Park House Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Park House Surgery on 30 November 2016. Overall the practice is rated as good.

- A system was in place for reporting and recording significant events, keeping these under review and sharing learning where this occurred.
- Risks to patients were assessed and well managed.
- Systems were in place to deal with medical emergencies and all staff were trained in basic life support.
- There were arrangements in place to safeguard adults and children from abuse that reflect relevant legislation and local requirements. Staff understood their responsibilities and adhered to safeguarding policies and procedures. However safeguarding meetings with other health professionals was not taking place.
- The standard of cleanliness and hygiene was good. Reliable systems were in place to prevent and protect people from a healthcare associated infection. These systems were monitored with regular infection control audits.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling was safe but the storage of prescription pads required improving.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Feedback from patients about their care was consistently positive. We saw good communication with patients from staff so that they understood their care, treatment and condition.
- