Roe Lane Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	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 Roe Lane Surgery on 21 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, safe, effective, caring and responsive services. It was also good for providing services for all population groups it served.

Our key findings were as follows:

- The practice had clearly defined governance systems that promoted patient safety and gave all staff a framework to reference and work within.
- Areas for improvement had been identified and progress on improvement actions were discussed at practice meetings. A system of clinical audit was in place to measure the quality of patient outcomes.
- Monitoring of patient telephone traffic had been used to bring about improvements in telephone access to the practice and GPs.
- All feedback we received on the day, from CQC comment cards and on reviewing results of the practice Family and Friends test, showed that patients were satisfied and appreciative of the services provided by the practice.
- There was a clear vision and strategy in place; the practice was well-led by staff committed to the care of its patients and to the development of patient services.

However, there were also areas of practice where the provider needs to make improvements.

The provider should:

- Increase its efforts to engage with the Patient Participation Group, considering all ways to increase actual meetings.

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. The practice used every opportunity to learn from internal and external incidents, to support improvement. All staff understood their duty to raise and report any concerns. Strong governance systems meant risk was assessed and reviewed over time. Safeguarding systems were understood and followed by all staff. Staff had recently been trained in dementia awareness and the practice was working toward accreditation as a Dementia Friendly practice by the Alzheimer's Society.

Are services effective?

Good

The practice is rated as good for providing effective services. The practice manager and lead GPs were able to show us how they reviewed various aspects of the practice and performance in relation to treatment of patients. For example, we saw how review of telephone traffic had resulted in clear pathways for staff to follow when allocating the most suitable appointments for patients. The practice was able to show examples of completed clinical audit cycles, which demonstrated their commitment to providing high quality effective treatment for patients.

Are services caring?

Good

The practice is rated as good for providing caring services. Feedback in the form of CQC comment cards and results from the Friends and Family test showed that patients experienced a high rate of satisfaction from the practice and valued the services provided. When we reviewed standards of record keeping at the practice, we saw that additional information about patients' circumstances made it easier for patients to explain their needs to staff when calling the practice. Throughout our visit we saw patients were treated with dignity and respect.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice used a number of data sources to capture information to aid the planning and delivery of services to meet patient needs. The practice had amended the patient management system templates to capture practice specific information which would contribute to planning services tailored to patients needs.

Are services well-led?

Good

The practice is rated as good for providing well-led patient care and treatment. There was a clear vision and strategy in place at the

Summary of findings

practice, which staff were aware of and could relate their everyday roles to. Leadership was visible and supportive. All staff were engaged in training which went beyond what is considered as mandatory. Plans were in place to manage the retirement of one of the partners and for the possible move of the practice to a purpose built facility, subject to funding.

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 and treatment of older patients. The practice considered the rise in patient numbers at the practice (equivalent to 7.6% increase since 31 March 2014), in the planning and delivery of services. The practice partners recognised that within this figure, there was three times the number of expected older patients, living in nearby care homes. The practice had independently contracted to deliver a 'step up step down' 23 bed facility, to avoid hospital admission for these patients, and to allow additional recovery time for patients that may otherwise struggle if discharged directly to their home. The practice also recognised that by supporting care homes well, patients could avoid moving to a nursing home. This was particularly important to those patients who wished to stay amongst people and staff they had come to regard as friends in that time.

People with long term conditions

Good

The practice is rated as good for the provision of care and treatment to patients with long- term conditions. We saw how disease registers were managed and reviewed and how patients registering with the practice were added to these in a timely fashion. Because the practice had modified templates used to capture information on patient conditions, registers of those patients with multiple health problems could be requested. These facilitated the delivery of flu vaccine clinics, and timing of length of appointments for medicines reviews and other health checks.

Families, children and young people

Good

The practice is rated as good for the provision of services to families, children and young people. Governance systems in place provided a confidential service for all patients and staff awareness of this was in place. We saw cases where GPs had recorded they were satisfied for certain patients under 16 to collect their own prescriptions. We saw how younger patients were treated in an age appropriate way; all staff demonstrated awareness and application of the Mental Health Act 2005, The Children's Act 1989 and 2004 and Gillick competency.

