

Dingle Park 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?

Outstanding



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 Dingle Park Practice. Dingle Park Practice is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on 15 October 2014 at the practice location in the Riverside Centre for Health. We spoke with patients, staff and the practice management team.

The practice was rated as Good. A caring, 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. However, improvements were needed to the recruitment of staff to ensure all necessary checks were undertaken to demonstrate their suitability for their roles.

- 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.
- Patients 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. Patients felt involved in decision making around their care and treatment.

Summary of findings

- 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 encouraged patients to give their views about the services offered and made changes as a consequence
- There was a clear leadership structure in place. Quality and performance were monitored, risks were identified and managed. The practice ensured that staff had access to learning and improvement opportunities.

We saw an area of outstanding practice:

- The practice had assessed the needs of the practice population and employed a nurse to work mainly with housebound patients to ensure pro-active care of older patients and patients with long term conditions who were housebound.

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

Importantly, the provider must:

- Take action to ensure its recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 to ensure the necessary employment checks are in place for all staff.

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 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 reviewed to ensure that patients were safe and their care and treatment needs were met. However, improvements were needed to the recruitment of staff to ensure all the necessary checks were undertaken to demonstrate their suitability for their roles.

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 monitored its performance and had systems in place to improve outcomes for patients. 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. We looked at 28 CQC comment cards that patients had completed prior to the inspection and spoke with four patients on the day of the inspection. Patients 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. 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 outstanding for responsive. The practice had assessed the needs of its patient population and as a result a practice nurse was employed to work mainly with housebound patients who were older and with patients who needed support with

Outstanding



Summary of findings

chronic disease management. The practice nurse carried out reviews of patients with chronic diseases and provided a range of healthcare support and advice. This pro-active service ensured that patients who were unable to attend the service had their health monitored and good health promoted, for example by the provision of the flu vaccine. The practice engaged with the local Clinical Commissioning Group (CCG) to identify patient needs and service improvements that needed to be prioritised. The practice was accessible for people with a physical disability. Staff were knowledgeable about interpreter services for patients where English was their second language. 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.

Are services well-led?

The practice is rated as good for well led. The practice had a clear vision and set of values which were understood by staff and evident in our discussions with patients. 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 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 participation group (PPG) was in operation 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 had assessed the needs of its patient population and as a result a practice nurse was employed to work mainly with housebound patients to ensure pro-active care of older people who were housebound. 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. All nursing home and housebound patients also had a named GP. Patients over 75 received an annual health check. We found the practice worked well with other agencies and health providers to provide support and access specialist help when needed. A dedicated phone line was available at the practice for health care professionals to contact a GP to assist with communication and improve patient safety.

Good



People with long term conditions

The practice is rated as good for the population group of people with long term conditions. The practice had assessed the needs of its patient population and as a result a practice nurse was employed to work mainly with housebound patients to ensure they received the care they needed around chronic disease management. 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. Regular chronic disease management meetings were held to enable clinical staff to discuss patients with complex needs, keep up to date with changes to protocols and seek advice from colleagues.

Good



Families, children and young people

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

Good



Summary of findings

and the needs of families. For example, a weekly clinic was run which combined immunisations and routine child health screening. Eight week baby checks and post-natal checks were also combined for the benefit of patients. 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. 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 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)

The practice is rated as good for the population group of 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. Appointments could be booked and repeat prescriptions ordered on line. The need for extended hours service had been reviewed through surveys and was being monitored through patient and staff feedback. Well man and well woman checks were being offered to patients to promote patient well-being and prevent any health concerns.

Good



People whose circumstances may make them vulnerable

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. The practice worked with Addaction to support patients to overcome their problems with drugs and alcohol by prescribing any medication required and carrying out health

Good



Summary of findings

screening and any necessary health interventions. 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)

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 care, implement new care pathways and share care with specialist teams. The practice maintained a register of patients who experienced poor mental health. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. The Quality Outcomes Framework (QOF) indicated that the practice was meeting its targets for annual reviews of people experiencing poor mental health. The practice referred patients to appropriate services such as psychiatry and counselling services. Referrals were made to Child and Adolescent Mental Health Services (CAHMS) to support younger patients. 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.

