P D Medical Centre

Quality Report

485 – 487 Princess Drive
Liverpool
L14 8XE
Tel: 0151 228 2036
Website: www.princessdrivemedicalcentre.nhs.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at P D Medical Centre on 19 February 2015. Overall the practice is rated as good.

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

- Patient safety was a priority of the practice staff and clinicians. Systems in place supported this and all staff were clear about their responsibilities, however –
- Further work was needed to update risk assessments for staff who may work in isolation and for those staff who may be required to perform chaperone duties. A risk assessment was also required on how medical emergencies could be managed without access to oxygen.
- Care and treatment of patients was effective. We found the 'sit and wait' system of seeing patients worked effectively as opposed to an appointment system. This had eliminated any time lost by GPs due to patients' failure to attend appointments.
- Patients we spoke to on the day of our inspection, and information from CQC comment cards, confirmed that the practice staff and clinicians were caring and compassionate.
- The practice was responsive to patients' needs. Access to clinicians was good and patient feedback had been considered by the practice in preparing for its merger with a neighbouring practice.
- Staff responded quickly and effectively to any safeguarding concerns in relation to young children and vulnerable adults.

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

Summary of findings

- Ensure all staff who are required to carry out chaperone duties are risk assessed on whether they should have an enhanced Disclosure and Barring Service check (DBS) for their suitability to carry out this work.
- Ensure staff receive annual performance and appraisal review.

Additionally the provider should

- Keep appropriate records in respect of all staff training;
- Carry out risk assessments in respect of lone working and how it would manage any medical emergencies without the availability of oxygen.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe care and treatment. The practice staff had a good understanding of their responsibilities in terms of identifying and reporting signs of abuse in children and vulnerable adults. Staff were experienced in dealing with patients who may display challenging behaviour and were able to demonstrate how they managed these patients. Staff at the practice understood and could refer to policies, procedures and systems in place which promoted safe practice and kept patients safe. We saw medicines were stored and used safely and that staff had the training and equipment needed to respond safely to an emergency. When we made checks, we found some risk assessments had not been updated or applied to staff working alone, or at times, in isolation. We saw that administrative support staff had received performance and appraisal reviews in previous years, but not in the past 12 months. Although staff had received literature on how to carry out the duties of a chaperone, we found a risk assessment on the suitability of staff to carry out this duty had not been conducted. There was no rationale as to why Disclosure and Barring Checks had not been conducted on staff performing chaperone duties.

Are services effective?

Good

The practice is rated as good for providing effective services. The practice manager and clinicians used multiple data sources to ensure that those patients' who required services, received them in a timely manner. For example, by inviting vulnerable patients to attend the practice for flu or shingles vaccinations, and ensuring patients with a diagnosis of dementia had their care reviewed by their GP.

Are services caring?

Good

The practice is rated as good for providing caring services. All patients we spoke with and CQC comment cards we received, confirmed feedback in the last patient survey carried out by the practice. Patients particularly liked the open surgery in the mornings and the knowledge that they would be able to see a GP on that day. Patients also commented on the administrative support staff, saying they were friendly, respectful and understood their concerns.

Are services responsive to people's needs?

Good

The practice is rated as good for being responsive to patients' needs. The practice had consulted with patients to check how extended hours appointments could be provided to meet patients' needs. The

Summary of findings

practice found it would suit working patients or those with caring commitments, to have extended hours early in the morning rather than in the evening. As a result of this, the surgery offered appointments each week day from 7.30am. Patients commented that this was a feature of the service that they valued.

Are services well-led?

Good

The practice is rated as good for being well-led. The lead GP had led the practice for many years. All clinicians had received performance review and appraisal, and could demonstrate evidence of continuing professional development. The practice was due to merge with another nearby surgery in April 2015. Staff had engaged in discussion with their leaders and patients and about the move and how this may affect the way they worked in the future. Staff we spoke with viewed the move positively and as an opportunity to learn new skills.

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 treatment of older people. From data we reviewed before our inspection we could see that key services to older patients, for example, in health promotion and protection initiatives were being delivered. Those patients with a diagnosis of dementia were having their care reviewed by their GP regularly, patients aged 65 and over who required flu vaccination were contacted and received this service. Older patients we spoke with on the day of our inspection told us the GP they saw always allowed them sufficient time to discuss their health concerns and that staff took time to explain things to them, for example, any changes a GP had made to their medicines.