Working age people (including those recently retired and students)

Good

The practice is rated as good for services provided to working age patients, including those recently required and students. The practice evaluated access needs of patients in this group and acted positively when addressing barriers patients found to access. The

Summary of findings

practice has invested and developed the skills of its practice nurse, who is now a nurse prescriber. The practice has also directly employed a pharmacist for five hours each week. As a result of these two measures, access for working age patients for annual health checks and medicines reviews has improved. The review of how appointments were allocated also meant that more 'on the day' appointments were made available. Feedback in the NHSE GP Patient Survey confirmed that patient access has improved.

People whose circumstances may make them vulnerable

Good

The practice was still able to offer the services of a Health Visitor to their patients who was based at the practice. GPs and nurses spoke of the benefits of this, particularly in relation to feedback on how new mothers were coping post childbirth, and whether any child was failing to thrive. The practice also linked the high rate of uptake in screening, immunisations and vaccines uptake to the additional communication link provided between the health visitor and the patients.

People experiencing poor mental health (including people with dementia)

Good

One of the practice partner's areas of special interest was mental health, the Mental Capacity Act and Deprivation of Liberty Safeguards. A productive working relationship was in place between the local mental health liaison practitioner and the practice pharmacist, to ensure patients medication needs were met following any review whilst in secondary (hospital) care. Training on suicide awareness had been delivered to all staff at the practice. The practice had the third highest recorded rate of prevalence of dementia in patients within the Southport and Formby Clinical Commissioning Group (CCG) area. To this end, the practice was working towards accreditation as a Dementia Friendly practice by the Alzheimer's Society.

Summary of findings

What people who use the service say

We received 14 Care Quality Commission (CQC) comment cards, which patients had used to express their views on the service at Roe Lane Surgery. All comments received were positive. Patients particularly commented on the continuity of care that they had received over the years and on the way in which clinicians took time to explain their medical condition and treatment options available.

Patients spoke positively about access to the service. Results from the last NHS England GP Patient Survey showed that just over 98% of patients said it was easy to get through to the surgery by phone. The average for other practices in the same Clinical Commissioning Group (CCG) was just 68% and nationally the average score was just 74%. We know from experience that ease of phone access to the practice is something that is valued highly by patients.

The practice scored highly in other areas relating to access and how responsive the practice was to patient needs. For example, 93.9% of patients asked said it was easy to get an appointment to see or speak to someone the last time they tried. The local average for this score was 87.3%, and nationally 85.4%. When asked, 89.6% of patients described their experience of making an appointment as being good. Locally the average score for this was 87.3% and nationally 73.8% said their experience of making an appointment was good.

The practice had a Patient Participation Group (PPG); this is a virtual group and communication is by email. Members of the group were unable to attend to speak with us on the day of our inspection. Members of the group were invited to telephone us if they wanted to share any concerns. No concerns were raised by the PPG.

Areas for improvement

Action the service SHOULD take to improve

The practice should increase its efforts to engage with the PPG, considering all ways to increase actual meetings as opposed to email communication only.

Roe Lane Surgery

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 Advisor, and a Practice Manager Specialist Advisor.

Background to Roe Lane Surgery

Roe Lane Surgery is located in Churchtown, Southport, Merseyside. The practice falls within Southport and Formby Clinical Commissioning Group (CCG), and is run by three GP partners, supported by a salaried GP, a part time pharmacist, a nurse prescriber and two health care assistants. The practice manager works on a part time basis, supported by an administrative team of eight part time employees. Services are provided under a Personal Medical Services (PMS) contract.

The practice is open between 8am and 6.30pm, Monday to Friday of each week. On Monday evening an extended hours surgery is available between 6.30pm and 8pm.

The practice serves approximately 2,600 patients and is located in a former domestic property which has been converted for use as a GP practice. All consulting and treatment rooms are located on the ground floor. The practice is fully accessible to patients with impaired or limited mobility. The upper floor of the practice provides office space and permanent room for the community based health visitor, who operates from the practice. The practice is also a training practice, hosting GP registrars (qualified doctors who are training as a GP).