Good



Summary of findings

What people who use the service say

We looked at 28 CQC comment cards that patients had completed prior to the inspection and spoke with four patients on the day of the inspection. Patients 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. Patients we spoke with told us they had enough time to discuss things fully with the GP, 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 published in 2013 found that 97.8% of patients at Dingle Park Practice would recommend their GP surgery. 97.5% said receptionists were helpful. 96.3% rated their experience of making an appointment as good or very good. These responses placed the practice amongst the best GP practices nationally. When the results from the National Patient Survey were compared nationally the practice was ranked 89 out of 7952 in England making them by comparison a high performing practice.

We looked at the results of the last patient survey undertaken by the practice in February 2014. Ninety eight surveys were completed and the results showed that 100% of patients found the reception staff helpful, 100% felt when speaking to the nurses or GPs they were very good or good at listening. 100% felt that the GPs or nurses were good or very good at treating patients with care and concern. 95.9 % of patients said they would definitely recommend the practice to someone new to the area and 97.6% of patients said when seeing/ speaking to a GP or nurse they were either very good or good at involving them in decisions.

We were shown a sample of recent GP appraisals which contained feedback from patients. Again, patients commented that the GPs treated them with respect, listened to their concerns and were good at explaining tests and treatments.

Areas for improvement

Action the service MUST take to improve

- The provider must take action to ensure its recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 to ensure the necessary employment checks are in place for all staff.

Outstanding practice

- The practice had assessed the needs of the practice population and employed a nurse to work mainly with housebound patients to ensure pro-active care of older patients and patients with long term conditions who were housebound.

Dingle Park 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 Dingle Park Practice

Dingle Park Practice is one of three practices based in the Riverside Centre for Health in the Dingle area of Liverpool. The practice registered with CQC to provide primary care services, which include diagnostic and screening services, 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 four GP partners, a part-time locum GP, a practice nurse, a community practice nurse, an advanced nurse practitioner, a healthcare assistant, a practice manager, an office manager and administrative and reception staff. The practice is a GP training practice and has GP registrars working for them as part of their training and development in general practice. The practice is also a location for clinical placement for medical students from the University of Liverpool.

The practice is open Monday to Friday from 8.30am until 6.30pm. Patients can book appointments in person, by telephone or on-line. Patients can book on the day, for the next working day or in advance, 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 Urgent Care 24 (UC24).

The practice is part of NHS Liverpool Clinical Commissioning Group. It is responsible for providing

primary care services to approximately 4514 patients. The practice is situated in an economically deprived area of the city which has an ethnically diverse population. 19.5% of the practice population are children, 6.9% are below the age of 5, 14.6% are over 65 years old and 7.7% identify themselves as non English speakers. The practice has a General Medical Services (GMS) contract.

The practice shares a building 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 building.

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.

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:

Detailed findings

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

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

- Older people
- People with long-term conditions
- 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 15 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: two GPs, a practice nurse, a healthcare assistant, practice manager and three reception and administration staff. We spoke with four patients who were using the service on the day of the inspection and with a member of the patient participation group.

Are services safe?

Our findings

Safe Track Record

NHS Liverpool Clinical Commissioning Group and NHS England 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 on going 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.

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, the analysis of a delayed diagnosis of clostridium difficile infection (a type of bacterial infection that can affect the digestive system) resulted in a review of how information is gathered from patients to determine symptoms and aid diagnosis.

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 and involved in any required changes to practice or any actions that needed to be implemented. We found that these alerts were not stored in a centrally accessible location that would assist staff in locating this information at a future date.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring safety incidents. Staff told us and 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 consequence of a test result being sent electronically to the wrong inbox and being overlooked the system for managing tests results sent from hospitals electronically had been reviewed.