People with long term conditions

Good

The practice is rated as good for the care and treatment of people with long term conditions. The practice nurse worked in partnership with community teams that helped patients manage longer term and chronic conditions, for example by working with the dedicated chronic obstructive pulmonary disease (COPD) team. GPs planned their day so that they could accommodate any home visits to patients who required further support and treatment. Telephone appointments were also available at the end of each surgery. The practice had an electronic prescribing service and patients appreciated that their medicines could be ordered through their nominated pharmacy. Patients would receive further reminders through their pharmacy if any of their medicines needed to be reviewed by their GP.

Families, children and young people

Good

The practice is rated as good for the care and treatment of families, children and young people. The practice nurse worked to ensure that any child who had missed immunisations as a baby, received an invitation letter to attend the practice to take up that immunisation. Other baby vaccinations and immunisations were delivered in structured clinics. The practice nurse we spoke with displayed a good understanding of consent, the Mental Capacity Act 2005 and Gillick competency. This nurse was able to show how they communicated with younger patients in an age appropriate way to ensure they fully understood any treatment delivered. The nurse also delivered cytology screening and worked with the specialist diabetic nurse to support patients with diabetes.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care and treatment of working age people. The practice had consulted with patients and asked when extended hours surgeries could be planned to best meet their needs. In response to patient feedback, extended hours surgeries had been moved from evenings to first thing in the morning. The practice staff worked to meet the needs of patients requiring repeat prescriptions, ensuring these were ready to send to community pharmacies to enable collection in the evening. Typical turnaround of requests for repeat prescriptions was 24 hours.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care and treatment of people whose circumstances may make them vulnerable. The practice kept registers of those patients whose circumstances could make them more vulnerable to poor health, such as those patients with learning disabilities and patients who were carers. Annual health checks were offered to these patients to ensure any underlying health conditions were diagnosed and treated in a timely manner. Patients who were also carers could be referred to a community service to access further support. Details of palliative care patients were entered onto a register. Details of those patients' who may require a visit from out of hour's services, were sent to the out of hours care provider and updated on a daily basis. The practice GPs worked closely with multi-disciplinary care teams to ensure patients receiving palliative and end of life care, were well supported.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care and treatment of people experiencing poor mental health. The practice signposted and referred patients to specialist services within the community who could offer support to patients experiencing low mood to mild depression. For example, referring older patients to a service called Listening Ear, a community based counselling service. The practice was also able to refer any children or younger adults to a community based bereavement service called Butterflies. Here, younger patients could be seen by specially trained counsellors for talking therapies. The practice also had a good working relationship with the community matron, who would provide on-going support for patients who had attended hospital emergency departments on multiple occasions for non-urgent problems. This could include patients recently diagnosed with dementia.

Summary of findings

What people who use the service say

On the day of our inspection we collected 24 CQC comment cards, where patients had expressed their views about the service. All comments were positive. Patients commented on the 'sit and wait' system of seeing their GP, saying this had always worked well and that they valued the fact that they could be seen by their GP 'on the day'. Patients had also commented that they valued the reception staff and practice manager, saying that staff knew their patients well and always treated them with kindness and compassion.

We were able to speak with three patients on the day of our inspection. Patients expressed concerns about the up-coming merger of the practice with another larger surgery in the neighbourhood. When we asked what those concerns were, patients said they had received information about the move and had been told they would still have access to their GP. However they felt the changes would mean they would lose the 'sit and wait' system to see their GP 'on the day'.

The practice had conducted a patient survey in 2014. The survey questionnaire was distributed to patients from 28th January 2014 to 14th March 2014. Further copies were available from the reception desk at the practice, so patients calling in, for example to order a repeat prescription, could take a copy to complete and submit later. In total, 71 responses were received but the practice had not recorded how many survey questionnaires were given out (or how many questionnaires were issued to each of the defined population groups). Therefore, we would question the statement in the summary of findings by the practice, that "71 responses were received. This is a similar response rate achieved by other local practices."

Overall the findings on key questions put to patients were good; 98% of patients were satisfied with the opening hours of the practice. This supports the decision of the practice to move extended hours surgeries to early mornings as opposed to late evenings. The survey findings reflected the comments made to CQC by patients, for example patients had written in free text boxes on the survey that "If you need to see someone, you will always be seen." Almost 95% of patients were satisfied with the reception staff at the practice, almost 94% of patients said the GP was good at treating them with care and concern. Areas highlighted as requiring improvement related to waiting times of patients when at the practice, privacy at the reception desk and access to longer appointments with the GP.

