

Dr S Singh's Practice

Quality Report

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

Ratings

Overall rating for this service

Good



Are services safe?

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

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Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Dr S Singh's Practice which is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on 25th February 2015 at the practice location. We spoke with patients, staff and the practice management team.

The practice was rated overall as Good. A caring, effective, responsive and well- led service was provided that met the needs of the population it served. However, improvements were needed to ensure the practice was operating safely.

Our key findings were as follows:

- There were systems in place to protect patients from avoidable harm, such as from the risks associated with medicines and infection control. However, improvements were needed in respect of staff recruitment as the recruitment records did not demonstrate that all necessary checks were

undertaken to demonstrate suitability for their roles. Improvements were also needed to the systems in place to ensure that checks of electricity systems and water services were carried out.

- Patients care needs were assessed and care and treatment was considered in line with best practice national guidelines. Staff were proactive in promoting good health and referrals were made to other agencies to ensure patients received the treatments they needed.
- Feedback from patients showed they were overall satisfied with the care given by all staff. They felt listened to, treated with dignity and respect and had confidence in the GPs and nurse. Patients felt involved in decision making around their care and treatment.
- The practice planned its services to meet the differing needs of patients. The appointment system allowed good access to the service. The practice encouraged patients to give their views about the services provided and took these views into account when reviewing service provision.

Summary of findings

- There was a leadership structure in place and clear lines of accountability. The practice had systems to seek and act upon feedback from patients using the service. Quality and performance were monitored, risks were identified and managed.

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

Importantly, the provider must:

- Take action to ensure its recruitment policy, procedures and arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 to ensure necessary employment checks are in place for all staff and the required information in respect of workers is held.

- Protect patients against the risks associated with unsafe equipment by ensuring that the electrical wiring is properly maintained and suitable for purpose.

The provider should:

Carry out an assessment of the risks presented by legionella and take appropriate action to address these risks.

Carry out an assessment of access for patients with a physical disability and take appropriate action where any reasonable adjustments can be made.

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?

The practice is rated as requires improvement for safe. There were systems in place to protect patients from avoidable harm and abuse. Staff were aware of procedures for reporting significant events and safeguarding patients from risk of abuse. There were appropriate systems in place to protect patients from the risks associated with medicines and infection control. Staffing numbers and skill mix were reviewed to ensure that patients were safe and their care and treatment needs were met. However, improvements were needed in respect of staff recruitment as the recruitment records did not demonstrate that all necessary checks were undertaken to demonstrate suitability for their roles. Improvements were also needed to the systems in place to ensure that checks of electricity systems and water services were carried out.

Requires improvement



Are services effective?

The practice is rated as good for effective. Patients care needs were assessed and care and treatment was being considered in line with best practice national guidelines. Staff were provided with the training needed to carry out their roles and they were appropriately supported. Staff were proactive in promoting good health and referrals were made to other agencies to ensure patients received the treatments they needed. The practice worked with health and social care services to promote patient care.

Good



Are services caring?

The practice is rated as good for caring. Patients were positive about the care they received from the practice. They commented that they were treated with respect and dignity, staff were caring, supportive and helpful. Patients felt involved in planning and making decisions about their care and treatment. Staff we spoke with were aware of the importance of providing patients with privacy. Patients were provided with support to enable them to cope emotionally with care and treatment.

Good



Are services responsive to people's needs?

The practice is rated as good for responsive. The practice had systems in place to respond to and meet the differing needs of patients. They monitored the service to identify patient needs and service improvements that needed to be prioritised. Patients reported good access to the service. The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint.

Good



Summary of findings

Are services well-led?

The practice is rated as good for well led. There was a clear leadership structure in place. Staff told us they felt the practice was well managed with clear leadership from clinical staff and the practice manager. Staff told us they could raise concerns and felt they were listened to. The practice had systems to seek and act upon feedback from patients using the service. A Patient Reference Group (PRG) was in place and members of the group told us how the practice had been improved following patient feedback.

Good



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

The practice is rated as good for the care of older people. The practice was knowledgeable about the number and health needs of older patients using the service. They kept up to date registers of patients' health conditions and used this information to plan reviews of health care. The practice had a record of carers and used this information to discuss any support needed and to refer carers on to other services if necessary. The practice ensured each person who was over the age of 75 had a named GP. The practice worked with other agencies and health providers to provide support and access specialist help when needed. The practice had identified all patients at risk of unplanned hospital admissions and a care plan had been developed to support them.

Good



People with long term conditions

The practice is rated as good for the population group of people with long term conditions. The practice held information about the prevalence of specific long term conditions within its patient population such as diabetes, chronic obstructive pulmonary disease (COPD), cardio vascular disease and asthma. This information was reflected in the services provided, for example, reviews of conditions, screening programmes and vaccination programmes. The practice had a system in place to make sure patients attended regular reviews for long term conditions. The practice nurse visited housebound patients to carry out long term condition reviews. The practice had identified all patients at risk of unplanned hospital admissions and a care plan had been developed to support them. A dedicated number was given to healthcare professionals supporting patients who were at risk of unplanned admission to hospital to ensure quick access to clinical services. The practice had implemented the gold standards framework for end of life care. One of the GPs took the lead for this group of patients. They had a palliative care register and liaised with other health care professionals to discuss the care and support needs of patients and their families. Patients at high risk of hospital admission and receiving end of life care had a care co-ordinator and a named GP to ensure continuity of care.