A protocol around learning and improving from safety incidents was available for staff to refer to. A central log/summary of significant events was maintained that would allow patterns and trends to be easily identified and enable a record to be made of actions undertaken and reviewed. We noted that a review of the effectiveness of changes made following a safety incident did not formally take place.

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.

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 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. 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. A chaperone policy was on display in the waiting area that advised patients that this service could be requested at reception.

Are services safe?

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. 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 at 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. 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 and a recent cold chain audit had been undertaken and identified no concerns. We noted that although staff were aware of what to do should there be concerns that the cold chain was not maintained, the action to be taken was not clearly indicated in the cold chain policy and procedure.

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. 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 four patients we spoke with commented that the practice was clean and appeared hygienic. We looked around the premises and found them to be clean. The treatment rooms, waiting areas and toilets were in good

condition and supported infection control practices. Surfaces were intact, easy to clean and the premises were uncluttered. Staff had access to gloves and aprons and there were appropriate segregated waste disposal systems for clinical and non-clinical waste. We observed good hand washing facilities to promote good standards of hygiene. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms.

The premises were leased by NHS Property Services who carried out an infection control audit at the practice in July 2012. This showed that overall the practice was providing effective infection control measures. We found that regular infection control audits were not undertaken by the practice. These should be undertaken to ensure that good infection control practices are promoted.

The practice used an external cleaning company. A log of cleaning works undertaken was maintained. The practice manager reported that designated staff always checked the work carried out by the cleaning company to ensure good standards were maintained.

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 by the company that managed the premises.

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, vaccine fridge, thermometers and blood pressure machines had been tested and calibrated. All portable electrical equipment was routinely tested.

Staffing & Recruitment

The practice had a procedure for the safe recruitment of staff. This included guidelines about seeking references, proof of identity, checking qualifications/clinical registration, obtaining Disclosure and Barring service (DBS),

Are services safe?

formerly Criminal Records Bureau (CRB) checks (these checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post).

We looked at a sample of recruitment files for two GPs, one receptionist and two nurses. We found that there were gaps in the required information to determine suitability for employment.

The practice manager told us that a number of the staff had transferred from another employer to work at the practice and that their original recruitment documentation had not been provided.

We found that a Criminal Records Bureau (CRB) had been carried out for both GPs. However, one check was carried out nine years ago and was not an enhanced check so did not include a check of the barred list of people who are unsuitable to work with children or vulnerable adults.

Evidence of a DBS or CRB check were not available for the two nurses. Evidence of this check was also not available for the receptionist who acted as a chaperone for patients. No references were available on any of the staff records looked at. We did not see any evidence that checks had been undertaken to ensure potential staff were physically and mentally fit to undertake the roles and responsibilities required.

We found that employment contracts and job descriptions were in place and we saw evidence that demonstrated professional registration for clinical staff was up to date and valid. However, there was no system in place to record checks of on going professional registration with the General Medical Council (GMC) and Nursing Midwifery Council (NMC).

Monitoring Safety & Responding to Risk

Staffing levels were reviewed to ensure patients were kept safe and their needs were met. In the event of unplanned absences staff covered from within the service. The registered manager told us that the number of patients to GP hours was kept low to ensure good access and a good standard of care. All GPs had a day a week when they were not in the practice and were available to cover any staffing shortfalls.

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. GPs and the practice manager told us that patient demand was monitored through the appointment system and staff and patient feedback to ensure that sufficient staffing levels were in place.

The practice had other systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual checks of the fire fighting equipment, medicines management, dealing with emergencies and monitoring the safety of equipment. Health and safety information was displayed for staff to see around the premises. A health and safety policy and procedure had been developed by NHS Property Services (owners of the premises) and related to all the services provided in the building. This did not give specific tasks to any staff from Dingle Park Practice around the maintenance and promotion of health and safety. The practice manager was the lead for health and safety and was working with Health at Work, a service commissioned by NHS Liverpool Clinical Commissioning Group (CCG) to develop health and safety policies and procedures specific to the practice.

