Mere Lane Group 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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Mere Lane Group Practice on 14 April 2015. Overall the practice is rated as good.

Mere Lane Group Practice provided safe, effective, responsive care that was well led and addressed the needs of the population it served.

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

- Systems were in place to ensure incidents and significant events were identified, investigated and reported. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Lessons learnt from the investigation of safety incidents were disseminated to staff. Infection risks and medicines were managed safely.
- People's needs were assessed and care was planned and delivered in line with current legislation and guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned. Patients experienced clinical outcomes that were in line with or above the national average. The practice used innovative and proactive methods to improve patient outcomes, working with the CCG and other local providers. For example the OWLS project (Older Wiser Living Socially).
- Patients spoke highly of the practice. They said they were treated with care, compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice provided care to its population that was responsive to their health needs. Patients were listened to and feedback was acted upon. Complaints were managed appropriately.
- There was a clear leadership structure, staff enjoyed working for the practice and felt well supported and valued. The practice monitored, evaluated and improved services. The practice proactively sought feedback from staff and patients, which it acted on.

There was an area of practice where the provider needs to make improvements.

The provider should:

Summary of findings

- Improve access to GP appointments by reviewing the telephone system.

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?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learnt and communicated to all staff to support improvement. Child and adult safeguarding was well managed, staff were trained and supported by knowledgeable safeguarding lead members of staff. Medicines and infection control risks were managed safely. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were around average for the locality, including the Quality and Outcomes Framework (QOF). The Quality and Outcomes Framework (QOF) is a system for the performance management and payment of GPs in the NHS. It was intended to improve the quality of general practice and the QOF rewards GPs for implementing "good practice" in their surgeries. The practice had achieved a score of 91.5% for QOF last year. Staff referred to and used guidance from National Institute for Health and Care Excellence (NICE). The practice had identified the specific needs of their patients and was proactive in assessing and planning care particularly for older, vulnerable patients and those with long term and mental health conditions. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and demonstrated knowledge and skills required to care for their patient population.

Are services caring?

Good

The practice is rated as good for providing caring services. Results from the national GP patient survey, patients we spoke with and those who completed the CQC comment cards were complimentary and positive about the service and the care and treatment they received. Patients said they were treated with care, compassion, dignity and respect and they were involved in decisions about their care and treatment. Staff we spoke with were aware of the importance of providing patients with privacy and of confidentiality. We also observed that staff treated patients with dignity and respect.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had identified and reviewed the needs of their local

Summary of findings

population and provided tailored services accordingly. They engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Information about how to complain was available and evidence showed that the practice responded appropriately to issues raised with learning and improvements implemented as a result. However patients said they experienced difficulty in accessing appointments due to the telephone system. The practice had identified this as a problem and was taking steps to address it.

Are services well-led?

Good 

The practice is rated as good for being well-led. It had a clear vision and values for care. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular clinical and team meetings. The practice proactively sought feedback from staff and patients. Staff received inductions, appraisals and attended staff meetings and learning and development events.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. For example the Quality and Outcomes Framework (QOF) information indicated that last year 77% of patients aged 65 and older had received a seasonal flu vaccination. This was higher than the national average. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, avoiding unplanned admissions, seasonal flu vaccinations and in dementia and end of life care. It was responsive to the needs of older people, and offered home visits to deliver care to those older patients who were not able to attend the surgery. The practice had led in the implementation of the OWLS (Older Wiser Living socially) project which supported and addressed social isolation in patients aged over 75.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice had a higher than national average number of patients with long standing health conditions (67.8% of its population). Patients with long term conditions were supported by a healthcare team that cared for them using good practice guidelines and were attentive to their changing needs. There was proactive intervention for patients with long term conditions. Patients had health reviews at regular intervals depending on their health needs and condition. For example 92% of patients with rheumatoid arthritis had received an annual review.

The practice maintained and monitored registers of patients with long term conditions for example cardiovascular disease, diabetes, chronic obstructive pulmonary disease and heart failure. These registers enabled the practice to monitor and review patients with long term conditions effectively. The Quality and Outcomes Framework (QOF) information indicated that patients with long term health conditions received care and treatment as expected and above the national average. For example, patients with asthma had received a review in the last 12 months and clinical risk groups (at risk due to long term conditions) had good uptake rates for seasonal flu vaccinations. Patients on the 'at risk of unplanned admissions to hospital' register had all had a care plan devised and agreed with them.