Good



Families, children and young people

The practice is rated as good for the population group of families, children and young people. Child health surveillance and immunisation clinics were run on a weekly basis. The practice monitored any non-attendance of babies and children at

Good



Summary of findings

vaccination clinics and worked with the health visiting service to follow up any concerns. Staff were knowledgeable about child protection and a GP took the lead for safeguarding. Staff put alerts onto the patient's electronic record when safeguarding concerns were raised. The practice liaised with the health visiting service to discuss any children who were at risk of abuse and to review if all necessary GP services had been provided.

Working age people (including those recently retired and students)

Good



The practice is rated as good for the population group of working-age people (including those recently retired and students). The practice was open Monday to Friday and offered extended hours GP appointments until 19:30 on Mondays, 18:30 on Tuesday, Wednesday and Thursday and until 19:00 on Fridays. The practice offered bookable appointments up to five weeks in advance, on the day appointments for urgent medical conditions and telephone consultations. Appointments could be booked on line and repeat prescriptions could be ordered on-line. The practice monitored patient satisfaction with access to the service through patient feedback. Patient feedback indicated patients were overall satisfied with the arrangements for access to the service. The practice offered health promotion and screening that reflected the needs for this age group such as smoking cessation. Health checks were offered to patients over 40 years of age to promote patient well-being and prevent any health concerns.

People whose circumstances may make them vulnerable

Good



The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice was aware of patients in vulnerable circumstances and ensured they had appropriate access to health care to meet their needs. For example, a register was maintained of patients with a learning disability and annual health care reviews were provided to these patients. Patients' electronic records contained alerts for staff regarding patients requiring additional assistance in order to ensure the length of the appointment was appropriate. Staff were knowledgeable about safeguarding vulnerable adults. They had access to the practice's policy and procedures and had received training in this.

People experiencing poor mental health (including people with dementia)

Good



The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). GPs worked with other services to review and share care with specialist teams. The practice maintained a register of patients who experienced poor mental health. The register supported clinical staff

Summary of findings

to offer patients an annual appointment for a health check and a medication review. The practice referred patients to appropriate services such as psychiatry and counselling services. The practice had information for patients in the waiting areas to inform them of other services available. For example, for patients who may experience depression or those who would benefit from counselling services for bereavement.

Summary of findings

What people who use the service say

No CQC comment cards had been completed by patients prior to our visit. We spoke with six patients who were very positive about the care they received from the practice. They commented that they were treated with respect and dignity, staff were caring, supportive and helpful. They told us they had enough time to discuss things fully with the GPs, treatments were explained, they felt listened to, involved in decisions about their care and they were happy with the system for booking appointments.

The National GP Patient Survey in March 2014 found that 93% of patients at the practice stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern. Ninety one percent of patients stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern. Ninety two percent of patients who responded to this survey described the overall experience of their GP surgery as fairly good or very good. Ninety four percent of patients said the GPs were good or very good at involving them in decisions about their care and 87% felt the nurses were good or

very good at involving them in decisions about their care. These responses were average when compared to other GP practices nationally. Seventy percent of patients said they always or almost always see or speak to the GP they preferred. This response was better than the national average.

The National GP Patient Survey in March 2014 found that patients were overall happy with access to the service. Eighty two percent were very satisfied or fairly satisfied with opening hours. Ninety percent gave a positive answer to “Generally, how easy is it to get through to someone at your surgery on the phone.” These responses were average when compared to other GP practices nationally.

We looked at the results of the last patient survey undertaken by the practice in March 2014. One hundred and sixty five surveys were completed and the results showed patients were generally satisfied with the service provided in terms of obtaining test results, repeat prescriptions, access and assistance given by reception staff.

Areas for improvement

Action the service **MUST** take to improve

- Take action to ensure its recruitment policy, procedures and arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 to ensure necessary employment checks are in place for all staff and the required information in respect of workers is held.
- Protect patients against the risks associated with unsafe equipment by ensuring that the electrical wiring is properly maintained and suitable for purpose.

Action the service **SHOULD** take to improve

- Carry out an assessment of the risks presented by legionella and take appropriate action to address these risks.
- Carry out an assessment of access for patients with a physical disability and take appropriate action where any reasonable adjustments can be made.

Dr S Singh's Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and the team included a GP and a practice manager.

Background to Dr S Singh's Practice

Dr S Singh's Practice is based in Huyton a town in the Metropolitan Borough of Knowsley, in Merseyside. The practice treats patients of all ages and provides a range of medical services. The staff team includes two GP partners, one salaried GP, a practice nurse, a practice manager, office manager and five reception/administrative staff.

