining the provisions of this legislation and on how it could impact on their daily work.

Supporting patients to live healthier lives

The practice identified some patients who may be in need of extra support.

- Carers were signposted to services they could access locally to provide further support.
- It was more difficult to ascertain from staff how many patients requiring advice on their diet, smoking and alcohol cessation were engaged with. This was because the number of patients who had received an annual health check from this practice, was mixed with patients of the second practice in the same building, owned by Dr Sapre. We were told that 273 health checks had been delivered, but that this was the combined total for both practices.We noted that patients were signposted to relevant services for additional help, for example, with smoking cessation.
- The practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG average and the national average of, with an exception rate of 9.7%. This exception rate was 0.7% below the CCG average and 3.4% above the England average. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. Practice staff had introduceda process to record in patient records, details of when patients had declined the offer of cytology screening. This helped make any exception reporting on cytology screening, more transparent. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.
- Childhood immunisation rates for vaccinations given were good. For example, childhood immunisation rates for the vaccinations given to under two year olds was 100% and 100% for five year olds.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Care Quality Commission comment cards received from patients were in the main, positive about the service experienced. We received 32 comment cards, 29 of which gave positive feedback. Patients said they felt the practice offered a good service and staff were caring and treated them with dignity and respect. We received three comment cards that gave more negative feedback around the length of wait on arrival at the practice for an appointment, about some prescription errors and on the onward referral of patients for further investigations.

We spoke with a member of the recently formed patient participation group. They told us that as a patient, they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that support staff responded compassionately when patients needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 78% said the GP was good at listening to them compared to the CCG average of 87.2% and national average of 88.6%.
- 81% said the GP gave them enough time (CCG average 84.7%, national average 86.6%).
- 84% said they had confidence and trust in the last GP they saw (CCG average 94.3%, national average 95.2%)
- 81% said the last GP they spoke to was good at treating them with care and concern (CCG average 83%, national average 85.1%).
- 81% said the last nurse they spoke to was good at treating them with care and concern (CCG average 90.7%, national average 90.4%).
- 87% said they found the receptionists at the practice helpful (CCG average 83.3%, national average 86.8%)
- 56% of patients would recommend this surgery to someone new in the area (CCG average 69%, national average 78%).

Care planning and involvement in decisions about care and treatment

In comment cards, patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also in the main, positive.

Results from the national GP patient survey showed scores for patients' responses to questions about their involvement in planning and making decisions about their care and treatment, were slightly below scores achieved by other practices locally (CCG average) and for scores nationally. For example:

- 78% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83.9% and national average of 86%.
- 77% said the last GP they saw was good at involving them in decisions about their care (CCG average 79.9%, national average 81.4%)
- 77% said the last nurse they saw was good at involving them in decisions about their care (CCG average 84.6%, national average 84.8%)

Staff told us that translation services were available for patients who did not have English as a first language. However there was no hearing loop available at the practice for patients with hearing difficulties.

Good

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. Written information was available to direct carers to the various avenues of support available to them. However, a carers register for the practice showed only three carers, which suggests that records required updating.

In the case of bereaved carers and family members, where a GP felt it was appropriate to do so, they would contact the bereaved relative or carer. GPs could refer on to bereavement services or other outside organisations that were able to support families and carers through bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice had signed up to an number of enhanced services, for example for delivery of shingles vaccines to patients of this practice.

- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who would benefit from these.
- Same day appointments were available for children and those with serious medical conditions.
- Patients were able to receive travel vaccinations available on the NHS.
- The practice premises were fully accessible.
- Language line was available for any patient requiring translation services.

Access to the service

The practice is open between 8am and 6.30pm Monday to Friday. Appointments are from 9am to 11.30am every morning and from 3.30pm to 6pm daily. Extended surgery hours' are offered at the practice on Tuesday of each week, from 6.30pm to 8pm. In addition to pre-bookable appointments that could be booked up to seven days in advance, urgent appointments were also available for people that needed them.

The equitable access to appointments by patients from both practices (which shared the extended hours surgery) was difficult to establish. Under the access scheme for the practice, patients should be provided with 20 minutes of the hour long extended hours surgery provided on Tuesday of each week. As the provider is required to provide approximately 52 minutes of the hour long extended hours surgery each Tuesday to patients of the second practice within the same building, it is difficult to see how the hour provided currently, fulfils this requirement.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 70% of patients were satisfied with the practice's opening hours compared to the CCG average of 71% and national average of 75%.
- 89% patients said they could get through easily to the surgery by phone (CCG average 66%, national average 73%).

People told us on the day of the inspection that they were were able to get appointments when they needed them.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system in leaflets available from the practice and on the practice website.

We looked at all formal complaints received by the practice in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, and that appropriate responses were sent to patients following investigation of the complaint. We did see that lessons were learnt from concerns raised and action was taken as a result of findings from investigations, to improve patient services. We did note that the practice did not record verbal complaints, and did not follow-up as far as possible to do so, complaints posted on the NHS Choices website. This was raised during feedback to the practice at the end of our inspection day.