Summary of findings

Clinical staff managed chronic long term conditions and diseases. Patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. Patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, the practice maintained a register of children who had a child protection plan. Immunisation rates were average for standard childhood immunisations. We received positive feedback regarding care and treatment at the practice for this group. Patients we spoke with told us they were confident with the care and treatment provided to them. Appointments were available outside of school hours and the premises were suitable for children and babies including the provision of breast feeding and baby changing rooms. We saw good examples of joint working with midwives and health visitors. For example there were regular safeguarding meetings with health visitors. The practice responded to the needs of this group and children or young people were always given a same day appointment or urgent appointment as necessary.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered flexibility in appointments and a range of services such as health promotion and screening that reflected the needs for this age group. For example smoking cessation and travel advice. Routine health checks were available to patients aged over 45. Online booking, cancellation of appointments and ordering of repeat medications facilities were available.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including

Summary of findings

homeless people, children and adults at risk of abuse, patients with dementia, terminally ill and those with a learning disability. It had carried out annual health checks for people with a learning disability and it offered longer appointments for vulnerable patients.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It was able to signpost vulnerable patients and their carers to various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Ninety six percent of people experiencing poor mental health had an agreed documented care plan and 83% of those diagnosed with dementia had received a review of their care in the preceding 12 months. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice worked closely with the mental health services in Liverpool. The practice was able to signpost patients experiencing poor mental health to access various support groups and voluntary organisations including MIND. Patients with poor mental health were accommodated, where possible, with same day appointments with a preferred clinician. Some of the staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with three patients on the day of our inspection. We received 20 completed CQC comment cards. Patients whom we spoke with varied in age and population group.

All patients were positive about the practice, the staff and the service they received. They told us staff were caring, and compassionate and that they were always treated well with dignity and respect.

Patients had confidence in the staff and the GPs who cared for and treated them. The results of the National GP Patient Survey published in July 2014 demonstrated they performed well with 99% of respondents saying they had confidence and trust in the last GP they saw or spoke with. Ninety one percent said the last GP they saw or spoke to was good at treating them with care and concern, 92% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern. Ninety nine percent said the last GP they spoke to or saw was good at listening to them, whilst 96% said the GP was good at explaining treatment and tests. The data demonstrated the practice was performing above average for the majority of questions asked.

Some patients that we spoke with and from comments cards reviewed expressed concern regarding accessing appointments. They told us they found it difficult to get through to the practice to make an appointment as the telephone line was always engaged. They explained that when they did eventually get through then all that days appointments were taken. This was collaborated by the national GP patient survey (2014) which said the practice could improve on getting through to the practice by phone. Only 63% of respondents said they found it easy to get through by phone, compared to the local CCG average of 76%. Seventy six percent described their experience of making an appointment as good, with 93% saying the last appointment they got was convenient. Sixty eight percent of respondents with a preferred GP got to see or speak to that GP (this was above the local CCG average).

Patients told us they considered that the environment was clean and hygienic.

Areas for improvement

Action the service SHOULD take to improve

- Improve access to GP appointments by reviewing the telephone system.

Mere Lane Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector and included a GP specialist advisor.

Background to Mere Lane Group Practice

Mere Lane Group Practice is registered with the Care Quality Commission to provide primary care services. It provides GP services for approximately 6200 patients living in Liverpool. The practice is situated in a new modern purpose built health centre which houses another GP practice, other health care clinics and a pharmacy. The practice has six GPs (four male and two female), a practice management team, three practice nurses, administration and reception staff. Mere Lane Group Practice holds a General Medical Services (GMS) contract with NHS England.

The practice is open during the week, between 8.30am and 6.30pm.They are closed one day every two to three months for staff training and development. Patients can book appointments in person, via the telephone or online. The practice provides telephone consultations, pre bookable consultations, urgent consultations and home visits. The practice treats patients of all ages and provides a range of primary medical services.

The practice is part of Liverpool Clinical Commissioning Group (CCG).The practice is situated in an area with high deprivation. The practice population is made up of a slightly higher than national average working age population. Sixty eight percent of the patient population has a long standing health condition, whilst 60% have health related problems in daily life. There is a higher than national average number of unemployed patients.

The practice does not provide out of hours services. Out of hours medical care is provided by a company called Urgent Care 24 (UC24). They provide telephone advice, surgery consultations with a GP, and where appropriate home visits.

Why we carried out this inspection

We inspected this service as part of our new 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. 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 (Regulated Activities) and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

Detailed findings

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

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

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

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

We reviewed all areas of the practice including the administrative areas. We sought views from patients face-to-face, looked at survey results and reviewed comment cards left for us on the day of our inspection.

We spoke with the practice business and IT manager, registered manager, GPs, practice nurses, administrative and reception staff on duty. We spoke with patients who were using the service on the day of the inspection.

We observed how staff handled patient information, spoke to patients face to face and talked to those patients telephoning the practice. We discussed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

Good

Are services safe?

Our findings

Safe track record

Liverpool Clinical Commissioning Group and NHS England reported no concerns to us about the safety of the service. The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents, concerns and near misses. GPs and nurses told us they completed incident reports and carried out significant event analysis routinely and as part of their on-going professional development.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time. Staff told us how they actively reported any incidents that might have the potential to adversely impact on patient care. We were told there was an open and 'no blame' culture at the practice that encouraged staff to report adverse events and incidents.

Learning and improvement from safety incidents

We reviewed the records of significant events that had occurred during the previous 12 months. There was evidence that appropriate learning had taken place and that findings were disseminated to relevant staff through discussions, meetings and via email. Staff, including receptionists, administration and nursing staff, knew how to raise an issue for consideration at meetings and they felt encouraged to do so. The practice carried out an overview of significant events every three months in order to identify themes or trends. All staff were involved in feedback and lessons learnt from incidents and complaints by attending regular team meetings at which these were discussed. Minutes from the meetings were distributed to all staff.

The practice showed us the system they used to manage and monitor incidents. We tracked some incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of documented action taken as a result and implementation of learning. Where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken.

We saw evidence to confirm that, as individuals and a team, staff were actively reflecting on their practice and critically looked at what they did to see if any improvements could be made

National patient safety alerts were disseminated by the practice manager to relevant staff. Staff we spoke with were able to give an example of recent alerts/guidance that were relevant to the care they were responsible for. For example the recent guidance on Ebola (Ebola is a contagious viral infection causing severe symptoms and caused an epidemic in West Africa). They also told us that alerts were discussed at team meetings or disseminated via email to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems in place to safeguard vulnerable children, young people and adults. The practice had up to date safeguarding child and adult policies and procedures in place. They provided staff with information about identifying, reporting and dealing with suspected abuse and at risk patients. The policies were available to staff on the practice computer system. Staff had access to contact details for both child protection and adult safeguarding teams. We saw these contact details displayed in clinical and non-clinical areas.

We looked at training records which showed that all staff had received relevant role specific training in safeguarding. Clinical staff had a higher level of training than other staff. Staff we spoke with were knowledgeable about the types of abuse and how to raise concerns or report incidents. Staff were able to discuss examples of at risk children and vulnerable patients and how they were cared for.

The practice had a dedicated GP lead in safeguarding; they were supported by a deputy. They had attended appropriate training to support them in carrying out their work, as recommended by their professional registration safeguarding guidance. They were knowledgeable about the contribution the practice could make to multi-disciplinary child protection meetings and serious case reviews. The safeguarding lead could not attend every safeguarding conference they were invited to due to time constraints; however they completed all requested reports for child protection and serious case review meetings. All staff we spoke to were aware that the practice had a

safeguarding lead and knew who to speak to in the practice if they had a safeguarding concern. There was a system to highlight vulnerable patients on the practice's electronic records. This system included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. Codes and alerts were applied on the electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The clinical staff were fully aware of the vulnerable children and adult patients at the practice and discussed them at regular clinical meetings internally and at multi-disciplinary safeguarding meetings.

The practice had a current chaperone policy. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). A chaperone policy notice was displayed in the reception area and in all treatment and consultation rooms.

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 temperature sensitive medicines. We saw the checklist that was completed daily to ensure the fridge remained at a safe temperature and spoke to staff who managed the vaccines. They all had a clear understanding of the actions they needed to take to keep vaccines safe. A cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was in place for the safe management of vaccines. We noted that the fridges used to store vaccines and other medicines were not hard wired and did not have warning notices displayed to alert people not to inadvertently unplug them. The practice told us they would address this.

GPs reviewed their prescribing practices as and when medication alerts or new guidance was received. Patient medicine reviews were undertaken on a regular basis in line with current guidance and legislation depending on the nature and stability of their condition. We saw records and were told about actions taken in response to a review of prescribing and patient medicines. Audits had been undertaken and improvements actions were evident.