Areas for improvement

Action the service MUST take to improve

- Ensure all staff who are required to carry out chaperone duties are risk assessed on whether they should have an enhanced Disclosure and Barring Service check (DBS) for their suitability to carry out this work.
- Ensure staff receive annual performance and appraisal review.

Action the service SHOULD take to improve

- Keep appropriate records in respect of all staff training;
- Carry out risk assessments in respect of lone working and how it would manage any medical emergencies without the availability of oxygen.

P D Medical Centre

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 and a Practice Manager.

Background to P D Medical Centre

P D Medical Centre is located in the Huyton – Dovecot area of Liverpool, and sits within Knowsley Clinical Commissioning Group (CCG). The practice is in an area measured as one of the most socio-economic deprived areas in the country. (Measuring 1 on the scale of deprivation, where 1 is the most deprived and 10 is the least deprived.) Two statistics that express the effect of this are the practice Income Deprivation score, which is 55.7 compared to the average practice in England, which is 23.64. (Last available figures from 2012). Life expectancy for males in the area is 76.6 years and 80.7 years for females. Life expectancy at a practice that falls within an area that is the least deprived (with a score of 10 on the deprivation measurement scale) for men is 81.95 years and for women 86 years.

The practice premises is a former domestic property, although we understand it has been used as a GP practice for almost 80 years. The premises has two GP consulting rooms on the ground floor, a nurse treatment room and a patient reception and waiting area. The upper floor of the premises is given over to a staff area and the practice manager's office. There is a small amount of parking available at the surgery. There are approximately 3,000 patients registered with the practice. Dr Messing is registered with the Care Quality Commission (CQC) as the provider and Registered Manager of the service, and delivers care and treatment under a Primary Medical Services contract.

We saw that availability of GP consultations was good; the practice did not operate a formal appointment system throughout the day. If patients arrived at the practice before 10.45am, they would be seen by a GP. Patients who wished to make an appointment could be seen at the structured clinics which ran between 3.00pm and 6.30pm. For those patients with working commitments, extended hours appointments were available between 7.30am and 8.00am. A practice nurse worked two days each week, delivering disease management clinics, baby vaccinations and immunisations, cytology screening and contraception advice. The lead GP Dr Messing was supported by two, part time GPs. The practice does not provide out of hours services. These are provided by a separate, external provider called Urgent Care 24 (UC24).

Why we carried out this inspection

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

Detailed findings

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?
- 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. The practice was asked in advance of our visit to send us a range of information for review before our inspection, such as current policies and procedures and recent clinical audits conducted. This was provided to us on the day of our inspection. We carried out an announced visit on 19 February 2015. During our visit we spoke with a range of staff including the lead GP, the practice manager and administrative support staff. We were able to spend time speaking with the practice nurse and three patients visiting the practice.

Requires improvement

Are services safe?

Our findings

Safe track record

Information provided by the practice and from NHS England showed the practice had a safe track record in delivery of care and treatment. We saw that any accidents at the practice were recorded and investigated. Any learning from analysis of the cause of accidents was shared. From incidents we reviewed we saw that staff had developed good 'people skills' that enabled them to communicate with patients effectively. We saw that staff were proficient in managing those patients who presented with challenging behaviour, and when any incident had occurred, this was reviewed to ensure staff safety going forward, and to address unacceptable behaviours displayed by a minority of patients.

Learning and improvement from safety incidents

The Practice has a system in place for reporting, recording and monitoring significant events. We reviewed two examples of significant events that had occurred within the last 12 months. From these we saw that detailed records were kept of the incidents; on each occasion a GP or the practice manager had been appointed as the lead in the investigation and analysis of the incident. The form used to record the incidents prompted staff involved to reflect on any positive or negatives about the event, which promoted discussion on how the practice had dealt with and responded to the event. The form required the investigation lead to record a conclusion and any changes to how the practice and staff operated on a daily basis. Finally, the question was posed as to whether this incident could happen again. When we tracked the handling, investigation, discussion and analysis of significant events, and put questions about these to staff and clinicians, it was clear that the system worked well and any lessons learnt were applied immediately by staff. For example, staff had become more knowledgeable about NHS prescription fraud and how to report this.

