# Drs Hegde & Jude's Practice

## Quality Report

The Riverside Centre For Health
Park Street, Liverpool, Merseyside, L8 6QP
Tel: Tel: 01512 959213
Website: www.drshegdeandjudespractice.nhs.net

Date of inspection visit: 1st October 2014
Date of publication: 22/01/2015

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

## Ratings

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

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

This is the report of findings from our inspection of Drs Hegde and Jude's Practice. Drs Hegde and Jude's Practice is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on 1 October 2014 at the practice location in the Riverside Centre for Health and we also visited the branch location at the Picton Neighbourhood Health and Children's Centre. We spoke with patients, staff and the practice management team.

The practice was rated as Good. An effective, responsive and well- led service was provided that met the needs of the population it served.

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 cross infection.
- Patients care needs were assessed and care and treatment was being 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 happy with the care given by all staff. They felt listened to, treated with dignity and respect and had confidence in the GPs and nurses.
- The practice planned its services to meet the differing needs of patients. The appointment system in place allowed good access to the service.
- The practice had a clear vision and set of values which were understood by staff and publicised for patients. There was a clear leadership structure in place. Quality and performance were monitored, risks were identified and managed.

The provider should:

- Consider carrying out regular infection control audits.
- Consider having the same range of medication available to be used in an emergency at both surgeries.
- Consider responding to the actions arising from all significant events in a timely manner.

# Summary of findings

- Consider carrying out drills to test out the accessibility of emergency equipment and staff response times.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The practice is rated as good for 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 clear processes in place to investigate and act upon any incident and to share learning with staff to mitigate future risk. There were appropriate systems in place to protect patients from the risks associated with medicines and cross infection. The staffing numbers and skill mix were set and reviewed to ensure that patients were safe and their care and treatment needs were met.

**Are services effective?**

Good

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 monitored its performance and had systems in place to improve outcomes for patients.

**Are services caring?**

Good

The practice is rated as good for caring. We looked at 19 Care Quality Commission (CQC) comment cards that patients had completed prior to the inspection and spoke with nine patients on the day of the inspection. Patients were overall positive about the care they received from the practice. They commented that they were treated with respect and dignity. Staff we spoke with were aware of the importance of providing patients with privacy. Reception staff told us there was a room available if patients wished to discuss something with them away from the reception area. Patients were provided with support to enable them to cope emotionally with care and treatment.

**Are services responsive to people's needs?**

Good

The practice is rated as good for responsive. The practice planned its services to meet the differing needs of patients. The practice was accessible for people with a physical disability. Staff were knowledgeable about interpreter services for patients where English

# Summary of findings

was their second language. The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. We saw documentation to record the details of concerns raised and action taken.

**Are services well-led?**

Good

The practice is rated as good for well led. The practice had a clear vision and set of values which were understood by staff, publicised at the practice and evident on the practice website. There was a clear leadership structure in place. Quality and performance were monitored, risks were identified and managed. Staff told us they felt the practice was well managed with clear leadership from clinical staff and the business 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 participation group (PPG) was in the early stages of development.

# Summary of findings

## The six population groups and what we found

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

**Older people**

Good

The practice is rated as good for the care of older people. 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 information was held to alert staff if a patient was housebound. They used this information to provide services in the most appropriate way and in a timely manner. The practice ensured each person who was over the age of 75 had a named GP. Medication reviews were completed with all patients over the age of 75. We found the practice worked well with other agencies and health providers to provide support and access specialist help when needed.

**People with long term conditions**

Good

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) and hypertension. This information was reflected in the services provided, for example, reviews of conditions and treatment, screening programmes and vaccination programmes. We found staff had a programme in place to make sure no patient missed their regular reviews for long term conditions. Staff were skilled and regularly updated in specialist areas which helped them ensure best practice guidance was always being considered.

**Families, children and young people**

Good

The practice is rated as good for the population group of families, children and young people. There were screening and vaccination programmes which were managed effectively to support patients and the needs of families. For example, appointments for new patients were offered alongside vaccination appointments. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns. All of the staff were very responsive to parents' concerns and ensured parents could readily bring children who appeared unwell into the practice to be seen. 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. Regular meetings were held within the practice to ensure the staff team were aware of any children who were at risk of abuse and to review if all necessary GP services had been provided.