Out of hours services are provided by an alternative provider, 'Go to Doc'. When patients ring the practice out of hours, their call will be directed to this service.

Appointments can be booked on-line, by phone or in person. There are telephone consultations available each day. GPs offer home visits to those patients with higher dependency needs who would not be able to visit the surgery themselves. The practice has been recognised by the local Clinical Commissioning Group (CCG) as having introduced an effective appointment booking system, which meets patient need and ensures that patients are seen by the most appropriate person. As a result of this, the practice is due to share a presentation on the workings of their appointment system, to all GP surgeries in Sefton, in November 2015.

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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

- Is it safe?

Detailed findings

- 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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 21 July 2015. During our visit we spoke with a range of staff including three GP partners, a practice pharmacist, the practice manager, practice nurse prescriber, a healthcare assistant and three administrative staff. We reviewed a range of information from patients, for example CQC comment cards, patients surveys and emails from the practice Patient Participation Group (PPG).

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. The staff we spoke with where aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Systems were in place to receive, share and discuss updates on safety alerts, for example, from the Medicines and Healthcare Products Regulatory Agency, and from Public Health England. Minutes of meetings held by the practice confirmed that this was an item on the agenda for a number of practice meetings, such as clinical meetings and practice meetings.

Learning and improvement from safety incidents

The Practice has a system in place for reporting, recording and monitoring significant events. We reviewed three recorded incidents, chosen at random. From these we could see that each event was investigated thoroughly and findings were recorded and shared appropriately. Where any incident involved a patient, they were advised of the outcome of the investigation. The practice was able to demonstrate how they learned from findings of investigations into significant events. One example we reviewed had resulted in a change in the way the practice dealt with patient recall and medicines optimization; we saw how the nurse practitioner would review results of blood tests and escalate details of patients that were considered as being more complex. This could prompt an appointment with the pharmacist for a medicines review, to ensure that medicines were being taken correctly, or with the GP to alter medications prescribed. The practice were also able to show that where necessary, outcomes from incidents investigated, could prompt clinical audit, for example on those patients prescribed a statin who were also taking an anti-biotic. This audit increased awareness of contra-indications in patient medications amongst those patients and promoted patients safety.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. GPs were trained to Level 3, nurses to Level 2 and administrative staff to Level 1. All staff had received updates and refresher training on safeguarding within the last 12 months. Staff knew how to recognise signs of abuse in vulnerable adults, including older people, and children. They were also aware of their responsibilities to report concerns. We saw that instructions and flow charts on when and whom to report concerns to, were clearly displayed in all staff areas of the practice including reception areas and administrative offices.

One of the GP partners was the practice lead on safeguarding. Deputising arrangements were in place to cover any period of leave. All staff we spoke with were aware of who these leads were and who to speak with at the practice if they had a safeguarding concern. Particularly, we saw good communication between practice staff and the community based Health Visitor who operated from a room within the practice. For example, in relation to parents who failed to bring children to planned GP appointments, immunisation and vaccination appointments, and milestone child health assessments. We saw that GP's submitted reports in response to requests from any Safeguarding Review boards. When GPs where unable to attend these meetings, the Health Visitor was given the opportunity to attend. This enhanced communications on safeguarding to the practice.

There was a system to highlight vulnerable patients on the practice's electronic records. A safeguarding register was held by the practice. Governance arrangements in place ensured that GPs were aware of dates of safeguarding meetings with the local authority, and when any reports on the health and welfare of any safeguarded patients were due for submission. If a patient's safeguarding status had changed, for example, to that of a looked after child, this was annotated on records, in a place where the information could be seen by out of hours services. Registers held at the practice were generated from the practice computer system and we saw that governance systems ensured information was updated without delay. We found that all staff were using the correct read codes to identify each patients safeguarding status. This meant that summary care records would give this information to out of hours practitioners and hospital staff.