Reliable safety systems and processes including safeguarding

The practice had a safeguarding policy in place which all staff could refer to, and we saw how they applied this within their daily duties. Reception staff were particularly good at applying safeguarding protocols to some patients who may initially be vulnerable, for example, patients from other countries who may have been recently granted leave to remain in the United Kingdom. Where any incident involving anti-social or unacceptable behaviours of patients had occurred, staff acted quickly, applying a 'zero tolerance' approach. The staff also had details of support groups within the community that they could refer potentially vulnerable patients to.

The lead GP at the practice led on safeguarding matters. We reviewed two referrals the GP had made to the local safeguarding teams. Detailed report forms had been completed by the GP who had acted quickly to ensure patients involved were picked up and seen by safeguarding teams. The GP was able to demonstrate that he and the other salaried GPs were up to date with their safeguarding training and this had been completed to the required levels. When we asked the lead GP how many children at the practice were subject to a safeguarding protection plan, the GP could tell us immediately without checking records. Later in the day we checked this and found the GP was correct. This confirmed that updates and alerts on any children subject to a protection plan were received, communicated and recorded effectively.

The practice had a chaperone policy in place. Staff confirmed they had read this and could refer to it. Staff had received some chaperone training from the practice manager. When any patient had requested a chaperone, the GP recorded this in the patient notes and staff confirmed they had acted as the chaperone. Staff had received safeguarding training, including the practice manager, but this was due for refreshing and update. We were able to confirm a skills audit for all staff was being undertaken and training organised by the practice they were merging with at the end of March 2015.

Medicines management

The practice had systems in place to manage and store medicines safely. GPs did not carry emergency medicines when visiting patients, other than a GTN spray (a medicine used for angina pain) for treatment of patients with a heart condition. Emergency medicines were available at the practice; we saw these were stored safely, securely and where accessible in the event of an emergency. When we checked these medicines we found they were all in date and suitable for use.

The practice nurse and other staff were trained in the handling and storage of vaccines. We saw these were kept

in a dedicated fridge at the practice. The temperature of the fridge was checked and recorded twice daily to ensure it stayed within the range required to keep vaccines safe for use. The fridge was well ordered and tidy; we saw that stock had been rotated so that it was used in date order. Designated staff checked and recorded temperatures on the days when the nurse was not at the practice.

There was a clearly advertised system in place for patients who wished to order repeat prescriptions. These could be requested in writing by the patient or via a designated pharmacy in the community. We saw that this worked well, with the average turnaround of repeat prescriptions being 24 hours. We particularly noted that the practice had managed to apply effective controls on the ordering of repeat prescriptions. These had been reviewed to check that medicines or healthcare products were not ordered unnecessarily. The practice had achieved this by placing certain items on the acute prescribing list rather than repeat prescribing, for example items such as dressings or salbutamol (a medicine to treat asthma).

Cleanliness and infection control

We conducted a visual inspection of the practice and found that the nurse's treatment room and the GPs consulting rooms were clean and tidy. The practice building is a former domestic property and comes with the challenges to infection control a building such as this would present. The practice consulting and waiting areas and the treatment room were seen to be very clean; stocks of personal protective equipment were available, such as gloves, aprons and face masks. All treatment equipment was disposable and for single use only; waste bins were in place and we saw that all clinical and sharps waste was segregated and collected in the correct colour coded sacks. A contract was in place for the safe removal of clinical waste. Staff knew where kits to deal with spillage of body fluids were kept and we saw these were accessible and ready for use. When asked, staff could describe how and when these must be used and how they must be disposed of. The practice nurse showed us how, for example, the treatment couch, would be cleaned between patients and the alcohol wipes used to do this.

Cleaning at the practice was carried out by a designated cleaner who attended the practice each morning and evening. We saw a cleaning schedule was in place, with a description of which cleaning products and materials should be used in the different areas of the practice. The practice manager conducted periodic checks on the standard of cleaning in all areas of the practice.

We reviewed a copy of the last infection control audit for the practice, carried out by 5 Boroughs Partnership (NHS Trust) Community Health Services. This audit was completed in November 2013. The practice had scored well in all areas, other than the staff kitchen area, were some improvements were required. Overall the practice scored 95%. Any improvements identified as being required had been made.

Equipment

The practice manager showed us contracts in place for the servicing, testing and calibration of equipment, for example, weighing scales and blood pressure monitoring equipment. We saw that all of the equipment had been tested and the practice had contracts in place for portable appliance tests (PAT) to be completed on an annual basis. The practice manager showed us a comprehensive record which listed the equipment within the practice, contact details for the maintenance contractor, when the equipment was last checked and the date it was next due for inspection. We saw that all the checks had been completed within the scheduled timescales.