# Summary of findings

**Working age people (including those recently retired and students)**

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). We found the practice had a range of appointments available including pre-bookable, on the day and telephone consultations. Staff told us they would try to accommodate patients who were working to have early or late appointments wherever possible. Patients were also able to book a consultation with a GP through the extended hours service. This was available from 6.30pm to 8.00pm during the week and on Saturday mornings. Patients unable to attend during the normal opening hours were able to book in advance to be seen at the 'extended hours' service run at both sites until 8pm on Mondays. During periods of high patient demand, such as for flu vaccinations the practice opened on a Saturday morning.

**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. Staff told us they would ensure homeless people received urgent and necessary care. They were also aware of the GP practice in the Clinical Commissioning Group (CCG) that took the lead for managing homeless patients' long term care and referred patients on appropriately. Asylum seekers were registered with the practice and there was information for staff to refer to around initial screening examinations that were undertaken by another service provider. 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). Staff we spoke with were knowledgeable about the annual reviews available for patients experiencing poor mental health. GPs worked with other services to review care, implement new care pathways and share care with specialist teams. The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. The

# Summary of findings

| | |
|---|---|
| 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

We looked at 19 Care Quality Commission (CQC) comment cards that patients had completed prior to the inspection and spoke with nine patients on the day of the inspection. Overall 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 said that they felt listened to. Patients we spoke with on the day of our inspection told us that health issues were discussed with them and treatments were explained. Seven out of the nine patients we spoke with felt involved in decision making about the care and treatment they received. Patient feedback on the comment cards we received indicated they felt listened to and supported.

We looked at surveys completed by patients around the service provided by four individual GPs in 2013 and 2014. This demonstrated that patients overall satisfaction with the GPs, opportunity to express concerns or fears, GPs explanations of treatments and confidence in the GPs abilities was overall rated as good, very good or excellent.

The National GP Patient Survey published in 2013 found that 86.5% of patients would recommend their GP surgery and 93.1% of patients would rate their practice as good or very good. 86.3% of patients were happy with opening hours and 91.2% rated their experience of making an appointment good or very good. These survey results were among the best nationally.

The National GP Patient Survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, 84% of patients said the GP involved them in care decisions and 95% felt the nurse involved them in decisions about their care.

The practice was part of a group of 13 practices in Liverpool which worked together with NHS Liverpool Clinical Commissioning Group to measure their service against each other and nationally and identify areas for improvement. Performance information collated in July 2014 around patient experience indicated that 91% of patients found the receptionists helpful, 90% had confidence and trust in the nurses and 89% had confidence and trust in the GPs.

## Areas for improvement

**Action the service SHOULD take to improve**

The provider should:

- Consider carrying out regular infection control audits.
- Consider having the same range of medication available to be used in an emergency at both surgeries.
- Consider responding to the actions arising from all significant events in a timely manner.
- Consider carrying out drills to test out the accessibility of emergency equipment and staff response times.

# Drs Hegde & Jude'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 second inspector, a GP, a practice manager and an expert by experience who is someone that has used health and social care services.

## Background to Drs Hegde & Jude's Practice

Drs Hegde and Jude's Practice is one of three practices based in the Riverside Centre for Health in the Dingle area of Liverpool. There is also a branch service based in the Picton area of Liverpool at Picton Neighbourhood Health and Children's Centre. The practice registered with CQC to provide primary care services, which include access to GPs, minor surgery, family planning, ante and post natal care. The practice treats patients of all ages and provides a range of medical services. The staff team includes two GP partners, five salaried GPs, two regular locum GPs, three practice nurses, a healthcare assistant and administrative and reception staff. Both sites have core staff with some staff working across both sites.

Both sites are open Monday to Friday from 8.00am/8.30am until 6.30pm. Both sites offer extended hours consultations until 8pm on Mondays. Patients can book appointments in person and by telephone. Patients can book on the day or in advance, home visits are offered to housebound and terminally ill patients and telephone consultations are available. When the practice is closed patients access the GP out-of-hours provider UC24.

The practice is part of NHS Liverpool Clinical Commissioning Group. It is responsible for providing primary care services to approximately 9,400 patients. The practice is situated in an economically deprived area of the city. 24.2% of the practice population are under 18 years of age. 58.9% of the practice population have a long standing health condition. The practice has a GMS contract.

The Riverside and Picton sites share a building with other GP practices and with a number of community services such as chiropody, physiotherapy, health trainer service and counselling services. There is also a private pharmacy located within the buildings.

## 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.

This provider had not been inspected before and that was why we included them

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 01 October 2014 and spent eight hours at the practice.