The practice is open Monday to Friday with consulting hours in the morning from 8.30 -11.30. Afternoon consulting times start at 15:00/16:00 until 19:30 on Mondays, 18:30 on Tuesday, Wednesday and Thursday and until 19:00 on Fridays. The practice offers bookable appointments up to five weeks in advance and on the day appointments for urgent medical conditions. Patients can book appointments in person, by telephone or on-line. Telephone consultations are available and home visits are offered to patients whose condition means they cannot visit the practice. When the practice is closed patients access the GP out-of-hours provider operated by UC24.

The practice is part of NHS Knowsley Clinical Commissioning Group. It is responsible for providing primary care services to approximately 3,668 patients. The practice is situated in an area with average levels of economic deprivation when compared to other areas nationally. The practice has a large proportion of older patients with around thirty percent of the practice

population aged 65 years and over. Twenty three percent of patients have caring responsibilities and 51% have a long standing health condition. The practice has a Personal Medical Services (PMS) contract.

The CQC intelligent monitoring placed the practice in band 5. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

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.

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

Detailed findings

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people

- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health (including people with dementia)

Before our inspection we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We also reviewed policies, procedures and other information the practice provided before the inspection. This did not raise any areas of concern or risk across the five key question areas.

We carried out an announced inspection on 25th February 2015. We reviewed all areas of the practice, including the administration areas. We sought views from patients via comment cards and talking to patients. During our visit we spoke with one GP, the practice nurse, the practice manager and five administrative/reception staff and with members of the patient participation group.

Are services safe?

Our findings

Safe Track Record

NHS Knowsley Clinical Commissioning Group and NHS England reported no concerns to us about the safety of the service. Clinical staff told us they completed incident reports and carried out significant event analysis in order to reflect on their practice and identify any training or policy changes required. We looked at a sample of significant event reports and saw that a plan of action had been formulated following analysis of the incidents.

Alerts and safety notifications from national safety bodies were dealt with by the clinical staff and the practice manager. Staff confirmed that they were informed about and involved in any required changes to practice or any actions that needed to be implemented. For example we could see the alert regarding the Ebola outbreak in Africa had been actioned and notices were on display in the waiting room.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring safety incidents. A protocol around learning and improving from safety incidents was available for staff to refer to. We looked at a sample of records of significant events that had occurred in the last 12 months. There was evidence that appropriate learning had taken place and that findings were disseminated to relevant staff at team meetings. We noted that the actions to be taken were not very detailed in the team meeting minutes which would assist staff if this information were needed for future reference.

Staff we spoke with told us they felt able to report significant events and that these incidents were analysed, learning points identified and changes to practice were made as a result. Staff were able to describe the incident reporting process and told us they were encouraged to report incidents. They told us they felt confident in reporting and raising concerns and felt they would be dealt with appropriately and professionally. Staff were able to describe how changes had been made to the practice as a result of reviewing significant events.

We found that a protocol around reporting and learning from safety incidents was available for staff to refer to and there was a central log/summary of significant events that

would allow patterns and trends to be identified. We noted that a review of actions taken was not recorded to demonstrate that any actions taken had been appropriately implemented.

Reliable safety systems and processes including safeguarding

Staff had access to safeguarding policies and procedures for both children and vulnerable adults. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were available to staff on their computers and in hard copy. Staff had access to guidance flow charts and contact details for both child protection and adult safeguarding teams. Information leaflets were available for patients about promoting the safety of children and vulnerable adults, these leaflets included contact telephone numbers such as the NSPCC.

Staff had received training in safeguarding children, we noted that, some staff had received this in 2011 and were due for refresher training. Training around safeguarding vulnerable adults had recently been provided by Knowsley Social Services as part of their training around meeting the needs of patients with a learning disability. Staff we spoke with demonstrated a good knowledge and understanding of safeguarding and its application. All staff we spoke with were aware of who to speak to in the practice if they had a safeguarding concern.

One of the GPs took the lead for safeguarding and in their absence another GP covered this role. Both GPs had attended training in safeguarding vulnerable adults and children appropriate for this role.

Regular liaison took place with the health visitor to discuss any children who were at risk of abuse and to review if an appropriate level of GP service had been provided. Codes and alerts were applied to the electronic case management system to ensure identified risks to children, young people and vulnerable adults were clearly flagged and reviewed.

Medicines Management

There were systems in place for medicine management. The GPs re-authorised medication for patients on an annual basis or more frequently if necessary in accordance with patient need. A system was in place to highlight

Are services safe?

patients requiring medication reviews through electronic alerts on the practice computers. We noted that an audit to ensure that medication reviews had been carried out when needed had not been undertaken.

A system was in place to ensure that any changes made to medication by the out of hours service or following hospital discharge were actioned without a delay. GPs worked with pharmacy support from the Clinical Commissioning Group (CCG) to review prescribing trends and medication audits.