The practice had a defibrillator (used to attempt to re-start a person's heart), which was checked regularly to ensure its readiness for use in the event of emergency. The practice did not keep oxygen on site and had not risk assessed how they would manage emergencies effectively.

We checked documents and contracts for maintenance in relation to fire extinguishers, fire alarm systems, central heating system servicing, boiler safety checks and electrical checks. These were all in date and showed fixtures and appliances (boilers, fire extinguishers and electrical supply) had been checked and serviced.

Staffing and recruitment

Practice staff were all longstanding employees. The most recent recruit was employed two years previously. When checking staff records, we saw that the recruitment process described in the in the practice recruitment policy, had been followed in respect of this employee. Other staff files we reviewed required some updating; we could see staff had received an appraisal early in 2014, but this had not

been completed for this year. The practice manager had a Disclosure and Barring Service check in place and was trained to act as a chaperone if a patient requested this service. The practice manager told us that the administrative staff had been not been subject to a Disclosure and Barring Service (DBS) check. We were aware that some staff had received literature and training from the practice manager on chaperone duties. We were told staff could be asked to perform this duty, on the rare occasion that the practice nurse or the practice manager were not available. Where any staff acted as a chaperone, a risk assessment should be in place to determine whether a DBS check is required. The decision on this should be documented and held in staff records. There was no risk assessment in place for administrative staff who undertook any chaperone duties.

Monitoring safety and responding to risk

The practice had systems in place for reporting, recording and monitoring significant events. We saw that these were recorded, investigated and findings shared with staff. Any learning from incidents was shared amongst staff at regular practice meetings. Systems were in place to receive any alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA). These were circulated to clinicians daily, who recorded that they had received and read these alerts. The practice worked with CCG medicines management teams to recall and review any patients whose treatment would be effected by these alerts.

The practice could demonstrate that there were sufficient staff, clinical and administrative, who had the knowledge, experience and expertise to meet the needs of the patients registered with the practice. Staff had received training in adult and paediatric resuscitation and on how to use a defibrillator. The practice manager and lead GP oversaw the rota for clinicians and we saw they ensured that sufficient staff were on duty to deal with expected demand including home visits and daily telephone consultations. We did note that when the practice nurse was on annual leave, there was no nurse to cover this absence. However, when we reviewed records we saw that there was sufficient GP presence by the two regular GPs to absorb any patients that may wish to have their health conditions reviewed by a clinician. Also, the practice could refer patients to the specialist community teams, for example there is a specialist COPD nursing team that works within Knowsley and nurses based at the main Knowsley treatment centre deal with wound management and dressings.

Health and safety visual checks by the practice manager included the waiting areas for patients. The practice manager kept records of servicing and repair to the practice building, for example invoices for servicing and repair of the shutters on the outside of the building. The building had an alarm and this was in working order.

The practice issued staff with a handbook, which covered health and safety in the workplace. As the practice was in a former domestic property, this did present challenges. A fire escape was clearly marked which led patients and staff to a safe area at the rear of the property.

We found that the door to the working area behind the reception desk was not locked. The handbook issued to staff, at page 13 in the section on security, stated that any staff entering staff only areas must ensure that doors are kept locked. We found risk assessments in place had not been adapted and updated to cover any lone working of staff, for example, staff working in the front reception area.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support and use of a defibrillator. This was delivered through a formal training course, and staff could refer to an on-line resource to refresh this training. When we asked members of staff, they all knew the location of emergency equipment and records confirmed that it was checked regularly.

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. The document also contained relevant contact details for staff to refer to.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance. Patients received a full health check assessment when registering at the practice. Any patient's diagnosis of long term conditions were confirmed and checked. The practice screened patients for cardio-vascular disease (CVD), chronic obstructive pulmonary disease (COPD), for asthma detection in children and for diabetes. The nurse at the practice had received training in managing diabetes patients from the specialist diabetes nurse that works in the Knowsley area. This nurse visited the practice to see some patients whose diabetes had been harder to manage. The practice nurse was able to refer to best practice guidance updates, for example, on management of childhood asthma, and was also able to refer patients to the specialist asthma nurse working in the area. The nurse also delivered health checks to patients in the 40 – 74 years age range. This included monitoring of blood pressure and weight. The nurse was able to provide patients with advice and literature on ways to maintain their health and improve their fitness.