Arrangements to deal with emergencies and major incidents

Emergency medicines were available and staff knew of their location. Processes were also 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) that was shared between the three practices located in the building. 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). Samples of training certificates confirmed that this training was up to date. 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, which was reviewed in October 2014. The plan included the actions to be taken following loss of building, loss of telephone system, loss of computer and electrical

Are services safe?

equipment and loss of utilities. Key contact numbers were included for staff to refer to. We noted that the plan did not contain a plan for the risks presented by unplanned staff absence.

Records showed that the fire alarm, emergency lighting and fire fighting equipment were checked to ensure they were operating safely. 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 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 and nurses discussed new clinical protocols at regular clinical meetings. These meetings also provided the opportunity to review complex patient needs and keep up to date with best practice guidelines and relevant legislation. For example, we found that as a result of a recent clinical meeting the cardio-vascular risk assessment policy had been reviewed to reflect up to date NICE guidelines. We found that there was no formal process for reviewing new guidelines and the guidelines reviewed were often as a result of personal interest.

The practice nurses 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. Nurses met with nurses from other practices which assisted them in keeping up to date with best practice guidelines and current legislation.

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

The practice provided a service for all age groups. They provided services for patients in the local community with diverse cultural and ethnic needs, patients with learning disabilities, patients living in deprived areas and care homes and for patients experiencing poor mental health. We found GPs and nursing staff were familiar with the needs of patients and the impact of the socio-economic environment. For example, the practice employed a practice nurse to monitor the health of housebound patients. Clinicians offered Muslim patients with diabetes cholesterol checks during Ramadan. The practice worked with patients with a learning disability with a dislike of health care related environments to encourage access to

health care provision through a series of desensitization visits. The practice had agreed to be part of study being carried out by Liverpool University around how debt contributes to poor mental health.

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 seen included BMI (body mass index) checks for patients prescribed oral contraceptives and prescribing of statins (medication to reduce cholesterol). 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, clinical interest or as a result of Quality and Outcomes framework (QOF) performance. 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 the audits we looked at changes had been made to how the practice operated. New guidelines had been introduced around the prescribing of statins and a record of both weight and BMI was now made to give a better indicator of patient health.

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 in all areas and particularly well in relation to carrying out diabetes checks such as monitoring cholesterol and foot examinations, number of patients with mental ill-health who have had an up to date cervical screening and carrying out regular multi-disciplinary reviews of all 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.

Are services effective?

(for example, treatment is effective)

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. Information provided by the CCG showed that the practice was performing well, the practice well exceeded all three cancer screening targets, achieved all mental health indicators for patients with dementia, lithium therapy and health checks for patients with severe mental illness and achieved its targets for referrals to secondary care. The practice had a development plan that highlighted areas where they wanted to make improvements. For example, this included reducing hospital attendance. Representatives from the practice attended regular meetings to look at their practice development plan with the CCG. The practice worked with the CCG to ensure prescribing practices promoted patient safety and met current clinical guidelines.

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. Staff told us they had easy access to a range of policies and procedures to refer to and support them in their work.

An appraisal policy was in place. The practice manager told us that staff were offered annual appraisals to review performance at work and identify development needs for the coming year. The practice manager was appraised by two partner GPs, GPs carried out the appraisal of nursing staff and a nurse undertook the appraisal of the health care assistant. We looked at the records relating to one nurse which indicated they had received an annual appraisal. Two GPs spoken with and records confirmed they had an annual appraisal. All GPs had up to date revalidations. 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. Appraisals had recently been re-introduced for administrative staff and they had been given a date for an appraisal which would be undertaken within the next month.

Clinical and administrative staff told us they felt well supported to carry out their work. The practice manager had introduced administration staff meetings which they

said had been useful for addressing issues relating to the administration and reception roles. The last practice meeting involving all practice staff had taken place in September 2014. Prior to this these meetings had not been held on a regular basis. The practice manager was addressing this to ensure regular practice meetings.