There was a chaperone policy in place at the practice and details of this were available to patients. The chaperone service was highlighted on notice boards and in consulting rooms. (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). All nursing staff, including health care assistants, had received chaperone training. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones. All staff undertaking chaperone duties had been subject to a Disclosure and Barring Service (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).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely, used in date order and were only accessible to authorised staff. Checks were in place to ensure medicine stocks were rotated and were within their expiry date. There was a cold chain policy in place, which staff could refer to. This policy gave guidance on safe temperature controlled storage and described the action to take in the event of a failure in continuity of the cold chain. Records showed fridge temperature checks were carried out at least twice daily, which allowed staff to respond quickly to any rise in fridge temperature, beyond the range considered as safe for storage of some medicines.

The practice had moved to electronic prescribing in January 2015 and reported that this worked well. Electronic Prescribing System (EPS) allows patients to order their prescriptions through a nominated pharmacy, who send a medicines request to the GP practice electronically. The request is authorised by the GP and medicines will then be issued to the patient, without the requirement for a patient to be issued with a paper prescription. All patients had received information on this prior to opting to using EPS. Some patients had declined to move to EPS and stocks of prescription pads were still held to use in printers, or to take with the GPs on home visits. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance. We saw that access to these was appropriately restricted and batch numbers issued to the practice and then individual clinicians was recorded.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. The practice demonstrated it had a system in place to ensure that completed and signed shared care protocol agreements were in place before commencing the medication regime from the practice.

The practice had recruited a pharmacist to work at the practice for five hours per week, to undertake some of the work in relation to medication reviews and authorisation of repeat prescription requests and medicines optimisation advice. The practice partners said the work of the pharmacist had made a considerable impact in reducing their workload, which allowed them to spend a greater amount of time with patients.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Information on products used were available to the practice manager and staff, and were kept in a folder at the practice. Cleaning was delivered by an external contractor, and regular checks and cleaning audits were undertaken by the practice nurse who was the lead on infection control.

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. For example, personal protective equipment such as disposable gloves, were available for staff in each room at the practice. Disposable aprons, masks and treatment bed covers were available in the treatment room. Staff where able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice nurse was responsible for bringing any issues to the attention of the practice manager and for sharing updates on infection control. The practice had been audited on infection control in September 2013 by Liverpool Community Health and achieved a score of 99% compliance. The only area found non-compliant were consulting rooms that were carpeted. The practice partners were waiting on a decision around funding to move to new premises. In the event that this funding is not available,

plans would be put into action to replace any carpeted areas with sealed flooring appropriate for GP practices. We were able to confirm that no minor surgical procedures or joint injections were delivered in carpeted rooms.

All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the infection control lead had carried out re-audits and had confirmed that any improvements identified for action were completed and staff were aware of any updates to the infection control policy for the practice. Hand hygiene audits were in place and we noted that alcohol hand sanitizer was available from dispensers throughout the practice. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment and consultation rooms. Legionella testing was done for the building in January 2015 and a certificate issued to evidence this.

A member of staff took responsibility for ensuring compliance with segregation of waste requirements and the safe disposal of clinical waste and sharps. We noted that sharps bins were in treatment rooms and that all waste was collected and stored in the appropriate colour coded bin liners. We reviewed contracts for the disposal of clinical waste and found arrangements in place were suitable for the needs of the practice.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw all equipment was tested and maintained and equipment maintenance logs and other records confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating when the next testing date was due, which was May 2016. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and fridge temperature gauges. These were due for re-testing in May 2016.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

The practice had arrangements in place for members of staff, including GPs and administrative staff, to cover each other's annual leave. Where this was not possible, the practice partners had three named locums they would use to provide cover. The practice manager had staff files in place for each of these locums and was aware of the need to check that working arrangements did not exceed the hours covered by each locums insurance.