We reviewed all areas of the practice, including the administration areas. We sought views from patients both face-to-face and via comment cards. During our visit we spoke with a range of staff including: four GPs, two practice nurses, a healthcare assistant, business manager and a number of reception and administration staff. We spoke with patients who were using the service on the day of the inspection and with a member of the patient participation group.

Good

# Are services safe?

## Our findings

### Safe Track Record

NHS Liverpool Clinical Commissioning Group reported no concerns to us about the safety of the service. GPs told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development in order to reflect on their practice and identify any training or policy changes required. These were shared within the practice. We looked at a sample of significant event reports and saw that a plan of action had been formulated following analysis of the incidents.

The practice minutes of meetings we reviewed showed that new guidelines, complaints, incidents, safeguarding children registered at the practice and significant events, were discussed at each meeting. Staff were able to describe the incident reporting process and were encouraged to report in an open, no blame culture. 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 operation of the practice as a result of reviewing significant events and complaints. For example, changes were made to the appointment system, how referrals were made to district nursing services and to medication contained within the emergency medication trolley.

Alerts and safety notifications from national safety bodies were dealt with by the clinical staff and the business manager. Staff confirmed that they were informed and involved in any required changes to practice or any actions that needed to be implemented.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring safety incidents. We saw evidence that significant events, incidents and complaints were investigated and reflected on by the clinical staff and non-clinical staff as appropriate.

Staff we spoke with told us they felt able to report significant events and that these incidents were analysed and learned from and changes to practice were made as a result. For example, as a result of the analysis of one incident changes were made to urgent referrals to district nurses, which included staff following up telephone referrals with paper notifications and contacting the patient to ascertain if a district nurse visit had been made. We saw that where necessary the support of NHS Liverpool Clinical Commissioning Group was sought to minimise the risk of significant events being repeated. For example, the medicines management team were asked to identify all patients prescribed a certain type of medication following a prescribing error.

We found that a protocol around learning and improving from safety incidents was not available for staff to refer to. There was no central log/summary of significant events that would allow patterns and trends to be easily identified and enable a record to be made of actions undertaken and reviewed. Following our visit the business manager provided us with a summary of all significant events for the last 12 months that would enable a review to be undertaken. A significant event policy was also made available to us which provided clear guidance to staff.

### Reliable safety systems and processes including safeguarding

Staff had access to safeguarding procedures for both children and vulnerable adults. These provided staff with information about identifying, reporting and dealing with suspected abuse. We saw that staff had access to contact details for both child protection and adult local authority safeguarding teams.

Records and staff we spoke with confirmed they had received training in safeguarding at a level appropriate to their role. Staff we spoke with demonstrated good knowledge and understanding of safeguarding and its application. They were able to give us recent examples of raising concerns and the process undertaken.

One of the GPs took the lead for safeguarding. They attended regular meetings with the safeguarding lead from the commissioning organisation. This established link meant that advice and guidance could be easily sought as needed. Staff put alerts onto the patient's electronic record when safeguarding concerns were raised. Regular meetings were held within the practice to ensure the staff team were aware of any adults and children who were at risk of abuse and to review if all necessary GP services had been provided. Health Visitors were invited to attend these

meetings. Staff were proactive in monitoring if children or vulnerable adults attended Accident and Emergency or missed appointments frequently. These were then brought to the GPs attention.

We found that there were systems and processes in place to keep patients safe. This included systems and processes around infection prevention and control, medicines management, equipment and building maintenance and staff recruitment checks. A chaperone policy was on display in the waiting area that advised patients that service could be requested at reception.

### Medicines Management

There were clear systems in place for medicine management. The GPs re-authorised medication for patients on an annual basis or more frequently if necessary. A system was in place to highlight patients requiring medication reviews through electronic alerts on the practice computers. GPs worked with pharmacy support from the Clinical Commissioning Group (CCG) to review prescribing trends and medication audits.

We looked how the practice stored and monitored emergency drugs and vaccines, to ensure patients received medicines that were in date and ready to use. 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 use of the 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. The practice did not hold stocks of controlled drugs (these are medicines which require extra administration checks to ensure safety).

Prescription pads and repeat prescriptions were stored securely. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them.

### Cleanliness & Infection Control

There was a current infection control policy with supporting policies and guidance. We found that staff had completed training in infection control relevant to their role. Staff we spoke with were able to describe their own roles and responsibilities in relation to infection control. One of the nurses was the lead for infection control and had undertaken training to support her in this role.