Repeat prescriptions were held securely. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Medicines for use in medical emergencies were kept securely in the treatment room. We saw evidence that stock levels and expiry dates were checked and recorded on a regular basis.

The practice staff and GPs were supported by the medicines management team of the Clinical Commissioning Group (CCG) in keeping up to date with medication and prescribing trends. The CCG medicines management team visited the practice and regular recorded meetings were held with them.

Cleanliness and infection control

The patients we spoke with commented that the practice was clean and appeared hygienic. We looked around the premises and found them to be clean, tidy and well maintained. The treatment rooms, waiting areas and toilets were in good condition. Staff had access to gloves and aprons and there were appropriate segregated waste disposal systems for clinical and non-clinical waste. We observed good hand washing facilities to promote good standards of hygiene. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms, couches were washable and clean and we saw evidence that the curtains in clinical rooms were renewed on a regular basis.

The practice had a GP lead for infection control. Infection control training and annual updates were undertaken by all staff. Staff understood their role in respect of preventing and controlling infection. For example, reception staff could describe the process for handling submitted specimens. 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 had an infection control audit carried out by the community infection control team in 2014. We saw the completed report however there was no evidence of an

action plan to address the minor issues found. Cleaning was carried out under contract by the premises management team and the cleaning standards and schedule were monitored.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection.

The premises management team contracted regular testing and investigation of legionella (a bacterium found in the environment which can contaminate water systems in buildings).

Equipment

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments.

All equipment was tested and maintained regularly and we saw equipment maintenance logs, contracts and other records that confirmed this. There were contracts in place for regular checks of fire extinguishers and portable appliance testing (PAT). All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw that annual calibration and servicing of medical equipment was up to date, for example weighing scales, spirometers and blood pressure measuring devices.

Emergency equipment was stored in a treatment room. This included nebulisers and oxygen. An automated external defibrillator (used to attempt to restart a person's heart in an emergency) was available within the practice also. These were maintained and checked regularly.

Staffing and recruitment

There was an up to date recruitment policy in place. This was in line with current guidance and regulations and was sufficient to ensure a suitable process was in place for safe recruitment of staff.

We looked at four staff files including clinical and non-clinical staff. We found these were well organised and contained all the required information relating to workers. We found that a Disclosure and Barring Service (DBS) check had been undertaken for all staff at a suitable level for their roles (these checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post). However two of the disclosures had been taken from a previous employer. We were informed these would be updated and DBS checks undertaken by the practice themselves.

Chaperone training had been undertaken by reception and administrative staff and we saw evidence that these staff had a suitable DBS check in place.

Records demonstrated clinical staff's professional registration with the General Medical Council (GMC) and the Nursing Midwifery Council (NMC) were monitored and checked regularly. GPs were checked to ensure they were suitable to work in their role and that they were on the NHS England Performers List. This included checking any locum GPs used.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. 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 activity 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 regular checks of the premises, medicines management, staffing and dealing with emergencies and equipment. The practice had a health and safety policy in place. Health and safety information was displayed for staff to see. Risk assessments were in place for general environmental risks, Control of Substances Hazardous to Health (COSHH) and fire risks.

The practice used electronic record systems that were protected by passwords and smart cards on the computer system. Historic paper records were stored securely on site.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example: ill children and young people were usually given an appointment the same day or directed to appropriate health services where needed.

Arrangements to deal with emergencies and major incidents

Good

Are services safe?

A current disaster recovery and business continuity plan was in place. The plan covered business continuity, staffing, records, electronic systems, clinical and environmental events. The document contained relevant contact details for staff to refer to. Staff we spoke with were aware of the business continuity plan.

The practice had arrangements in place to manage emergencies. Staff could describe how they would alert others to emergency situations via the electronic systems.

Staff were up to date with their training in basic life support. There was emergency equipment and medicines available including an automated external defibrillator and oxygen. Suitable emergency medicines were available in the practice and staff knew of their location.

Records showed that fire fighting equipment and fire safety equipment (such as the fire alarm) were routinely checked and maintained under contract. Most staff were up to date with fire training, this included regular fire drill practise.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinicians were familiar with, and used current best practice. The staff we spoke with and evidence we reviewed confirmed that care and treatment was aimed at ensuring each patient was given support to achieve the best health outcomes for them. We found from our discussions that staff completed, in line with The National Institute for Health and Clinical Excellence (NICE) and local commissioners' guidelines, assessments and care plans of patients' needs and these were reviewed appropriately.