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. The practice manager was able to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

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 building, the environment, medicines management, staffing, dealing with emergencies and equipment and training of staff in relation to health and safety. 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 we spent time with the Mental Health Liaison practitioner for the area, who visited the practice regularly to discuss the needs of patients with the practice and to attend multi-disciplinary team meetings in relation to patients with mental health problems including dementia. Staff had received training in suicide awareness and on dementia and its effects on patients. If any member of staff encountered a patient experiencing a mental health crisis they had direct dial numbers to staff who worked on the mental health team. Similarly, GPs could seek advice if they were concerned about any of their patients who experienced a mental health crisis.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated

Good

Are services safe?

external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. Relevant contact details for staff to refer to were regularly updated. The plan was reviewed annually and the practice manager confirmed that copies of the plan were held on and off site by key staff members.

Records showed that staff where up to date with fire training and that they practised regular fire drills. The last fire safety check at the practice was done by Merseyside Fire Service in the last four years and showed all areas of the building met fire safety standards.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurse at the practice could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Care and treatment approaches were discussed with the pharmacist that the practice employed to ensure that they were suitable for each patient, and that the impact of multiple long term conditions of some patients were considered. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and were in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. To evidence this, we saw copies of enhanced patient information templates. These had been taken from the patient management system and adapted to capture even more detail in each patient assessment. We also reviewed a copy of a care plan, drawn up between a patient and their GP. The care plan covered all aspects of patient health, well-being and clinical needs. We saw that the care plan was reviewed at each health check. In the cases of patients who may be particularly vulnerable to unplanned hospital admission, the care plan had details of the patients named GP was and how they should be contacted by ambulance staff and paramedics.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Management, monitoring and improving outcomes for people

The practice has a system in place for completing clinical audit cycles. Examples of clinical audits included an end of life audit, prescribing safety audit, prescribing for patients with dementia audit and an audit of atrial fibrillation patients. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example we saw from the audit of prescribing safety, all patients who had been prescribed a particular type of antibiotic who were also taking medication for cardio vascular problems, were recalled, reviewed and given further advice on how to take their medicines. This was to avoid the risk of increase in possible adverse effects whilst taking the medicines together. We saw how this audit cycle was repeated to review how lowered doses of the medicines prescribed, still provided therapeutic effects for the patients concerned.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of analgesics and non-steroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, but does have the highest prevalence in the locality of the five main long term conditions measured in QOF. In the year 2014-15 the practice achieved 100% of the points available from QOF.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good

Good

Are services effective?

(for example, treatment is effective)

skill mix among the doctors with one of the partners being an associate GP Dean and the lead at the practice as mentor for GP Registrars. The practice partners also recognised the 'fresh' input to the practice provided by the GP Registrars; the GP Registrars had commented particularly on the value of having a pharmacist employed by the practice to advise on medicines prescribing when needed. All GPs were up to date with their yearly continuing professional development requirements and all either have 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 the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The practice had invested in their practice nurse, who had achieved her prescribing qualifications. Two health care assistants supported the nurse, providing a three person team that delivered screening and chronic disease management clinics. A recent review of appointment systems and patient recall meant that patients with multiple conditions were invited for one appointment, which would include phlebotomy services (blood collection), health check and review on management of their condition and often, a medication review with the pharmacist. The practice was particularly proud of this achievement as it put the patient at the centre of their care. Also, it had a positive impact on any carers involved, as all parts of the health review could be delivered in one, longer appointment, rather than having to make several trips to the practice.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training, for example on suicide awareness and on understanding the effects of dementia. Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. All staff we spoke with told us that leaders at the practice were approachable and supportive of them in their everyday work.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It 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. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications.

The practice worked closely with the community mental health liaison practitioner, who attends multi-disciplinary team meetings for the case management of patients with mental health conditions, including those with dementia. This practitioner reviews the practice mental health register to ensure that patients are involved with and engaged in their care and care planning. This can often result in the practice managing to reach patients who may feel marginalised, allowing the GPs to look after their physical health needs. The mental health practitioner also reviews shared care arrangements, to ensure these are being observed and are delivered in a timely manner. We reviewed a shared care monitoring record and saw that all required blood tests for these patients were recorded and future repeat tests diarised into the practice patient management system. The dates of required future repeat prescriptions were also recorded, which assisted in assessing patients compliance with medicines regimes.