The nine patients we spoke with commented that the practice was clean and appeared hygienic. We looked around the premises of both sites and found them to be clean. The treatment rooms, waiting areas and toilets were in good condition and supported infection control practices. The chairs in some of the GPs rooms were not covered in washable material. The business manager told us that when they required replacement they would be replaced with chairs that are easier to clean. Surfaces were easy to clean, staff had access to gloves and aprons and we observed appropriate segregated waste disposal systems for clinical and non-clinical waste. We observed good hand washing facilities to promote good standards of hygiene. Instructions about hand hygiene were available throughout the practices with hand gels in clinical rooms.

The premises were leased from NHS PropCo who carried out an infection control audit at the Riverside site in September 2014 and at the Picton site in September 2013. The results showed Picton was 100% compliant. We were not provided with the audit for Riverside. We found that regular infection control audits were not undertaken by the practice. Following our visit the business manager provided a completed infection control audit for both sites and reported that monthly infection control audits were to be undertaken.

We found that daily and weekly checks were carried out by staff to ensure the cleanliness of the premises and treatment rooms. The practice used an external cleaning company. The business manager reported that the company employed did not complete cleaning schedules at the Riverside site. The business manager reported that designated staff always checked the work carried out by the cleaning company and we saw that they had recently begun to complete the cleaning schedules.

We were told the practice did not use any instruments which required decontamination between patients and that all instruments were for single use only. 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.

Legionella testing was carried out to ensure patient safety.

### Equipment

The Riverside site had a defibrillator and a facility to store medication to be accessed in the event of an emergency. Records showed that checks were made of the defibrillator to ensure it was working and ready to use and that regular checks were made of the emergency medication. We found that a defibrillator was not accessible at the Picton site and that the only emergency medication available was adrenalin.

When we were shown the facility where the emergency medication and defibrillator were stored we found that two clinical members of staff were unable to immediately open the drawers to access this equipment. Drills to test out the accessibility of emergency equipment and staff response times were not undertaken.

Records showed that contracts were in place for annual checks of fire extinguishers, portable appliance testing and calibration of clinical equipment.

The computers in the reception and clinical rooms had a panic button for staff to call for assistance.

### Staffing & Recruitment

The practice had a procedure for the safe recruitment of staff including guidelines about seeking references, proof of identity and checking qualifications/clinical registration. We looked at four staff files and found the recruitment procedure had been followed. The business manager had carried out checks to show the applicants were suitable for the posts and eligible to work in the UK.

The business manager checked the professional registration for clinical staff. We saw that the practice carried out Disclosure and Barring service (DBS) checks for GPs and nurses. These checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post. The practice had carried out risk assessments for reception and administration roles to support their decision not to carry out DBS checks on those staff.

The business manager worked with the GPs, nurses and administration managers to ensure staffing rotas were managed in order to ensure sufficient staff were on site at all times.

### Monitoring Safety & Responding to Risk

We saw that staffing levels were set and reviewed to ensure patients were kept safe and their needs were met. In the event of unplanned absences staff covered from within the service and there was minimal use of agency and locum staff. Duty rotas took into account planned absence such as holidays. Staff we spoke with felt staffing levels were appropriate and met the needs of the service and patients. We were told by staff that in the event of extremely busy periods of activity, extra staff would be brought in to ensure patient safety. For example, nurse prescribers were employed on a sessional basis when patient demand was high. Also the practice opened on a Saturday morning to meet the demands of high numbers of patients requiring flu vaccination. GPs and the business manager told us that patient demand was monitored through the appointment system to ensure that sufficient staffing levels were in place.

There were procedures in place to assess, manage and monitor risks to patient and staff safety. These included checks and risk assessments of the building, the environment and equipment. Any risks were discussed at practice meetings. We found checks were made to minimise risk and best practice was followed. These included monitoring staff refresher training to ensure they had the right skills to carry out their work and monitoring stocks of consumables and vaccines to ensure they were available, in date and ready to use.

We found that the actions arising from one significant event had not been fully completed since the incident in February 2014. The action was to carry out a dummy run by sounding the alarm system. This was to be carried out to ensure an appropriate response by staff in the event of an incident that could effect patient and staff safety.
The business manager said this had not been carried out due to absence of the staff to co-ordinate this given the resource implications of involving the three practices that occupied the building and the local police.

### Arrangements to deal with emergencies and major incidents

A disaster recovery and business continuity plan was in place, which was reviewed in August 2014. The plan covered loss of building, power supply, incapacity of staff, loss of medical records, loss of electronic systems and loss of power supply. Key contact numbers were included and

Good

# Are services safe?

paper and electronic copies of the plan were kept at both sites. The business manager described two occasions when the plan was put into operation due to limited access to the Picton site.