We looked at how the practice stored and monitored emergency drugs and vaccines. Vaccines were securely stored and were in date and organised with stock rotation evident. We saw the fridges were checked daily to ensure the temperature was within the required range for the safe storage of the vaccines. A cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was in place for the safe management of vaccines.

Emergency drugs were listed and checked to ensure they were in date and ready to use. The emergency drugs were stored in a locked cupboard in an area which gave easy but secure access to staff. Prescription pads and repeat prescriptions were stored securely.

Cleanliness & Infection Control

There was a current infection control policy with supporting processes and guidance. There was a lead member of staff for infection control who had completed training relevant to this role and who attended regular infection control meetings with the Clinical Commissioning Group. Non-clinical staff had not received up to date training in infection control, further training in this area had been arranged. The non-clinical staff we spoke with demonstrated general knowledge around infection control to support them in their role.

The patients we spoke with commented that the practice was clean and appeared hygienic. We looked around the premises and found all areas seen to be clean and tidy. The consultation and treatment rooms seen had adequate hand washing facilities. Instructions about hand hygiene were available throughout the practice. We found protective equipment such as gloves and aprons were available in the treatment/consulting rooms. Couches were

washable. Privacy curtains in the treatment rooms were disposable and were routinely replaced every six months or as required. We noted that a record of this had not been made.

The practice carried out infection control audits. The last one was undertaken in December 2014 and indicated that overall the practice was meeting effective infection control standards. An action plan had been put in place to address the shortfalls identified. A cleaning schedule was in place and a log of cleaning works undertaken was maintained.

We were told the practice did not use any instruments which required decontamination between patients and that all instruments were for single use. Checks were carried out to ensure items such as instruments, gloves and hand gel were available and in date. Procedures for the safe storage and disposal of needles and waste products were evident in order to protect the staff and patients from harm.

The practice did not undertake regular testing and investigation of legionella (a bacterium found in the environment which can contaminate water systems in buildings). A risk assessment determining the risks presented had not been undertaken.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly. We were shown a certificate to demonstrate that equipment such as the weighing scales, ear syringes, thermometers and blood pressure machines had been tested and calibrated. All portable electrical equipment was routinely tested.

Staffing & Recruitment

We looked at the recruitment records of the practice nurse and an administrative member of staff who were the last two staff to be employed. We found that not all of the necessary recruitment checks had been undertaken. References were available, identity checks had been undertaken and interviews had been carried out. Administrative staff acted as chaperones for patients, however a Disclosure and Barring Service check (these checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post) had not been undertaken. A risk assessment as to whether they needed a DBS check had

Are services safe?

not been carried out. A DBS check was seen for the practice nurse, however it had been undertaken by their previous employer and not updated. Evidence of physical and mental suitability for the post was also not available on the recruitment records seen and the recruitment procedure did not demonstrate that this check was needed.

The professional registration of clinical staff was checked prior to appointment and there was a system in place to record checks of on going professional registration with the General Medical Council (GMC) and Nursing Midwifery Council (NMC).

Staffing levels were reviewed to ensure patients were kept safe and their needs were met. In the event of unplanned absences of non-clinical staff, staff covered from within the service. Reception and administrative staff were multi-skilled which meant they could cover each others duties if necessary. The practice manager told us that the same locum GP covered GP unplanned absences and holidays to promote continuity of care. Duty rotas took into account planned absence such as holidays. Staff we spoke with felt staffing levels and the skill mix of staff were appropriate and met the needs of the service and patients. Patient demand was monitored through the appointment system and staff and patient feedback to ensure that sufficient staffing levels were in place.

Monitoring Safety & Responding to Risk

The practice had other processes in place to manage and monitor risks to patients, staff and visitors to the practice. These included infection control and medicines management. Health and safety information was displayed for staff to see around the premises. The practice manager was the lead for health and safety. Health and safety issues were discussed at staff meetings.

A contractors check of the fire alarm and fire extinguishers had taken place. The practice manager tested the fire alarm to ensure this was working however, this was not recorded. No emergency lighting was provided in the building and a risk assessment to demonstrate why this was not needed had not been recorded. Following our visit the practice manager told us that they had arranged for this to be installed. An electrical wiring certificate demonstrating that the electrical wiring was safe was not available. A failure to the electricity supply had resulted in a loss of power to the vaccine fridge in January 2015.

Arrangements to deal with emergencies and major incidents

Emergency medicines were available and staff knew of their location. Processes were in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. The practice had access to an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Records showed that checks were made of the defibrillator to ensure it was working and ready to use.

Staff told us they had up to date training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). We looked at a sample of training records which confirmed this. We noted that drills to test out the accessibility of emergency equipment and staff response times were not undertaken.

A disaster recovery and business continuity plan was in place. The plan included the actions to be taken following loss of building, loss of telephone system, loss of computer and electrical equipment and loss of utilities.