When we looked at wider examples of the practice working with other services, we saw care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate. Copies of care plans for carers and patients also held contact details of named GPs or mental health support workers, for ambulance crews. The practice particularly benefitted from having the Health Visitor for the area, based at the practice. The Health Visitor was able to update the practice GPs and nurse on any concerns about patients they had seen in clinics or on home visits. Also, the Health Visitor was able to report back to the practice on any safeguarding review board meetings they had attended, where a GP from the practice had not been able to attend. The practice told us this was highly valued by the GPs.

Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future

reference. We saw that checks were carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified. For example, were there was any backlog in summarising of patient records, the practice could employ a member of 'bank' staff to assist in clearing any backlog. Checks we made on the day of our inspection showed that patient records were fully summarised and added to the patient management system within six weeks of the patient registering with the practice.

The practice was signed up to the electronic Summary Care Record record scheme, and all staff had been trained in the correct summarising and read coding of patient records. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). The practice also used the 'GP to GP' system on note transfer, wherever possible. This meant that patients who left and registered with other practices, could have their notes transferred to their new practice, if that practice was also on the 'GP to GP' scheme. The practice was committed to sharing information with other care providers as quickly and safely as possible, and staff confirmed that training had been provided to allow them to do this safely.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act (MCA) 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. One of the senior partners at the practice had a special interest in the MCA 2005 and the Mental Health Act 1983, and was a Section 12 approved doctor. (A section 12 approved doctor is a medically qualified doctor who has been recognised under section 12(2) of the Act. They have specific expertise in mental disorder and have additionally received training in the application of the Act.) For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. For example, for those patients with dementia who had made advance care decisions on where they wished to be cared for at end of life, this was recorded in their care plan.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

Health promotion and prevention

All new patients were offered a new patient health check with either the practice nurse or health care assistant. The work the practice had done on enhancing templates for gathering patient information was evident in how disease registers were updated after seeing patients, and in the practice recording prevalence of conditions of patients. This meant that all patients registering with the practice could be offered an appointment with the nurse or GP to discuss the management of those conditions, and future appointments could be diarised. This provided an effective way of reviewing and recalling these patients and minimised the chances of patients missing key health interventions.

The practice performed well in most screening programmes. Particularly, the practice had exceeded its target for cervical screening, achieving 87% testing against a target of 80%. This achievement was commented on by Public Health England in March 2015. The practice had also performed well in other areas of health promotion and prevention. Bowel screening had reached just over 62% of the practice eligible population, against a target of 60%. The national achievement for this screening programme was just over 56%, and locally, other practices only achieved 59%. (CCG average). In childhood immunisations, the practice had achieved 100% in five of the seven age specific childhood immunisation groups. In the influenza vaccine programme of January 2015, those patients deemed to be at risk were contacted and the practice recorded high levels of uptake of the vaccine. In the two

Good

Are services effective?

(for example, treatment is effective)

groups were the practice had lower uptake, (under 65's at risk and pregnant women), the practice still reached more people that the CCG average – 74.2% of under 65's at risk compared with a CCG average of 52.6%, and 57.1% of pregnant women registered with the practice, compared with a CCG average of 45.9%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received 14 completed cards which commented positively on the service patients experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. All patients commented that they were satisfied with the care provided by the practice.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting and treatment rooms so that patients' privacy and dignity were maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise this with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. All staff had received training on effective communication and on conflict resolution. When we spoke with staff they said they felt confident in dealing effectively with any patient that was upset or who displayed aggressive behaviour, but said this was rare. Staff commented that they always listened to patients, and let them finish what they were saying, allowing sufficient time to communicate their needs, concerns or worries.

Results from the latest NHS England GP Patient Survey (July 2015), supported the feedback patients shared with us using CQC comment cards. Of those patients asked, 100% said they found receptionists at the practice helpful. When asked, 97% of patients said they were able to get an appointment to see or speak to someone that last time they tried. Of those patients asked, 94% described their experience of making an appointment as good. When asked about their care and treatment, for example with a nurse at the practice, 100% of those patients asked said the last nurse they saw or spoke to was good at giving them enough time. 100% of patients said the nurse was good at listening to them. 100% of patients said the nurse was good at treating them with care and concern, and 100% of patients said they had confidence and trust in the nurse they saw or spoke to.