Staff told us they had training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). Samples of training certificates confirmed that this training was up to date.

Good

# 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 nursing staff 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. GPs discussed new clinical protocols informally and steps had been taken to set up regular formal meetings to provide peer support to GPs, review complex patient needs and keep up to date with best practice guidelines and relevant legislation.

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

The practice provided a service for all age groups. The local community provided services for people with learning disabilities, patients living in deprived areas and care homes and for people with mental health needs. We found GPs were familiar with the needs of patients; the impact of the socio-economic environment and had particular interest areas. For example one of the GP's had undertaken additional training in drug addiction and ran a clinic and other GPs had developed additional competencies around working with palliative care patients.

### Management, monitoring and improving outcomes for people

There were systems in place to evaluate the operation of the service and the care and treatment given. The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included conditions such as gout and prescribing of medication such as tramadol, oral supplementary medication and domperidone. We saw that audits of clinical practice were regularly undertaken and that these were based on best practice national guidelines. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of Quality and Outcomes framework (QOF) performance. For example we saw an audit regarding the prescribing of supplementary oral feeds. Following the audit the GPs carried out medication reviews for patients who were prescribed these products and altered their prescribing practice, in line with new nutritional guidelines.

All the clinicians participated in clinical audits. We discussed audits with GPs and found evidence of a culture of communication, sharing of continuous learning and improvement. For example we found that as a result of audits of urinary tract infection the practice had reviewed it's response to these conditions.

The practice used the information they collected for the QOF and their performance against national and local screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided. The report from 2012-2013 showed the practice was performing well and particularly well in relation to registers maintained for adult patients with a learning disability, patients in need of palliative care and carrying out regular multi-disciplinary reviews of patients on the palliative care register.

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 asthma and chronic heart disease which were used to arrange annual health reviews. They also provided annual reviews to check the health of patients with learning disabilities and patients on long term medication, for example for mental health conditions.

The practice was one of thirteen practices that belonged to a neighbourhood quality improvement scheme operated by NHS Liverpool Clinical Commissioning Group (CCG). The CCG worked on quality indicators with the practices in each neighbourhood. The practice had a development plan that highlighted areas where they wanted to make improvements; these included urgent care, mental health and children's services. Representatives from the practice attended regular meetings to look at their practice development plan with the CCG.

### Effective staffing

An induction was provided to new staff. The induction programme included time to read the practice's policies and procedures, role specific training, risk assessment, and health and safety guidance and shadowing colleagues.

Good

# Are services effective?

## (for example, treatment is effective)

Staff told us they had easy access to a range of policies and procedures to refer to and support them in their work. A staff handbook was provided to all new staff which outlined relevant employment policies and procedures.

The practice offered all staff annual appraisals to review performance at work and identify development needs for the coming year. The business manager told us that a system of appraisal for reception and administrative staff had been introduced in August 2014. The nursing staff spoken with told us they received an annual appraisal and we saw records that confirmed this. GPs had an annual appraisal and they confirmed that revalidations were up to date.

Clinical and administrative staff told us they felt well supported to carry out their work. Regular staff meetings were held where they could discuss their roles and the operation of the service. Nursing staff told us they worked well as a team and had good access to support from each other and their GP colleagues. GPs met informally to discuss clinical issues and changes to practice. Regular GP meetings were being introduced to provide peer support and monitor the service provided.

The business manager kept a record of all training carried out by clinical and administration staff to ensure staff had the right skills to carry out their work. The practice had a rolling programme of half day training for staff. GPs told us they had protected learning time and met with their external appraisers to reflect on their practice, review training needs and identify areas for development. Nurses spoken with told us they had access to good training opportunities to keep their clinical practice up to date.

### Working with colleagues and other services

The practice worked with other agencies and professionals to support continuity of care for patients. The GPs described how the practice provided the 'out of hours' service with information, to support, for example 'end of life care.' Information received from other agencies, for example A&E or hospital outpatient departments were read and actioned by the GPs on the same day. Information was scanned onto electronic patient records in a timely manner. GPs described how blood result information would be sent through to them electronically and the system in place to respond to any concerns identified.

The practice kept up to date disease registers for patients with long term conditions such as asthma and chronic heart disease which were used to arrange annual health reviews. They also provided annual reviews to check the health of patients with learning disabilities and patients on long term medication for example for mental health conditions. Multi-disciplinary team meetings for patients on the palliative care register took place on a regular basis to ensure patients had sufficient levels of support and equipment and drugs were in place in a timely manner.