GPs and nursing staff told us they worked well as a team and had good access to support from each other. GPs met to discuss clinical issues, provide peer support and monitor the service provided on a weekly basis. GPs and nurses met on a monthly basis to discuss clinical matters. We were shown the minutes of the meetings for the last two months. Clinical staff spoken with found these meetings a good source of support and a forum to raise any issues of concern. Nurses met with nurses from other practices to discuss changes to clinical practice and undertake training.

The practice manager kept a record of mandatory training carried out by clinical and administration staff. We found that the training record did not include dates which would assist in the planning of future training needs for staff. GPs and nurses 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. 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. Administrative staff told us they had the training they needed to support them in their roles and a nurse 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 in a timely manner. GPs described how blood result information would be sent through to them and the system in place to respond to any concerns identified. We observed the system for scanning onto

Are services effective?

(for example, treatment is effective)

electronic patient records and saw that this was managed efficiently. There was a system in place to identify patients at risk of unplanned hospital admissions and to follow up the healthcare needs of these patients within 72 hours.

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-professional working took place to support patients and promote their welfare. Clinical staff met with health visitors on a monthly basis with the main focus being reviewing the health care needs of children subject to a child protection plan. Gold Standards Framework meetings were held monthly with district and palliative care nurses to review the needs of patients on the palliative care register. 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

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

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.

The practice had systems in place to communicate with other providers. For example, there was a shared system 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. Where a patient needed to be seen within the timescale of two weeks (as indicated by National Institute of Clinical Excellence Guidelines (NICE)) when they had symptoms that may be caused by cancer this was followed up to ensure the referral had been received and an appointment offered to the patient.

Consent to care and treatment

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

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

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.

QOF information showed the practice performed at or above the national average regarding health promotion

Are services effective?

(for example, treatment is effective)

and ill health prevention initiatives. For example, in providing flu vaccinations, providing physical health checks for patients with severe mental health conditions and diabetes.

Health promotion clinics were offered to patients. These included smoking cessation, drug user support and obesity management. Travel advice was also provided including common travel vaccinations.

A health trainer employed independently of the practice was available each week to support patients with weight reduction, exercise, alcohol and drug related problems.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We looked at 28 CQC comment cards that patients had completed prior to the inspection and spoke with four patients on the day of the inspection. Patients 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. Patients we spoke with told us they had enough time to discuss things fully with the GP, treatments were explained and that they felt listened to.

The National GP Patient Survey published in 2013 found that 97.8% of patients at Dingle Park Practice would recommend their GP surgery. 97.5% said receptionists were helpful and 98.9% rated the practice as giving a good overall experience. These responses placed the practice amongst the best GP practices nationally. When the results from the National Patient Survey were compared nationally the practice was ranked 89 out of 7952 in England making them by comparison a high performing practice.

We looked at the results of the last patient survey undertaken by the practice in February 2014. Ninety eight surveys were completed and the results showed that 100% of patients found the reception staff helpful, 100% felt when speaking to the nurses or GPs they were very good or good at listening and 100% felt that the GPs or nurses were good or very good at treating patients with care and concern. 95.9 % of patients said they would definitely recommend the practice to someone new to the area.

We were shown a sample of recent GP appraisals which contained feedback from patients. Again, patients commented that the GPs treated them with respect, listened to their concerns and were good at explaining tests and treatments.

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. We observed that a notice advising patients of this was not on display. We observed that overall privacy and confidentiality were maintained for patients using the service on the day of the visit.

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 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 practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

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 most National GP Patient Survey showed 93% of practice respondents said the GP involved them in care decisions and 81% felt the nurse involved them in decisions about their care.

The results of the last patient survey undertaken by the practice in February 2014 and completed by 98 patients showed 97.6% of patients said when seeing/speaking to a GP or nurse they were either very good or good at involving them in decisions.