Management, monitoring and improving outcomes for people

The practice used a number of data sources to target improvements in patient diagnosis, treatment and care. We noted that the practice had a high rate of diagnosis of dementia. This showed in Quality and Outcomes Framework (QOF) data as being 83% of patients referred, being diagnosed, compared to an England average of 54% of patients referred being diagnosed. This suggested that the practice positively screens patients for signs of dementia – for example, by recalling patients who had a complaint of memory loss, and referred them appropriately for further tests and confirmed diagnosis.

The practice has a system in place for completing clinical audit cycles. An example of clinical audit we reviewed showed how the practice GP's had recalled and consulted with all patients that were prescribed anti-depressants. Patients' treatments were reviewed to see whether their health condition could be better treated through referral for psychotherapy, or by using an alternative anti-depressant. The audit took account of updated guidance issued by the National Institute for Health and Care Excellence. We saw that the audit cycle was completed and measured outcomes for patients over a 12 month period. Results and findings of the audit were shared and discussed at clinical meetings that the practice had with CCG pharmacists.

Effective staffing

All staff had access to and had completed what would be considered mandatory training, for example, in child and vulnerable adult safeguarding, infection control and emergency first aid. Some of this was via e-learning, which staff told us was sufficient to update more formal learning delivered in 2014. Staff had received training on chaperone duties from the practice manager. This was supported by a chaperone policy, which detailed how a patient should be chaperoned during any examination.

We reviewed the training and continuous professional development of the practice nurse. We saw a number of documents, such as confirmation of attendance at learning events, held by the CCG which showed the nurse had the knowledge and skills required to deliver her duties. The practice held a copy of the nurse's professional registration, which was up to date and due for renewal in March 2015. The nurse was able to demonstrate a sound understanding of the Mental Capacity Act, the Children's Acts 1989 and 2004 and Gillick competency. The lead GP had duties outside of the practice which required him to be highly proficient in understanding and application of the provisions of the Mental Capacity Act 2005. To this end, the GP attended a comprehensive course on the subject every five years, and attended other update events in between each workshop. We saw that both GPs were due for re-validation in 2015. Revalidation is the process by which doctors demonstrate they are up to date and fit to practice.

Working with colleagues and other services

All staff at the practice were aware of their duties. Incoming correspondence was dealt with by the practice manager and distributed to staff to scan onto patient records, once returned from GP scrutiny. We saw that this system worked well and that there was no significant delay in adding blood test results or medical reports from hospital specialists to patient notes. The practice had recently inherited approximately 400 patients from a surgery nearby that had closed. We saw that all records had been added to the practice computer system and there was no 'back-log' in relation to this work.

Good

Are services effective?

(for example, treatment is effective)

The practice worked well with the provider of out of hours services; we saw that staff ensured any details about out of hours care delivered to their patients, was seen by the GPs and any follow-up action recorded and taken. Community midwives visited the practice to provide ante-natal care to patients. The lead diabetic nurse for Knowsley visited the practice to see patients whose condition had been unstable or more difficult to manage.

The practice used the Choose and Book system of referring patients to secondary care. At the time of this inspection, almost all referrals were through this system. The system presents choices where available, to patients on where they can be seen by a specialist for further tests, surgery or follow-up care.

The practice refers patients to specialist consultants, who deliver review clinics at the practice, for example for patients diagnosed with atrial fibrillation. The clinic was sponsored by a pharmaceutical company that produced medicines used to treat atrial fibrillation. This provided a service to patients that they would otherwise have to travel to a local hospital to receive, and who may have to wait longer to receive an appointment. This demonstrated pro-active and collaborative working with the consultant, who provided expert review of the patients' condition.

Information sharing

We found that staff had all the information they needed to deliver effective care and treatment to patients. For emergency patients, patient summary records were in place. This electronic record was stored at a central location. The records could be accessed by other services to ensure patients could receive healthcare faster, for instance in an emergency situation or when the practice was closed.

The practice kept a register of those patients who were also a carer. This enabled staff, where patient permission had been given, to pass messages or talk to a carer about any appointments a patient was due to attend. We found that the level of information shared was sufficient to inform the carer but still offered the patient the level of confidentiality expected of the GP/patient relationship. A register of palliative patients was kept by the practice and details of those patients who may require a GP visit overnight, were faxed daily to the out of hours service provider. The practice showed us how they highlighted the records of any patients that were subject to a safeguarding plan. This meant any doctor seeing vulnerable patients out of hours, would be aware of this.

Consent to care and treatment

Clinicians were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling this. Clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. They gave examples of when best interest decisions were made and how mental capacity was assessed prior to consent being obtained for any invasive procedure. Staff demonstrated a clear understanding of Gillick competency. (This helps clinicians to identify children aged under 16 who have the capacity to consent to medical examination and treatment).

Health promotion and prevention

The practice nurse and doctors used each intervention to support patients in taking control of their health and well-being. The practice administrative staff showed us how information notice boards were kept up to date. Literature was available to take home and read, which covered initiatives to help patients stop smoking, manage alcohol consumption and support for patients suffering from anxiety and depression. Details on support available included information for carers on resources available in the community, and contact details of other community groups.

GPs screened patients for a number of common health conditions with a view to early diagnosis and effective early intervention. The practice also considered the family history of patients when considering referral for further clinical investigations.

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. They told us there was a room available if patients wished to discuss something with them away from the reception area. The practice offered patients a chaperone prior to any examination or procedure. Information about having a chaperone was in the waiting area to help ensure patients were aware of this facility. Staff we spoke with were knowledgeable about the role of the chaperone and had received training and instruction from the practice manager on how to carry out this work.

We observed that the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. Patients were positive about the care they received from the practice. They commented that they were treated with respect and dignity. Patients we spoke with told us they had enough time to discuss things fully with the GP and felt listened to by the GP's and nurse, who they said were extremely empathetic and compassionate.

Care planning and involvement in decisions about care and treatment

In the course of our inspection we saw several good examples of how the practice had ensured those patients who were vulnerable, due to their health conditions, had been assessed for their capacity to make decisions relating to their care. Evidence from assessment was corroborated by other clinicians involved in the care of the patient, for example the community matron. Decisions made were discussed and talked through with patients and documented in patient records. Where it was appropriate to share this information with carers and family, consent to do this was recorded.

Data from the 2013-14 NHS England GP Patient Survey, showed patients rated the practice highly for involving them in decisions about their care and treatment. When asked, 90.8% of patients said the nurse they saw was good at involving them in decisions about their care and treatment, and 95.3% of patients said the nurse treated them with dignity and respect. When patients were asked about their overall experience of their GP surgery, 94.5% of patients described this as good or very good.

Patient/carer support to cope emotionally with care and treatment

The practice had links to organisations within the community that patients and their carers could be referred to. These organisations could offer support through periods of treatment or support for patients who had experienced bereavement. The practice had access to referral pathways for child patients, for example to an organisation called Butterflies which provided emotional support to children experiencing bereavement. Patients could be referred to Knowsley Carers Service, who could offer advice, guidance and support to those patients who were carers. There was also access to a counselling service for adults. As the practice was relatively small in terms of patient numbers, staff knew the patients well; we saw that staff interaction with patients was supportive and compassionate. GPs also knew their patients well and offered sufficient time within appointments to ensure their health care needs were met.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to the needs of the population it served. We saw how the 'sit and wait' system of GP access worked extremely well for patients and that patients valued this service. The practice lead GP was supported by a second, part time GP. There was no female GP available at the practice. However, an advanced nurse practitioner provided a clinic once a month at the practice. If a patient expressed that they wanted to be seen by a female clinician they could be offered an appointment with this nurse. The practice nurse provided cytology screening. If a patient needed to be seen immediately, there was no other arrangement in place. When we asked the practice manager about this they told us that this particular situation had never arisen.

Tackling inequity and promoting equality

The practice had a stable register of patients and had recently inherited approximately 400 patients from a neighbouring practice that had closed. The practice manager told us they had very small numbers of patients from different ethnic backgrounds, but these were generally from North Africa, Afghanistan, China and Eastern Europe. Most of these patients could speak English but interpreting services were available if required. The practice had a hearing loop system in place for use by patients with hearing difficulties. The practice nurse and GP were able to say immediately how many patients with learning difficulties were registered with the practice. The practice manager told us that the afternoon appointment system was used to accommodate these patients, who would always be given a longer consultation appointment, which could accommodate interpreting services or a support worker accompanying a patient with learning disabilities.

Access to the service

We observed that access to the service for all patients was good. We spoke with two patients who told us getting an appointment to see a GP was not a problem. The practice did not use a fully structured appointment system for morning clinics. Patients who needed to be seen would use the 'sit and wait system'. As long as patients arrived before the cut-off time of 10.45am, they would be seen by a GP on that day. Afternoons were given over to structured appointment only clinics. These were utilized by GP's for follow-up consultations and appointments for those patients who required longer with their GP, for example, people with chronic long term conditions that required review with a GP, or for patients with learning disabilities attending with their support worker. From review of appointment bookings we saw that GPs were highly flexible, and worked to meet the demand of patients.