Panic buttons were available for staff in the treatment rooms and in the reception area for staff to call for assistance.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff we spoke with told us how they accessed best practice guidelines to inform their practice. GPs and the practice nurse attended regular training and educational events provided by the Clinical Commissioning Group and they had access to National Institute for Health and Care Excellence (NICE) guidelines on their computers. The GP we spoke with told us that clinical staff met to discuss new clinical protocols, review complex patient needs and keep up to date with best practice guidelines and relevant legislation. The practice nurse said that they received good clinical support from the GPs.

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

The practice nurse managed specialist clinical areas such as diabetes, heart disease and asthma. This meant they were able to focus on specific conditions and provide patients with regular support based on up to date information. The practice nurse met with nurses from other practices which assisted them in keeping up to date with best practice guidelines and current legislation.

Management, monitoring and improving outcomes for people

The practice had systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. The practice kept up to date disease registers for patients with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD), which were used to arrange annual health reviews.

There were systems in place to evaluate the operation of the service and the care and treatment given. The practice used the information it collected for the Quality Outcomes Framework (QOF) to monitor the quality of services provided. The report from 2013-2014 showed the practice was meeting national targets and performing well in relation to registers maintained for adult patients with a learning disability and patients in need of palliative care. The QOF indicated worse than average scores for the percentage of patients with diabetes with a record of a foot

examination within the preceding 12 months and percentage of patients with hypertension in whom the last blood pressure reading in the preceding 9 months was 150/90mmHg or less. We were informed that the practice had an action plan to address this. For example, the nurse had been booked on training to enable them to carry out diabetic foot examinations and in the interim patients were being referred to the walk in centre.

All GPs and nursing staff were involved in clinical audits. Examples of audits included prescribing of medications such as antibiotics and stroke prevention in atrial fibrillation therapy. Some audits had resulted in changes to prescribed medication for patients and reviews of patients care needs. We noted that an audit of the minor surgical procedures performed had not been undertaken.

The GPs and practice nurse had key roles in monitoring and improving outcomes for patients. These roles included managing long term conditions, safeguarding and palliative care. The practice had achieved and implemented the gold standards framework for end of life care. One of the GPs took the lead for this group of patients. They kept a record of patients needing palliative care. Gold Standards Framework meetings were held two/three monthly with frequent liaison occurring outside these meetings with district and palliative care nurses to review the needs of patients on the palliative care register. The out of hours service were updated to ensure good communication of changes in care and treatment.

Effective staffing

An induction protocol and check list were in place which identified the essential knowledge and skills needed for new employees. We spoke to a new member of staff who confirmed that they had received an induction. Records of induction were in place on a sample of staff records looked at.

An appraisal policy was in place. The reception and administrative staff spoken with confirmed they had received a recent appraisal which included a plan to address any training or learning needs identified. We spoke to four reception/administrative staff who told us the practice was supportive of their learning and development needs. We spoke with the practice nurse who told us they had good access to training and development opportunities to keep their knowledge and skills up to date. We spoke with one GP who told us they had annual

Are services effective?

(for example, treatment is effective)

appraisals and that they undertook training/learning to inform their practice. They told us they met with their external appraisers to reflect on their practice, review training needs and identify areas for development.

Clinical and reception/administrative staff told us they felt well supported to carry out their work. Practice meetings took place monthly and provided staff with the opportunity to discuss any issues with the operation of the practice. The GPs and practice nurse met to discuss clinical issues and changes to practice. The practice nurse and GP spoken with told us that the clinical staff worked well as a team. Reception/administrative staff met every three months to discuss their roles and the operation of the service.

We saw a basic training record for reception/administrative staff and the practice nurse which identified mandatory and role specific training and completion dates. This record demonstrated that staff were mostly up to date with mandatory training such as CPR. The practice manager had identified that training updates were needed in respect of chaperone skills, safeguarding and infection control. We noted that staff had not received fire safety training. The practice manager had identified this and she had taken steps to address it. We noted that the training record did not document all of the training undertaken by staff.

Staff also had access to additional training specific to their role. For example, most of the administrative/reception staff had completed an NVQ in customer care and they had undertaken training in the computer systems. Staff we spoke with told us they felt they had received sufficient training to carry out their role.

Clinical staff told us they had access to training opportunities to keep their clinical practice up to date. The GP spoken with told us they ensured they had protected learning time and met with their external appraisers to reflect on their practice, review training needs and identify areas for development. The practice nurse had been employed for four months and said that they were being supported to keep their skills and knowledge up to date. GPs kept a record of their clinical training. The practice manager told us that they were developing a system to enable them to maintain more detailed information about clinical training that would help them to plan for future training needs.

Working with colleagues and other services

The practice worked with other agencies and professionals to support continuity of care for patients. The practice provided the out of hour's service with information, to support, for example, end of life care. Information received from other agencies, for example the accident and emergency department or hospital outpatient departments was reviewed and actioned by the GPs in a timely manner. The GP spoken with described how blood result information would be sent through to them and the system in place to respond to any concerns identified. There was a system in place to identify patients at risk of unplanned hospital admissions and follow up their healthcare needs.