Patients we spoke with on the day of our inspection 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 feedback on the comment cards we received indicated they felt listened to and supported.

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

Are services caring?

included, information about the Citizen's Advice Bureau, debt management and domestic violence. The four patients we spoke with said that they had been referred to or given information about support groups if they were needed.

Staff spoken with told us that bereaved relatives known to the practice were offered support following bereavement. GPs and nursing staff were able to refer patients on to counselling services. There was written information available for carers to ensure they understood the various avenues of support available to them.



Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had assessed the needs of its patient population and as a result a practice nurse was employed to work mainly with housebound patients who were older and with patients who needed support with chronic disease management. The practice nurse carried out reviews of patients with chronic diseases and provided a range of healthcare support and advice. This pro-active service ensured that patients who were unable to attend the service had their health monitored and good health promoted, for example by the provision of the flu vaccine.

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. The practice had a current development plan to improve the services offered. The practice also worked with the local CCG to promote better patient care across healthcare services. For example, they had made a proposal to the CCG to allocate district nursing services within the practice which would better facilitate the monitoring of patient care and communication between healthcare professionals.

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 health care support. 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.

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 had a palliative care register and had monthly

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.

The practice offered patients a chaperone prior to any examination or procedure. Staff we spoke with said they had received sufficient guidance around carrying out this role. The practice manager said that a clinical member of staff provided guidance to staff around being a chaperone and that more formal training was being looked into.

A Patient Reference Group (PRG) had been established since 2011 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 the website, reorganising afternoon appointments and the development of a practice notice board.

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.

7.7% of the practice population identified themselves as non English speakers. Staff were knowledgeable about interpreter services for patients where English was their second language. Information about interpreting services was available in the waiting area. We noted that this information may not be immediately visible and accessible to patients given the small size of the sign, where it was located and that it was written in English.

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.



Are services responsive to people's needs?

(for example, to feedback?)

The practice was sensitive to patients religious and cultural needs. For example, tests that require fasting had been offered to Muslim patients during Ramadan.

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.

Staff spoken with indicated they had received training around equality, diversity and human rights.

Access to the service

Patients were able to make appointments in person, telephone and on-line. Pre-bookable appointments could be made two weeks in advance. Appointments could be booked on the day or for the next working day. To manage urgent appointments, every working day one of the GPs offered telephone consultations and from this determined if an urgent appointment at the practice was needed.

Home visits were made to patients who were housebound or too ill to attend the practice. The practice information leaflet and website provided information to patients about making appointments and about where to access GP services when the practice was closed. Out of hours medical assistance was provided by Urgent Care 24.

The appointment system was monitored to ensure that any issues around access to appointments were identified. The patient information leaflet and website reminded patients of the importance of cancelling an appointment so that the appointment could be offered to another patient. When a patient did not attend an appointment this was followed up with a telephone call and a letter to reiterate the importance of cancelling the appointment.

The National GP survey results published in 2013 showed that patients were overall happy with access to the service.

98.3% were satisfied with opening hours, 94.8% rated their ability to get through on the telephone easy or very easy and 96.3% rated their experience of making an appointment as good or very good. These responses placed the practice amongst the best GP practices nationally.

We looked at 28 CQC comment cards that patients had completed prior to the inspection. A number of the comments indicated that patients were happy with the system for booking appointments and that they could get an appointment when one was needed. We spoke with four patients on the day of the inspection who said it was easy to make an appointment and they were able to get appointment when they needed one. They said they were satisfied with arrangements for repeat prescriptions and that if a referral to another service was needed this had been done in a timely manner.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

We looked at the record of complaints and found three complaints had been made over the last four years. We saw documentation to record the details of the concerns raised and the action taken. 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 reference was made to the policy 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 Health Watch 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 any complaints were discussed at practice meetings. Training was provided to staff around the management of complaints.