Multi-professional working took place to support patients and promote their welfare. Health visitors, community matron, district nurses and Macmillan nurses were invited to attend weekly meetings at the practice to discuss any concerns about patient welfare and where further support may be required. GPs were invited to attend reviews of patients with mental health needs and where they were unable to attend they supplied a report about their involvement with the patient.

### Information Sharing

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 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.

New patients were offered a consultation to ascertain details of their past medical and family histories, social factors including occupation and lifestyle, medications and measurements of risk factors such as smoking and alcohol intake. Consultations were also offered to newly registered children.

Information to support patients to lead healthier lives was available to them in the waiting area and information was also provided by the GPs and nurses following consultations. For example, this included information around smoking cessation schemes, travel advice and sexual health.

There was a confidentiality policy which gave clear guidance to staff. Information around data sharing and data protection was available for patients to refer to.

### Consent to care and treatment

The practice had a consent to treatment policy which set out how patients were involved in their treatment choices

Good

# Are services effective?

## (for example, treatment is effective)

so that they could give informed consent. The policy identified where 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. The policy also included consent to treatment by children and young people and referred to Gillick competency in children (Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.) All staff we spoke with understood the principles of gaining consent including issues relating to capacity. We saw that systems were in place to ensure that consent was recorded in accordance with the policy of the practice. Information relating to consent to care and treatment was on display in the waiting area for patients to refer to.

### Health Promotion & Prevention

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

QOF information showed the practice performed well regarding health promotion and ill health prevention initiatives. For example, in providing flu vaccinations, providing physical health checks for patients with severe mental health conditions and diabetes.

The practice also provided patients with information about other health and social care services such as carers' support. We saw a range of information posters and leaflets in the practice and links to health and social care organisations on the practice website. Staff we spoke with were knowledgeable about other services and how to access them.

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 used the coding of health conditions in patients' electronic records and disease registers to plan and manage services. For example, patients on disease registers were offered review appointments with the nursing staff.

We observed that there was a lot of information in the waiting area that could be better organised to improve patient access.

Good

# Are services caring?

## Our findings

### Respect, Dignity, Compassion & Empathy

We looked at 19 Care Quality Commission (CQC) comment cards that patients had completed prior to the inspection and spoke with nine patients on the day of the inspection. 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 that they felt listened to. Three patients spoken with felt their conversations could be overheard at reception. Six patients were unaware that they could ask to speak to a receptionist in private. Two patients spoken with were not aware of the chaperone policy. We observed that where the information detailing these services was displayed may not be immediately visible to all patients.

The National GP Patient Survey published in 2013 found that 86.5% of patients would recommend their GP surgery and 93.1% of patients would rate their practice as good or very good.

We looked at surveys completed by patients around the service provided by four individual GPs in 2013 and 2014. This demonstrated that patients overall satisfaction with the GPs, opportunity to express concerns or fears, GPs explanations of treatments and confidence in the GPs abilities was overall rated as good, very good or excellent.

The practice was part of a group of 13 practices in Liverpool which worked together with NHS Liverpool Clinical Commissioning Group to measure their service against each other and nationally and identify areas for improvement. Performance information collated in July 2014 around patient experience indicated that 91% of patients found the receptionists helpful, 90% had confidence and trust in the nurses and 89% had confidence and trust in the GPs.

The practice had a clear set of values about patients being treated courteously and being well supported. This was reflected in the practice mission statement on their website and displayed in the reception area.

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. A notice advising patients of this was on display. We observed that overall privacy and confidentiality were maintained for patients using the service on the day of the visit. We found that some patient's private conversations with reception staff could possibly be overheard when there was more than one patient at the reception desk.

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 was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the business manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We discussed a recent incident with the practice manager that demonstrated appropriate action had been taken.

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

The practice offered patients a chaperone prior to any examination or procedure. Staff we spoke with were knowledgeable about the role of the chaperone and had received training to carry out this work.

### 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 generally rated the practice well in these areas. For example, data from the most recent National GP Patient Survey showed 84% of practice respondents said the GP involved them in care decisions and 95% felt the nurse involved them in decisions about their care.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them, treatments were explained and they felt listened to. Seven out of the

Good

# Are services caring?

nine patients we spoke with felt involved in decision making about the care and treatment they received. Patient feedback on the comment cards we received indicated they felt listened to and supported.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

### Patient/carer support to cope emotionally with care and treatment

Staff spoken with told us that bereaved relatives known to the practice were offered support following bereavement.