Multi-professional working took place to support patients and promote their welfare. Clinical staff met with and liaised with health visitors, district nurses, macmillan nurses and social workers to discuss any concerns about patient welfare and identify where further support may be required. GPs were invited to attend reviews of patients with mental health needs and child and vulnerable adult safeguarding conferences, when they were unable to attend these meetings they provided a report detailing their involvement with the patient. Gold Standards Framework meetings were held two/three monthly with frequent liaison occurring outside of these meetings with district and palliative care nurses to review the needs of patients on the palliative care register.

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the computer system for future reference. All members of staff were trained on the system, and could demonstrate how information was shared.

The practice had systems in place to communicate with other providers. For example, there was a system for communicating with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals.

Consent to care and treatment

We spoke with clinical staff about their understanding of the Mental Capacity Act 2005. They provided us with

Are services effective?

(for example, treatment is effective)

examples of their understanding around consent and mental capacity issues. They were aware of the circumstances in which best interest decisions may need to be made in line with the Mental Capacity Act when someone may lack capacity to make their own decisions. Clinical staff demonstrated an understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). The practice had consent to treatment policies which set out how patients were involved in their treatment choices so that they could give informed consent and the process to follow when a patient was not able to consent due to a lack of capacity. Patients completed consent forms for minor surgical procedures. Verbal consent for immunisations and vaccinations was recorded in patient notes.

Health Promotion & Prevention

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

Quality and Outcomes Framework (QOF) information showed the practice was generally meeting its targets regarding health promotion and ill health prevention initiatives. For example, in providing cervical screening,

providing flu vaccinations to high risk patients and health checks for patients with severe mental health conditions. The QOF indicated worse than average scores for the percentage of patients with diabetes with a record of a foot examination within the preceding 12 months and percentage of patients with hypertension in whom the last blood pressure reading in the preceding 9 months was 150/90mmHg or less. We were informed that the practice had an action plan in place to address this. For example, the nurse had been booked on training to enable them to carry out diabetic foot examinations and in the interim patients were being referred to the walk in centre.

New patients registering with the practice completed a health questionnaire and were given a new patient medical appointment. This provided the practice with important information about their medical history, current health concerns and lifestyle choices. This ensured the patients' individual needs were assessed and access to support and treatment was available as soon as possible.

The practice identified patients who needed on-going support with their health. The practice kept up to date disease registers for patients with long term conditions such as diabetes, asthma and chronic heart disease which were used to arrange annual health reviews. The practice also kept registers of vulnerable patients such as those with mental health needs and learning disabilities and used these to plan annual health checks.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We spoke with six patients who were very positive about the care they received from the practice. They commented that they were treated with respect and dignity and that staff were caring, supportive and helpful. They said they had enough time to discuss things fully with the GP, treatments were explained and that they felt listened to.

The National GP Patient Survey in March 2014 found that 93% of patients at the practice stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern. Ninety one percent of patients stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern. Ninety two percent of patients who responded to this survey described the overall experience of their GP surgery as fairly good or very good. These responses were average when compared to other GP practices nationally.

We looked at the results of the last patient survey undertaken by the practice in March 2014. One hundred and sixty five surveys were completed and the results showed patients were satisfied with the service provided in terms of obtaining test results, repeat prescriptions, access and assistance given by reception staff. Ninety two percent of patients rated the respect shown by staff for their privacy and confidentiality as good, very good or excellent.

We observed that in general privacy and confidentiality were maintained for patients using the service on the day of the visit. Reception staff we spoke with were aware of the importance of providing patients with privacy. They told us there was an area available if patients wished to discuss something with them away from the reception area. We observed that a notice advising patients of this was not on display. The waiting area was small and seating was close to the reception desk. The reception staff told us that they had received training around not asking for too much information from patients when booking an appointment so as to maintain their confidentiality. The proportion of respondents to the National GP Patient Survey who stated that in the reception area other patients couldn't hear them was in line with the national average.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity were maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice well in these areas. For example, data from the National GP Patient Survey in March 2014 indicated 94% of patients said the GPs were good or very good at involving them in decisions about their care and 87% felt the nurses were good or very good at involving them in decisions about their care.

Patients we spoke with told us that health issues were discussed with them, treatments were explained, they felt listened to and they felt involved in decision making about the care and treatment they received.

Patient/carer support to cope emotionally with care and treatment

Information was on display in the waiting area about the support available to patients to help them to cope emotionally with care and treatment. Information available included, information about the Citizen's Advice Bureau, mental health services, domestic violence and community support groups for people who were isolated or carers. We noted that further information about support services could be made available on the practice website.

Staff we spoke with told us that patients were offered support following bereavement. GPs and the practice nurse were able to refer patients on to counselling services. The practice signposted carers who would like support on to community support services.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice engaged with NHS Knowsley Clinical Commissioning Group (CCG) to address local needs and service improvements that needed to be prioritised.

The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions. The practice was proactive in contacting patients who failed to attend vaccination and screening programmes.