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 central aspiration of the GP partners was to run the practice how they would like their own practice to be run. The aims and objectives of the practice included treating patients with dignity and respect. Providing high quality, effective patient care, supporting patients to take an active role in their care and to work effectively with other agencies to ensure care is coordinated, therefore providing, safe, timely and cost effective care.

The aims and objectives of the practice were not clearly publicised at the practice or evident on the practice website. 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. The patients we spoke with told us that the practice was achieving its objectives.

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 a paper format. The practice manager had recently reviewed a number of policies and procedures and all policies and procedures we looked at were up to date. 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 QOF data for this practice showed it was performing in line with and exceeded national standards in a number of areas. The GPs spoken with told us that QOF data was regularly discussed 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.

The practice had completed clinical audits to evaluate the operation of the service and the care and treatment given. Examples of clinical audits seen included BMI (body mass index) checks for patients prescribed oral contraceptives and prescribing of statins (medication to reduce cholesterol).

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. Staff told us and minutes from clinical meetings indicated that the outcome of significant incidents and how they were to be learned from were discussed.

Leadership, openness and transparency

There was a clear leadership structure in place which had named members of staff in lead roles. For example, the practice manager was the lead for information governance and two of the GPs were the leads for safeguarding and clinical governance. We spoke with eight 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 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. They said that the last practice meeting had taken place in September 2014 and that prior to this they had not been held on a regular basis. The practice manager was addressing this to ensure regular practice meetings, involving all staff. Since their appointment the practice manager had introduced administration staff meetings which they said had been useful for addressing issues relating to the administration and reception roles.

Records showed that the GPs and nurses at the practice met together to discuss a range of clinical issues. We were shown the minutes of the meetings for the last two months. Clinical staff spoken with found these meetings a good source of support and a forum to raise any issues of concern.

The practice manager had been in post for three months and had reviewed a number of the policies and procedures that were available for staff to refer to. This included human resource policies and procedures. We reviewed a sample of these policies, for example, the disciplinary, induction and whistle blowing procedures. 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, monitor performance and implement new methods of

Are services well-led?

Good 

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

working to meet the needs of local people. GPs attended prescribing and medicines management and shared information within the practice. Multi-disciplinary meetings also took place to support the needs of patients.

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 and through the complaint procedure. We looked at the results of the last patient survey undertaken by the practice in February 2014. Ninety eight surveys were completed and the results showed that patients were happy with the system to book appointments, their overall experience of the practice and GP and nurse consultations.

We were shown a sample of recent GP appraisals which contained feedback from patients. Patients commented that the GPs treated them with respect, listened to their concerns and were good at explaining tests and treatments.

A Patient Reference Group (PRG) had been established since 2011 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. We saw that information about the PRG meetings, survey results and the action plan were available on the practice website. Surveys sent by the practice were agreed with the PRG prior to distribution. The results 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, improving the website, reorganising afternoon appointments and the development of a practice notice board. We met with a member of the PRG who told us they met two-three times a year and they felt listened to and improvements had been made to the practice as a result of

their suggestions. For example, administrative staff now wore a uniform to distinguish them from staff who worked for the other practices within the building. They said that new services and improvements were also discussed and the views of the PRG obtained.

We found that information about the PRG was not displayed in the waiting area to advertise the PRG, encourage new members and demonstrate the actions taken to improve the practice as a result of patients feedback.

Staff told us they felt able to give their views at practice meetings. 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 three staff that showed that appraisals took place which included a personal development plan. Appraisals had recently been re-introduced for administrative staff and they had been given a date for an appraisal which would be undertaken within the next month. Staff told us that the practice was very supportive of training and that when a training need had been suggested action was taken to address this.

The practice manager monitored staff training to ensure essential training was completed each year. They were developing their training records to give a better overall view of training received and training needed.

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

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Patients were not protected against the risks associated with unsuitable staff because the provider did not ensure that information specified in Schedule 3 was available for all staff employed. Regulation 21(a), (b) and (c)
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	