Information was on display in the waiting area around support with bereavement and the details of useful contact organisations were made available to patients. GPs and nursing staff were able to refer patients on to counselling services. Patients we spoke with who had had a bereavement confirmed they had received good support which included being able to talk to staff and being referred on to support services such as counselling.

Notices in the patient waiting room, on the TV screen and patient website signposted people to a number of support groups and organisations. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The needs of the practice population were understood and systems were in place to address identified needs. NHS Liverpool Clinical Commissioning group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We discussed with the GPs actions agreed to implement service improvements and manage delivery challenges to its population. For example, the practice development plan included making improvements to cancer care and children's and mental health services.

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. They worked with other health providers to support patients who were unable to attend the practice. For example patients who were housebound were identified and referred to the district nursing team to receive their vaccinations.

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 health care support. The referrals were done whilst the GP was with the patient with the GP completing the referral letter following the consultation. Administrative staff monitored referrals to ensure all referral letters were completed in a timely manner. Records indicated this system worked well with all referrals receiving prompt attention. Administrative staff followed up two week wait referrals to ensure they had been received and notified patients of appointments made.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient's and their families' care and support needs. They regularly updated shared information to ensure good communication of changes in care and treatment.

The practice had a mix of male and female GPs so that patients were able to choose to see a GP of the gender of their choice.

A Patient Participation Group had recently been established. We saw the minutes from the first meeting and saw that discussion had taken place to gather patient views around how to resolve issues such as missed appointments. Patients had also made suggestions to improve the waiting area which the practice manager was looking into.

### Tackling inequity and promoting equality

The practice provided disabled access in the reception and waiting areas, as well as to the consulting and treatment rooms. There were comfortable waiting areas for patients attending an appointment and car parking was available nearby. There were disabled toilet facilities.

Information about interpreting services was on display in the waiting area. Staff were knowledgeable about interpreter services for patients where English was their second language. Patients' electronic records contained alerts for staff regarding, for example patients requiring additional assistance in order to ensure the length of the appointment was appropriate. If a patient required interpreting services then a double appointment was offered to the patient to ensure there was sufficient time for the consultation.

Staff we spoke with were knowledgeable about how to support patients who were homeless. The staff told us they made sure the patient received urgent and necessary care whatever their housing status. They were also aware of the GP practice in the Clinical Commissioning Group (CCG) that took the lead for managing homeless patients' long term care. They told us they would ensure patients knew how to access this service.

Asylum seekers were registered with the practice and there was information for staff to refer to around initial screening examinations that were undertaken by another service provider.

A faith room was available at the Picton site to allow for prayer or provide a space for quiet reflection.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

Staff spoken with and training records showed staff had received training around equality, diversity and human rights.

### Access to the service

Patients were able to make appointments in person or by telephone. Pre-bookable appointments could be made two weeks in advance. Appointments could be booked on the day and each GP reserved some appointments in the morning and afternoon to see patients who needed urgent attention. Telephone consultations were also available and home visits were made to patients who were housebound or too ill to attend the practice. Patients unable to attend during the normal opening hours were able to book in advance to be seen at the 'extended hours' service run at both sites until 8pm on Mondays. During periods of high patient demand, such as for flu vaccinations the practice opened on a Saturday morning. The practice information leaflet and website provided information to patients about where to access GP services when the practice was closed.

The business manager reported that some patients failed to attend for a booked appointment and had not contacted the practice to cancel which meant that the appointment could not be offered to another patient. In order to manage this the appointment system was being closely monitored and when a patient missed three or more appointments a letter was sent to them to advise them of the consequences of this for other patients.

The National GP survey results published in 2013 showed that patients were overall happy with access to the service. 86.3% were satisfied with opening hours, 81.7% rated their ability to get through on the telephone easy or very easy and 91.2% rated their experience of making an appointment as good or very good. We spoke with nine patients during the inspection. Six said it was easy to make an appointment and three said it could be difficult to get through on the telephone. All nine patients were satisfied with arrangements for repeat prescriptions and they all said that if a referral to another service was needed this had been done in a timely manner.

The practice had recently developed a newsletter. This provided information around services available, staffing and signposted patients to helpful services and organisations. The practice manager told us that this would be made available to patients on a quarterly basis or more frequently if needed.

### Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their 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 looked at a sample of complaints. We saw documentation to record the details of the concerns raised and the action taken. For example, a patient complained about the attitude of a member of staff. Action was taken to address the issue with the member of staff concerned.

There was a central log/summary of complaints to monitor trends and ensure any changes made were effective.