Referrals for investigations or treatment were mostly done through the "Choose and Book" system which gave patients the opportunity to decide where they would like to go for further treatment. Administrative staff monitored referrals to ensure all referral letters were completed in a timely manner.

The practice worked to the National Gold Standard Framework in end of life care (The National Gold Standards Framework (GSF) Centre in End of Life Care provides training to enable generalist frontline staff to provide a gold standard of care for people nearing the end of life). The practice kept a record of patients receiving palliative care. Meetings took place to discuss patient's and their families' care and support needs with the community matron and macmillan nurses on a two to three monthly basis. The lead GP for palliative care and the practice manager told us the practice was supporting a few patients with palliative care needs and regular liaison took place outside of these meetings with district nurses, the community matron and out of hours service to ensure changes in care and treatment were communicated.

The practice offered patients a chaperone prior to any examination or procedure. Staff we spoke with said they had received training to carry out this role and training records confirmed this.

The practice had a Patient Reference Group (PRG). The purpose of the PRG was to meet with practice staff to review the services provided, develop a practice action plan, and help determine the commissioning of future services in the neighbourhood. Records showed the

changes made to the practice as a result of feedback from surveys and meeting with the PRG, for example, improving access to the service and making improvements to the waiting area.

Tackling inequity and promoting equality

One of the waiting rooms and the GP consulting rooms were on the ground floor. The consulting room for the nurse and a further waiting room were on the first floor with no disabled access. The staff told us that the nurse would see any patients who were not able to use the stairs in one of the ground floor consulting rooms. There was no disabled parking for the practice which was situated on a main road. A toilet was available on the ground floor but an assessment of whether this would meet the needs of wheelchair users had not been undertaken. An audio induction loop was available to support patients with reduced ranges of hearing. An assessment of whether the building met the needs of people with a physical disability had not been carried out.

Staff were knowledgeable about interpreter services for patients where English was not their first language. Information about interpreting services was on display for patients to refer to.

The reception staff told us that if patients required additional assistance they would ensure that the length of the appointment time was appropriate. For example, if a patient had a learning disability then a double appointment was offered to the patient to ensure there was sufficient time for the consultation.

Some staff spoken with indicated they had received training around equality, diversity and human rights. The practice manager told us that there was a plan in place to ensure that all staff had received this training.

Access to the service

The practice was open Monday to Friday with consulting hours in the morning from 8:30 -11:30. Afternoon consulting times started at 15:00/16:00 until 19:30 on Mondays, 18.30 on Tuesday, Wednesday and Thursday and until 19.00 on Fridays. The practice offered bookable appointments up to five weeks in advance and on the day appointments for urgent medical conditions. Patients could book appointments in person, by telephone or on-line. Telephone consultations were available and home visits

Are services responsive to people's needs?

(for example, to feedback?)

were offered to patients whose condition meant they could not visit the practice. When the practice was closed patients accessed the GP out-of-hours provider operated by UC24.

The appointment system was monitored to ensure that any issues around access to appointments were identified. Access to appointments was monitored through the systems for patient feedback and from feedback from staff. For example, the results of the last patient survey in March 2014 indicated that patients wanted improvements to be made to the telephone system due to problems experienced when contacting the practice. As a result the practice had installed an additional telephone line.

The National GP Patient Survey in March 2014 found that patients were overall happy with access to the service. Eighty two percent were very satisfied or fairly satisfied with opening hours. Ninety percent gave a positive answer to "Generally, how easy is it to get through to someone at your surgery on the phone." These responses were average when compared to other GP practices nationally.

We looked at the results of the last patient survey undertaken by the practice in March 2014. One hundred and sixty five surveys were completed and the results showed patients were generally satisfied with access to the service. Eighty five percent were happy with the speed at which the telephone was answered by reception staff, 86% were satisfied with the convenience of their appointment and 80% saw the GP of their choice.

We spoke to six patients who were generally happy with the system for booking appointments and said that they could get an appointment when one was needed. One patient said it could sometimes be difficult to get an appointment with a GP of their choice.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. We saw that the complaint policy was displayed in the patient waiting area for patients to refer to. Reference was made to how to make a complaint and the complaint policy on the practice's website and in the patient information leaflet. The policy included contact details for the Health Service Ombudsman and the Patient Advice and Liaison Service (PALS), should patients wish to take their concerns outside of the practice. We noted that the contact details for NHS England were not included.

We looked at the record of complaints and found documentation to record the details of the concerns raised and the action taken. Staff we spoke with were knowledgeable about the policy and the procedures for patients to make a complaint. We noted that a record was not made of verbal complaints. A record should be made of all complaints to enable any patterns to be identified and to demonstrate actions taken in response to issues raised by patients.

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 aims and objectives of the practice included providing a high standard of medical care, involving patients who use the service and being committed to their needs, showing patients courtesy and respect at all times and monitoring the service to identify ways it could be improved.