The GPs and practice nurse told us that they discussed together new clinical protocols, reviewed complex patient needs and kept up to date with best practice guidelines and relevant legislation. The practice nurses supported each other and were well supported by the GPs in clinical decision making. Clinical meeting minutes demonstrated that staff discussed patient treatments and care and this supported staff to continually review and discuss new best practice guidelines. Multi-disciplinary team meetings also demonstrated sharing and evaluation of care and treatment for older people, those with long term conditions, terminally ill patients and vulnerable patients with external health and social care workers.

The GPs specialised and led in clinical areas such as safeguarding and minor surgery. They also specialised and took the lead with different patient groups such as contraception for females and mental health patients. The practice nurses also managed specialist clinical areas such as diabetes, heart disease and asthma. This meant that the clinicians were able to focus on specific conditions and provide patients with regular support based on up to date information.

The practice provided a service for all age groups. They provided services for patients in the local community with diverse cultural and ethnic needs, patients with learning disabilities, patients living in deprived areas and care homes, and patients experiencing poor mental health. We found that staff were familiar with the needs of patients and the impact of the socio-economic environment. Services provided were tailored to meet these needs. The practice used coding and alerts within the clinical electronic record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register and palliative care register.

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

Management, monitoring and improving outcomes for people

The Quality and Outcomes Framework (QOF) is a system for the performance management and payment of GPs in the NHS. It was intended to improve the quality of general practice and the QOF rewards GPs for implementing "good practice" in their surgeries. This practice had achieved a score for QOF of 91.5% last year which was slightly lower than the national average but still demonstrated they provided good effective care to patients. QOF information indicators demonstrated for example, the percentage of patients aged 65 and older and patients with diabetes who had received a seasonal flu vaccination were higher than the national average. QOF information also indicated that patients with long term health conditions received care and treatment as expected and around the national average including for example patients with diabetes had regular screening and monitoring and clinical risk groups (at risk due to long term conditions) had good uptake rates for seasonal flu vaccinations. Child immunisations rates had been lower than the national average; however the practice were able to demonstrate that they had improved childhood immunisation rates over the last year to achieve their target. Uptake of cervical cancer screening had also improved over the last year with the practice achieving above the target for patients having had a cervical smear in the last 5 years (where relevant).

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 systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients for example the practice kept up to date disease registers for patients who were vulnerable and for those with long term

Good

Are services effective?

(for example, treatment is effective)

conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD).These registers were used to identify and monitor patients' health needs and to arrange annual health reviews.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included methotrexate and azathioprine treatment and treatment of atrial fibrillation with anticoagulation therapy. These were fully completed audits where the practice was able to demonstrate the changes resulting since the initial audit, improved patient outcomes and ensured the practice worked within NICE guidelines.

Clinical audits were often linked to medicines management, local Clinical Commissioning Group (CCG) enhanced service provision, locality and national performance indicators and QOF. For example, the practice participated in the national cancer audit and audited attenders to A & E departments. The medicines management support from the CCG also undertook regular frequent audits of medications and prescribing trends such as domperidone safety review and oxycodone review.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also monitored that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. Medication reviews for patients aged 75 and over were provided in a weekly clinic held with a pharmacist. The reviews were also conducted in patient's homes for those who were not able to attend the practice.

The practice participated in the Gold Standards Framework (GSF). (GSF is a systematic, evidence based approach to optimising care for all patients approaching the end of life, delivered by care providers). The practice had a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families. The patient's care plan and any other relevant information were shared with the out of hour's services to inform them of any particular needs of patients who were nearing the end of their lives.

Effective staffing

There was an induction procedure in place which identified the essential knowledge and skills needed for new employees. We spoke with staff who confirmed that they had received an induction.

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending essential (mandatory) training such as safeguarding, basic life support skills, infection control and information governance. We saw that the practice maintained an organised record (matrix) of staff training which demonstrated staff compliance against the training policy.

We noted a good skill mix among the doctors with each having special interests in different fields of general practice. GPs undertook continuing professional development for their roles for example, minor surgical procedures. They also undertook audits of minor surgery wound infections as part of their ongoing appraisals and revalidation.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. We spoke to staff who told us the practice was supportive of their learning and development needs. All GPs were up to date with their yearly continuing professional development requirements and they had either been revalidated or had a date for 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).

The practice nurses and GPs had completed accredited training around checking patients' physical health and around the management of the various specific diseases and long term conditions. Additional role specific training had been undertaken by clinical staff to support them in these roles. Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles (for example seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease) were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

Good

Are services effective?