We saw that the complaint policy was displayed in the waiting area and was on the practice's website. The steps to take to make a complaint were also referred to in the patient information leaflet. The policy included contact details for Healthwatch Liverpool and the Health Service Ombudsman, should patients wish to take their concerns outside of the practice.

Staff we spoke with were knowledgeable about the policy and the procedures for patients to make a complaint and confirmed complaints were discussed at practice meetings. Records showed that as a result of looking at a complaint made around the appointment system a change had been made to the protocol for GPs making next day appointments for patients. This ensured this information was clearly communicated to administrative staff as well as updating the appointment system.

# Are services well-led?

Good

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

## Our findings

### Vision and Strategy

The practice had a clear vision and set of values which were understood by staff, publicised at the practice and evident on the practice website. The practice's mission statement included a commitment to being responsive and supportive to patients and providing holistic care by working closely with hospitals and local trusts to provide as many services possible in the local community.

The staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these.

### Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically or in paper format. There was no central electronic storage facility for policies and procedures across both sites, however, the practice was moving to a new computerised system in February 2015 that would enable staff at both sites to access all policies and procedures from a central location. We spoke to staff who were aware of how to access policies and procedures. We looked at a sample of these policies and procedures and most staff had completed a cover sheet to confirm they had read the policy and when. All policies and procedures we looked at were up to date.

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. The GPs spoken with told us that QOF data was regularly discussed monthly team meetings and action plans were produced to maintain or improve outcomes.

The GPs spoken with told us about a local peer review system they took part in with neighbouring GP practices and the Clinical Commissioning Group. This enabled the practice to measure their service against others and identify areas for improvement. For example, the practice was working on improving services in relation to cancer care, the management of mental health conditions and urgent care.

The practice had completed clinical audits to evaluate the operation of the service and the care and treatment given. Examples of clinical audits included conditions such as gout and prescribing of medication such as tramadol, oral supplementary medication and domperidone.

The practice had systems in place for identifying, recording and managing risks. We looked at examples of significant incident reporting and actions taken as a consequence. Minutes from team meetings showed that significant incidents and how they were to be learned from where discussed.

### Leadership, openness and transparency

There was a clear leadership structure in place which had named members of staff in lead roles. For example there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with 13 members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly, generally weekly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Staff told us they felt the practice was well managed with clear leadership from clinical staff and the business manager. Staff told us they could raise concerns and felt they were listened to.

There were no formal clinician only meetings, however, this had been identified as being needed and there was a plan in place to develop a schedule of these meetings.

The business manager was responsible for human resource policies and procedures. We reviewed a sample of policies, for example, regarding induction and management of sickness which were in place to support staff. We were shown the staff handbook that was available to all staff, this included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

We saw evidence that showed the practice worked with the Clinical Commissioning Group (CCG) to share information,

# Are services well-led?

Good

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

monitor performance and implement new methods of working to meet the needs of local people. GPs attended prescribing and medicines management and shared information within the practice.

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

Patient feedback was obtained through comments/ suggestion boxes in the waiting areas and by carrying out surveys. We saw the results of four surveys of individual GP performance that were carried out in 2013 and 2014 and showed that patients were happy with the service and made no suggestions for improvements.

We saw that patients had left feedback on the NHS Choices website. We saw that in 2014 there had been six patient comments and that the comments were generally very positive. One patient had commented the referral and prescription process was disorganised. The business manager had responded to the patient encouraging them to contact her so their concerns could be looked into.

A Patient Participation Group (PPG) had recently been established. We saw the minutes from the first meeting in September 2014 and saw that discussion had taken place to gather patient views around how to resolve issues such as missed appointments. Patients had made suggestions to improve the waiting area which the practice manager was looking into. The business manager told us that a further meeting was scheduled for December 2014 and three monthly thereafter. The PPG was advertised on the practice website and in the practice waiting areas. Information about the PPG was also given out in leaflet format to any patient collecting a prescription.

Staff told us they felt able to give their views at the weekly practice meetings that involved all staff. Staff told us they could raise concerns and felt they were listened to.

### Management lead through learning & improvement

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. We saw the records of four staff that showed that appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had regular staff training sessions where guest speakers and trainers attended. GP appraisals were up to date and revalidation was taking place. Revalidation is the process by which all registered doctors have to demonstrate to the General Medical Council (GMC) that their knowledge is up to date, they are fit to practise and are complying with the relevant professional standards.

The business manager monitored staff training to ensure essential training was completed each year. Where training needs where identified the business manager had a plan to ensure this training took place.

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.