Care planning and involvement in decisions about care and treatment

Patients commented in CQC comment cards that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also expressed that 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. Figures from the NHS England GP Patient Survey reflected this; of those patients asked, 90% said the last GP they saw or spoke to was good at listening to them, and 86% of patients said the last GP they saw was good at explaining tests results and treatments to them.

Care plans we reviewed showed evidence of involvement of patients and where appropriate, their carer. In the case of more vulnerable older patients, we saw evidence that care plans to prevent unplanned admissions from this population group did have a positive effect. All care plans generated are registered with the North West Ambulance Service, and the practice pharmacist is the project manager and practice lead for this work. Also, the unplanned admissions for over 75's registered with the practice is the lowest within the CCG, at 24%.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room and on the practice website gave information to patients on how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, they would be contacted and offered an appointment with their GP, either face to face or a telephone appointment if this was preferred.

All staff at the practice had completed Dementia Awareness courses and spoke of the steps they take to make these

Good

Are services caring?

patients more comfortable when visiting the practice, and how important it was to communicate effectively with both them and their carer's. The practice had delivered a training session in June 2015 to other stakeholders in the community, to raise awareness and provide more joined up support for this patient group and their carers. This was driven by the practice having the third highest prevalence of dementia patients, within Southport and Formby CCG, and that local shops and services should be welcoming and supportive of these patients and their carers when they visit their premises or services.

GPs at the practice had started to use leaflets from Patient UK to offer greater written information for patients to explain tests and treatments more comprehensively. The practice had committed to all GPs completing a course ('Improving Care Through Patient Feedback') to ensure they were in tune with expectations of patients and their desire for greater understanding of their care and treatment.

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 and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice ran a 23 bed 'step up step down' care facility for older patients who required additional support. This support could be accessed GP practices within the CCG area, to prevent patients from being admitted to hospital, (step up care) or to give patients support on discharge from hospital. (step down care.) The salaried GP at the practice was the lead GP for this service; this was a service run by the practice, rather than a federation of practices. The practice pharmacist was also involved in this work and was able to deliver medication reconciliation work on patients discharge from hospital, which was improving patient recovery time and their readiness to be discharged to their own home.

The practice had a Patient Participation Group (PPG). However, this group was virtual and communicated via email. There was no on-line meeting facility in place, for example, on-line conferencing. However, the practice had engaged with the PPG to enable them to help with gaining patient opinion on what was needed, for example, to make the appointment system at the practice better. The practice had added information to its new patient questionnaire and information gathering template, to raise the profile and awareness of the PPG and encourage patients to join the group.

Tackling inequity and promoting equality

The practice had recognised the needs of different patient groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities, and for any patient with more complex needs. The practice had worked to ensure that those patients with multiple conditions were reviewed within one extended appointment, which was convenient for the patient and their carer if appropriate. This encouraged the uptake of review appointments across all patient groups.

Although the practice was located in an older, domestic style property that had been adapted over many years, the practice worked hard to meet the needs of those with restricted mobility, or other debilitating conditions. In the areas highlighted by the partners for improvement, we saw that focus was placed on the move to a purpose built facility. However, this was subject to funding requirements. As it was uncertain as to whether funding would be granted at the level required, the practice had included improvements to the existing building, as part of its development plans for practice. These plans included the installation of automatic entry doors, removal of carpets and improvements to GP consulting rooms, and upgrade work to the reception area to afford more patient privacy.

Access to the service

The practice opened from 8am to 6:30pm Monday to Friday. On Monday evening an extended hours surgery is available between 6.30pm and 8pm. There were arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. Telephone consultations were available each day and could be pre-booked up to three months in advance. Where patients requested a telephone consultation with a GP, beyond what was available on that day, this would be added to the list of the duty GP for that day.