Access to the building was good; we saw there was ramped access at the front of the building for wheelchair users and those patients with limited mobility. Consulting and treatment rooms were on the ground floor and were accessible.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy is in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice.

We reviewed any complaints received in the last 12 months. From these we could see that the same level of analysis used for significant events was applied to investigation of complaints. Where a complaint was around treatment of a patient, this was reviewed by the two GPs at the practice and the practice manager, to see if anything could have been done differently. We saw that notes were made on anything that, as a result of the investigation, could have contributed to the cause of complaint. Any complaints received were discussed at practice meetings, and findings were shared with staff. When we case tracked a complaint chosen at random, we saw that the patient had received a verbal and written response to their complaint, which included an acknowledgement from the GPs or practice nurse of the issues raised.

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

Dr Messing's practice had served the local community for many years, and was soon to merge with a larger, neighbouring practice. Staff had received support during the planning of the merger and had provided information to patients. This included reassurance that they would still be able to see their preferred GP (Dr Messing) and that the nurse would also continue to support patients who received treatment for longer term chronic conditions. Staff we spoke with confirmed they had visited the premises of the practice they were merging with and told us they had been encouraged to view it as an opportunity for further development, as they would be dealing with larger numbers of patients at a purpose built facility. Staff said they felt supported by the GPs and practice manager and were not overly anxious about the move.

Some patients had expressed their concerns, but this related to the possible loss of the 'sit and wait' system they had enjoyed for many years. Patients told us they had been offered reassurances regarding continuity of care, but that they would also have other professionals at the new site to offer further health care services.

Governance arrangements

The practice had a range of policies and procedures in place to ensure the safety of patients and staff whilst in the building. The practice manager looked after all checks in relation to health and safety and updated policies for staff to refer to in this regard. The practice manager reviewed performance with most of the administrative support staff, but accepted that there were some instances where staff had missed being appraised this year.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at team meetings and action points were agreed to maintain or improve outcomes.

The practice held regular staff meetings to discuss any changes to working practices. We saw minutes of these meetings, which included explaining to staff how they would move to their new place of work when the practice merged with a neighbouring surgery.

Leadership, openness and transparency

The practice lead GP and practice manager were able to demonstrate that they had considered the needs of the practice, its patients and how services could be best delivered to meet their needs in the future. As a result of this, the lead GP had taken the decision to accept the terms of a merger with a neighbouring practice. This would provide the practice with the opportunity to relocate its patients to a larger, more suitable facility on a site close by. We saw copies of communications issued by the practice to patients and staff. These confirmed that the practice had considered the views and any concerns patients and staff may have had about the move.

We spent time talking with staff on the day of our inspection. All spoke highly of the practice manager, the nurse and the GPs. Staff said they felt valued and that they had access to their leaders, who provided a positive and supportive working environment.

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

The practice had an active Patient Participation Group (PPG) which had been involved in co-ordination of the practice survey, which provided feedback from patients. A member of reception staff at the practice was also a member of the PPG. We saw that staff were encouraged to share their views at staff meetings and staff said they felt leaders listened to their opinions. Staff and management had been sensitive to the response of patients on the up-coming move of the practice to the new site and premises. Where possible, the practice had responded to any concerns sympathetically, providing assurances were possible around continuity of patient care.

Management lead through learning and improvement

The lead GP acknowledged that the up-coming changes to how the practice delivered its services where needed to meet the future challenges of delivering primary medical services. The lead GP told us he believed that the merger and move to better premises would benefit patients. The practice manager and lead GP were responsive to feedback we gave at the end of our inspection. There was a clear indication from the practice that they were aware of some of the areas we had highlighted for improvement, for example the gaps in staff training and appraisal, and issues around safe working for staff, for example, when lone working.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The provider was failing to comply with Regulation 21of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 19 of the Health and Social Care Act 2014. The practice did not keep full records in relation to persons employed for the purposes of carrying out the regulated activity, including information specified in Schedule 3. For example, records of risk assessments in respect of staff delivering chaperone duties and DBS checks on those staff when appropriate.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The provider was failing to comply with Regulation 23(1)(a) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The practice was not supporting staff in relation to their responsibilities. Staff were not receiving appropriate training when due, and timely supervision and appraisal of their work.