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

The practice had a vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which was shared with us during a presentation on the day of inspection. Staff we spoke to on the day of our inspection displayed a commitment to delivering a good service to all patients who used the practice.

Governance arrangements

The practice had a governance framework which supported the delivery of services by the practice but this was not as robust as it needed to be.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities, although the division of duties between the practice manager and the recently appointed practice administrator was at times unclear. For example, in the timely, routine sharing of MHRA alerts received, and tabling discussion of those relevant to patients in regular clinical meetings.
- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- Staff had an understanding of performance at the practice.
- There were members of staff who had not received a contract; the practice was relying on the services of two long term locum GPs and arrangements to take on a GP permanently as an additional partner had not been progressed or finalised.
- The practice had recently engaged a business manager, who had reviewed all policies and procedures for the practice. However, there were key issues that had not been addressed such as incomplete recruitment records and the registration status of the practice, which did not reflect the current way in which the practice was operating.

The lead GP described the practice as being run as a partnership. The registration of the practice with the Care Quality Commission did not reflect this arrangement. The two clinical sessions worked by the lead GP on Tuesday of each week, meant they were not in day to day control of the service, which is what the current registration with CQC requires. The support of the non-clinical partner assisted the management of the service but this required improvement.

There had been no work undertaken to ensure that access to appointments, specifically appointments in the extended hours surgery provided each Tuesday, was fair and equitable to patients in this practice. The one hour provided on Tuesday evening each week was open to patients of both practices in the building, both of which are owned by Dr Sapre. However, calculations show that the hour long extended surgery (shared by both surgeries) falls below the time expected to be provided under the extended hours agreements for both practices.

It was clear that there was a significant amount of work entailed in running the three practices owned by Dr Sapre. The practice we inspected had been taken over by Dr Sapre in 2012. It was Dr Sapre's intention to run the practice as one, with the other practice owned by Dr Sapre and based in the same building. However, the amount of work involved in this, the incorrect registration status of the practice and the pace of change had left a lack of focus, for example on registration matters, recruitment matters and other areas of governance. IT problems referred to by the practice had still not been effectively addressed.

Leadership and culture

The provider was aware of and complied with the requirements of the Duty of Candour. Staff told us the practice held regular team meetings.

- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice had set up a Patient Participation Group approximately three months ago (October 2015), but this had proved difficult to sustain. The practice had identified a

Are services well-led?

Requires improvement

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

key member who was willing to assist with establishing effective feedback mechanisms for patients and for presenting any ideas on how services could be improved. Work in this area is continuing.

The practice had conducted a patient survey in 2014, the results of which were available on the practice website. The practice had regular staff meetings which all staff were encouraged to contribute to.

The practice had not communicated with patients, the changes to the practice and how it was run, for example, that it was moving to a partnership arrangement, who the partners were and what days each partner would be working. The practice nurse had only recently started to work for four days each week at the site, split between patients of the two practices in the same building and there was no communication with patients on this, for example in relation to access.

Continuous improvement

The practice used QOF data to drive improvements and other national data which highlighted areas for improvement. However, there was a lack of clear plans on how each patient group would receive the interventions they needed, for example, for check-ups for 40-74 year olds and for dementia screening of patients identified as being at risk of dementia. The practice had conducted some audits aimed at monitoring and improving patient safety and we saw that essential audits were conducted, for example in relation to patients on methotrexate.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Person-centred care. Care plans were not in place for patients over the age of 75 years. 9(3)(a)

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was failing to comply with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment The provider did not have oxygen available for use in an emergency. 12(2)(b) The provider did not have an effective system in place for the timely sharing, review and action of MHRA alerts received into the practice 12(2)(b) The provider had failed to action points raised in an infection control audit, when they indicated that they had done this. 12(2)(h)

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Complaints The provider did not record and investigate verbal complaints, or those received via the NHS Choices website.

This section is primarily information for the provider

Requirement notices

16(1)

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Good governance. The provider did not maintain records necessary to be kept, in relation to the management of the regulated activitiy, such as the uptake of appointments by patients of the practice we were inspecting to ensure that access was fair and equitable both in terms of access to bookable appointments and to appointments available in the extended hours surgery for the practice. In relation to the holding of multi-disciplinary team meetings. 17(2)(d)(ii).

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Fit and proper persons employed. The provider is failing to comply with regulation 19(3)(a) and (b). All information required in respect of a locum GP and other administrative support staff, was not held in staff files and had not been taken up by the provider.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 CQC (Registration) Regulations 2009 Notifications – notice of changes The provider is registered with the Commission as a single handed practitioner and had not informed the Commission of changes to this, or that a person other than the registered person was carrying out or managing the regulated activities.