(for example, treatment is effective)

The practice worked with other service providers to meet patient's needs and manage those patients with complex needs. We were shown how the practice provided the 'out of hour's' service with information, to support, for example, end of life care. The practice received blood test results, X ray results, and letters from the local hospital including discharge summaries and out-of-hours GP services both electronically and by post and we saw that this information was read and actioned by the GPs in a timely manner. Information was also scanned onto electronic patient records in a timely manner.

The practice worked closely with other health and social care providers in the local area. They told us how they worked with the community mental health team, social workers and health visitors to support patients and promote their welfare. GPs attended child and vulnerable adult safeguarding multi-disciplinary meetings for their patients. The practice held multidisciplinary meetings (three monthly) to discuss the needs of complex patients, for example those with end of life care needs.

Information sharing

The practice used electronic systems to communicate with other providers. They shared information with out of hour's services regarding patients with special needs. They communicated and shared information regularly between themselves, other practices and community health and social care staff at various regular meetings.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the computer system for future reference. All members of staff were trained on the system, and could demonstrate how information was shared. Electronic systems were in place for making referrals, and the practice made most of its referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice has signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. They provided us with examples which demonstrated their understanding around consent and mental capacity issues. They were aware of the circumstances in which best interest decisions may need to be made in line with the Mental Capacity Act when someone may lack capacity to make their own decisions. Clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures a patient's written consent was obtained and documented in the patient notes. Implied consent was obtained for child immunisations with recorded explanation and consent held in their records.

Health promotion and prevention

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

The practice had a health trainer available in the practice every week. They were accessible to all patients who wanted support to improve their lifestyle. The practice ran regular health awareness events at the centre and these included charities and health providers such as Cancer Research UK and Liverpool Community Alcohol Service (LCAS).

We noted a culture among the GPs and practice nurses to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic cervical smear screening, diabetic lifestyle advice and smoking cessation advice to smokers. This was confirmed by patients we spoke with.

The practice offered NHS Health Checks to all its patients aged over 40. The practice offered a full range of immunisations for children, travel vaccines and flu

Good

Are services effective?

(for example, treatment is effective)

vaccinations in line with current national guidance. Last year's performance for children's immunisations was slightly lower than national average, however they were able to demonstrate the rate had improved to reach targets. Seasonal flu immunisation rates for the over 65 group were above average for the CCG. There was a clear policy for following up non-attenders by the named practice nurse.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. The practice kept up to date disease registers for patients with long term conditions such as diabetes, asthma and chronic heart disease which were used to arrange annual health reviews. The practice also kept registers of vulnerable patients such as those with mental health needs and learning disabilities and used these to plan annual health checks. For example, the practice kept a register of all patients with dementia and records showed 100% had received a face to face review in the last 12 months. The practice had also identified the smoking status of patients over the age of 16 and actively offered smoking cessation advice to these patients with data demonstrating 92% of smokers had been given support in the last year.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff we spoke with were aware of the importance of providing patients with privacy and of the importance of confidentiality. The computers at reception were shielded from view for confidentiality. We noted phone calls had to be taken at the reception desk and could be overheard if patients were waiting at the desk. However we noted reception staff spoke confidentially when taking calls. Staff and patients felt they could be overheard in the reception area when speaking, staff were aware of this and tried to ensure conversations were not overheard. They also offered a separate room where patients could speak confidentially with staff if necessary.

Consultations took place in purposely designed rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. We observed staff were discreet and respectful to patients. Patients we spoke with told us they were always treated with dignity and respect.

We looked at 20 CQC comment cards that patients had completed prior to the inspection and spoke with three patients. Patients were positive about the care they received from the practice. They commented that they were treated with respect and dignity, felt they had confidence in the staff caring for them and that their health needs were addressed. Patients we spoke with told us they had enough time to discuss things fully with the GP, treatments were explained and that they felt listened to.

The National GP Patient Survey 2014 found that 91% of patients at the practice stated that the last time they saw or spoke to a GP; the GP was good or very good at treating them with care and concern. Eighty four percent of patients who responded to this survey described the overall experience of their GP surgery as good or very good.