The aims and objectives of the practice were not publicised on the practice website or in the waiting areas. The staff we spoke with knew and understood the aims and objectives of the practice and knew what their responsibilities were in relation to these.

Governance Arrangements

Regular practice meetings took place which involved all staff. These meetings looked at the day to day operation of the practice, what was working well and where any improvements were needed. The GPs and nurse met to discuss clinical matters and the reception/administrative team met with the practice manager to discuss the operation of the service from their perspective. The practice manager met with one of the GP partners to discuss the operation of the service.

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically or in a paper format. The policies and procedures seen had been regularly reviewed. We spoke to staff who were aware of how to access policies and procedures.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The GP spoken with told us that QOF data was regularly discussed and action plans were produced to maintain or improve outcomes.

The practice had completed clinical audits to evaluate the operation of the service and the care and treatment given. For example, we looked at audits of prescribing medications such as antibiotics and stroke prevention in atrial fibrillation therapy. Some audits had resulted in changes to prescribed medication for patients and reviews of patients care needs. We noted that an audit of the minor surgical procedures performed had not been undertaken that would demonstrate how patient outcomes were monitored and evaluated.

Leadership, openness and transparency

There was a leadership structure in place and clear lines of accountability. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us that they felt valued and well supported.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at practice meetings or as they occurred with the practice manager or one of the GP partners. Staff told us they felt the practice was well managed with clear leadership from clinical staff and the practice manager. Staff told us they could raise concerns and felt they were listened to.

Clinical and reception/administrative staff told us they felt well supported to carry out their work. Practice meetings took place monthly and provided staff with the opportunity to discuss any issues with the operation of the practice. The GPs and practice nurse met to discuss clinical issues and changes to practice. The practice nurse and GP spoken with told us that the clinical staff worked well as a team. Reception/administrative staff met every three months to discuss their roles and the operation of the service.

We reviewed a number of human resource policies and procedures that were available for staff to refer to, for example, the induction, sickness and absence and disciplinary procedures. These procedures were in a staff handbook which was updated on an annual basis.

Practice seeks and acts on feedback from users, public and staff

Patient feedback was obtained through carrying out surveys, reviewing the results of national surveys, comments and suggestions forms located in the patient waiting area and through the complaint procedure. We looked at the results of the last patient survey undertaken by the practice in March 2014. One hundred and sixty five surveys were completed and the results showed patients were satisfied with the service provided in terms of obtaining test results, repeat prescriptions, access and assistance given by reception staff. We noted that few survey questions asked patients about their experience of the clinical care provided.

The practice had a Patient Reference Group (PRG). The purpose of the PRG is to meet with practice staff to review the services provided, develop a practice action plan, and

Are services well-led?

Good 

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

help determine the commissioning of future services in the neighbourhood. Surveys sent by the practice were discussed at PRG meetings and an action plan devised. Records showed the changes made to the practice as a result of feedback from surveys and meeting with the PRG, for example, the results of the last patient survey in March 2014 indicated that patients wanted improvements to be made to the telephone system due to problems experienced when contacting the practice. As a result the practice had installed an additional telephone line.

We met with representatives of the PRG who told us they felt listened to and improvements had been made to the practice as a result of their suggestions. For example, changes had been made to the opening times of the practice and improvements had been made to the waiting areas.

A leaflet was on reception and handed out to patients encouraging them to access and participate in the NHS friends and family test. The NHS friends and family test (FFT) is an opportunity for patients to provide feedback on the services that provide their care and treatment. It was available in GP practices from 1 December 2014. Results for January 2015 showed that 47 out of 50 patients were “extremely likely” or “likely” to recommend the practice. Results for February 2015 showed that 59 out of 62 patients were “extremely likely” or “likely” to recommend the practice.

Staff told us they felt able to give their views at practice meetings or to the practice manager or one of the partners. Staff told us they could raise concerns and felt they were listened to. A whistle blowing policy and procedure was available for staff to refer to in the staff handbook.

Management lead through learning & improvement

Staff told us and records showed that staff were up to date with annual appraisals which included looking at their performance and development needs. The practice had a basic induction programme which was evident in the records of newer staff. Training records showed that staff had access to role specific training and mandatory training but that updates were needed in being a chaperone, safeguarding and infection control. We noted that staff had not received training around fire safety. The practice manager had identified this and she had taken steps to address this.

Staff told us the practice was supportive of their learning and development needs and that they felt well supported in their roles. They said they worked well as a team and had good access to support from each other. Regular meetings took place to share information, look at what was working well and where any improvements needed to be made.

Procedures were in place to record incidents, accidents and significant events and to identify risks to patient and staff safety. The results were discussed at practice meetings and if necessary changes were made to the practice’s procedures and staff training.

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 Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed People who use services and others were not protected against the risks associated with unsuitable staff because the provider did not have an effective procedure in place to assess the suitability of staff for their role. Not all the required information relating to workers was obtained and held by the practice.
Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Patients were not protected against the risks associated with unsafe equipment because the provider did not ensure that the electrical wiring was properly maintained and suitable for its purpose.