The practice had responded quickly to feedback from patients about appointment availability and more specifically to the fact that those patients ringing the practice to book an appointment, were in a 'fastest fingers first' competition which was unfair to all. The practice addressed issues arising from this, including the patient responses to reception staff who asked patients about the degree of urgency they felt for seeing a GP. The latest results in the NHS GP Patient Survey show that patient satisfaction with the new appointment system is high, and their experience in trying to contact the practice by phone has also improved. Of those asked, 99% of patients said they found it easy to get through to the practice by phone. Also, 100% of patients asked, said receptionists at the practice were helpful; 97% of patients reported that they were able to get an appointment, and 99% of patients said the last appointment they got was convenient. These are all things we know to be very important to patients, and evidence reviewed shows that patients have been listened

Good

Are services responsive to people's needs?

(for example, to feedback?)

to and responded to quickly, which has been greatly appreciated by practice patients. It is also notable that the practice has experienced a 7.6% increase in its patient register in the past 12 months.

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.

Information was available and accessible to patients on how to make a complaint, and whom they should address their concerns to.

We reviewed complaints received in the last 12 months and found that all were dealt with in a timely way and in line with the practice complaints policy. We found responses showed openness and transparency when dealing with issues raised by the complainant and that an apology was always offered. All complaints, verbal or written were responded to by the practice manager and a log of all complaints was kept, which was reviewed annually to identify any trends or common themes. We saw from minutes of meetings held within the practice that all complaints were discussed and any learning that could be taken from, shared amongst all staff.

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 deliver high quality care and promote good outcomes for patients. The practice recognised that development of the practice team was central to its plans for growth and a move towards more integrated care. Leaders spoke of the possibilities offered by a move to a purpose built facility that was linked to the 23 bedded intermediate care unit it currently supports To this end, plans were in place to increase the hours that the practice pharmacist worked each week. This would allow more time for clinical project management for example, of effective patient focussed care plans which had proved successful in reducing unplanned hospital admissions of elderly patients. Also, the practice said they were looking to redefine the work of the nurse prescriber at the practice, recognising this work and that of the two health care assistants as being key in supporting effective disease management clinics. All staff we spoke with were engaged in the vision and supported each other in steps toward achieving this.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We reviewed a number of these policies and found them to be in date, accurate and that they reflected any applicable legislation, for example, Health and Safety legislation.

There was a clear leadership structure with named members of staff in lead roles. For example, the nurse led on infection control and the one of the GP partner's was the lead for safeguarding. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GPs and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance. The QOF data for this practice showed it was performing either in line with or above national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

Evidence from a number of data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the recruitment policy and information governance policy, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

The partners in the practice were visible, approachable and supportive of all staff. All staff were involved in discussions about how to run the practice and how to develop the practice. Staff said the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

The practice partners held annual strategic away days. These were used to discuss and formulate the basis for their business plan for the next 12 months, five and ten years. The first away day was used to design and develop an appointment system for the practice that 'we would want ourselves as a patient'. The second away day was held in April this year and was used for succession planning, retirement and how the practice wanted to be, moving forward. The value of these days has been shared across the local GP community and the practice is looking to start facilitating the same type of day for the practice administration team.

Are services well-led?

Good

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

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), the NHS England GP Patient Survey and through the Friends and Family test. Sets of action points had been agreed and we could see were these had been applied and improvements had followed. Staff told us that they were encouraged to express their views. If they were reluctant to do this, leaders reminded them of how many years they had worked at the practice for, confirming that their opinion was both valid and important in shaping how services could and should be delivered to patients. There was a strong ethic of team working within the practice and this appeared to have added to patients' positive view of and experience when visiting their nurse or GP.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at six staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that protected learning time was always observed. Two GP Registrars that had recently been on placement at the practice had recorded their experience throughout their placement. Both referred to the practice as being a 'team practice' and 'true family surgery'. One registrar said it reminded them of why they wanted to become a GP. The other recorded that they would recommend the practice as a training practice and as 'a desirable place to work once fully qualified.'