The practice offered patients a chaperone prior to any examination or procedure. Information about having a chaperone was seen displayed in the reception area and all treatment and consultation rooms. Patients confirmed with us that chaperones were offered regularly and they had used chaperones during examinations. There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

Patients who we spoke with and who made comments via the CQC comments cards, told us they felt involved in decisions about their own treatment, they received explanations about diagnosis and treatments and staff listened to them and gave them time to think about decisions. This was reflected in the patient survey results.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice well in these areas. For example, data from the National GP Patient Survey 2014 demonstrated 90% of patients said the GPs were good at involving them in decisions about their care. These results were around average when compared to CCG area and nationally. Only 83% of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care (this was lower than the CCG and national average).

Patients we spoke with told us that health issues were discussed with them, treatments were explained, and 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 they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with on the day of our inspection and the comment cards we received told us that staff were caring and compassionate.

Patients told us they had enough time to discuss things fully with the GP, they felt listened to and felt clinicians were empathetic and compassionate. Results from the National GP Patient Survey told us that 97% of patients said the last GP they saw or spoke to was good at giving them enough time, 99% said the GP was good at listening to them and 96% said they were good at explaining tests and treatment.

The practice cared for patients with terminal illness and those coming towards the end of their life. They had a

Good

Are services caring?

palliative care register and held regular multidisciplinary meetings with community healthcare staff to discuss the care plans and support needs of patients and their families. Patient care plans and supportive information informed out of hours services of any particular needs of patients who were coming towards the end of their lives.

Staff spoken with told us that bereaved relatives known to the practice were offered support. The practice signposted carers to support led by community services. The practice's computer system alerted GPs if a patient was also a carer however we were told the registers were not always accurate and staff felt that not all carers had been identified by the practice.

Good

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 patients' needs. The needs of the practice's population were understood and systems were in place to address identified needs in the way services were delivered. The practice held information and registers about the prevalence of specific diseases within their patient population and patient demographics. This information was reflected in the services provided, for example screening programmes, vaccination programmes, specific services and reviews for elderly patients, those patients with long term conditions and mental health conditions.

We were told the practice engaged with the NHS England Area Team, Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice was responsive to the needs of older patients, those with long term conditions and mental health conditions and vulnerable patients. They offered home visits and extended appointments for those with enhanced needs. Patients received annual health checks and had care plans in place.

Patients with dementia, learning disabilities and enduring mental health conditions were reviewed annually. They were encouraged to bring carers with them to these reviews. The practice had implemented the 'named GP' for patients over 75 to support continuity of care. The practice was proactive in contacting patients who failed to attend vaccination and screening programmes. The practice cared for older patients well. They had originated and implemented a pilot project called OWLS (Older Wiser Living Socially) which aimed to help support older patients living in social isolation with an aim of reducing hospital admissions. The project was in its infancy and hadn't yet been evaluated as to how patient outcomes had improved.

The practice had a patient participation group (PPG). However we were told they were not a very active group and no members had wished to speak with us on the inspection day. The practice was currently trying to recruit new members to the group.

Tackling inequity and promoting equality

The practice was situated in a purpose built health centre and provided disabled access in all area. There was disabled car parking available. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities and a room available for breast feeding mothers.

The practice analysed its activity and monitored patient population groups. This enabled them to direct appropriate support and information to the different groups of patients. The practice had a majority population of English speaking patients though it could cater for other languages as it had access to translation services. Three of the GPs also spoke other languages such as Urdu, Tamil, Sinhalese and Hindi. They had tailored services and support around the populations needs and provided a good service to all patient population groups.

The practice routinely provided equality and diversity training for its staff.

Access to the service

The practice was open Monday to Friday 8.00am until 6.30pm. They were closed one day every three months for training and development. Information was available to patients about appointments on the practice website and in the practice information leaflet. This included who to contact for advice and appointments out of normal working hours when the practice was closed such as contact details for the out of hours medical provider. The practice offered pre bookable, on the day appointments and home visits. Appointments could be made in person, online or by phone. Priority was given to children; babies and vulnerable patients identified as at risk due to their condition.

Appointments were tailored to meet the needs of patients, for example those with long term conditions and those with learning disabilities were given longer appointments. Home visits were made to older patients and those vulnerable housebound patients. Patients told us they usually got to see the GP of their choice. This was confirmed by the patient survey results which told us that 68% of patients with a preferred GP usually got to see that GP (this was higher than the local average).

Patients we spoke with, comment cards and patient survey results told us patients were not satisfied with the appointment system. They expressed concern around getting appointments and said there was difficulty getting

Good

Are services responsive to people's needs?

(for example, to feedback?)

through to the practice on the telephone and getting an appointment that day. The national GP patient survey told us that only 63% of patients said they found it easy to through to the practice by phone (lower than the local average). The practice had identified that patients preferred to make appointments on the day and that there was a high number of non-attenders for appointments booked in advance. Therefore the practice had opted to make the majority of appointments for the same day rather than in advance. The practice had also identified that the telephone system could not cope with high demand at peak times. This meant that patients could not always get through to the practice to book an appointment. The practice told us they had plans in place to implement a new system with the support of the health centre management in order to improve access to appointments.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance. The practice manager and clinical staff managed the complaints and they liaised with all relevant staff in dealing with the complaints on an individual basis.

We looked at the complaints log 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. The practice reviewed complaints quarterly to detect themes or trends. We looked at the log for the last 12 months and found no themes had been identified. However, lessons learned from individual complaints had been acted on.

We saw that information was available to help patients understand the complaints system in a patient leaflet and on the website. Patients we spoke with were not aware of the complaints procedure, however they told us what they would do if they needed to make a complaint and none of the patients we spoke with had ever had cause to complain.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to provide high quality healthcare to the whole population. Staff could articulate the practice ethos to put patients first and to provide the best care at all times.

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 shared drive and in hard copy. Policies and procedures were dated, reviewed and appropriate. Staff were familiar with the policies and procedures and confirmed they were aware of how to access them.

There was a clear organisational and leadership structure with named members of staff in lead roles. For example, there was a lead for infection control, safeguarding, palliative care, learning disability and mental health. We spoke with staff in different 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.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing around the national average. For 2013/14 the practice obtained 91.5%. We saw that QOF data was monitored and discussed between the team and actions taken to maintain or improve outcomes.

The practice undertook clinical audits which it used to monitor quality and systems to identify where action should be taken. Clinical audits were undertaken regularly by medical staff and supporting pharmacy staff. We looked at a selection of these. Generally they were completed well; with review of actions and improvements evident.

The practice had arrangements in place for identifying and managing risks such as fire, security and general environmental health and safety risk assessments. The premises management company mostly monitored the risks in conjunction with the health providers in the building.

The practice held regular meetings, these were documented. We looked at a sample of minutes from last year and found that performance, quality, significant events and complaints had been discussed.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings and with the practice management team. We also noted that staff had opportunities for learning and development with a full training programme, access to eLearning and development days. Staff were also encouraged to attend CCG protected learning events.

Staff felt confident in the senior team's 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 well supported. The leadership of the practice was caring and enthusiastic about the service they provided and about caring for their staff. They demonstrated they were considering the future of the practice, service provision and succession planning.

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

We looked at complaints and found they were dealt with appropriately. The practice investigated and responded to them in a timely manner, and complaints were discussed with staff to ensure staff learned from the event.

The practice had a patient participation group (PPG) however they were not currently very active and the practice were encouraging further recruitment to the group and developing this. Information was promoted in reception to patients encouraging them to access and participate in the NHS friends and family test. The NHS friends and family test (FFT) is an opportunity for patients to provide feedback on the services that provide their care and treatment. It was available in GP practices from 1 December 2014. We saw the results of the latest tests which were very positive with the majority of patients recommending the practice to others.

The practice had gathered feedback from patients through patient surveys, friends and family test comments and complaints. For example the results of the friends and

Are services well-led?

Good

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

family test for February 2015 demonstrated that when asked "would you recommend this service to friends and family", all 12 respondents said extremely likely or likely to recommend the practice. The results of the last survey undertaken by the practice in October 2014 showed that a majority of patients had concerns regarding booking appointments and the booking system. The practice responded with an action plan to address the appointments issues. They were implementing a new telephone system.

The practice gathered feedback from staff through formal and informal 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. Regular informal discussions and meetings were held at which staff had the opportunity and were happy to raise any suggestions or concerns they had.

Management lead through learning and improvement

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Staff had annual appraisals to review performance and identify development needs for the coming year. They were up to date with these

Staff told us they had good access to training and were well supported to undertake further development in relation to their role. Clinical and non-clinical staff told us they worked well as a team and had good access to support from each other. The practice had a training and development policy and we saw that staff were up to date with all mandatory and core training. Training was monitored to ensure staff were fully trained. Staff were trained through face to face sessions, eLearning, and CCG learning and development days.

The practice had completed reviews of significant events, complaints and other incidents. The results were disseminated via email, verbally and discussed at practice meetings and if necessary changes were made to the practice's procedures and staff training.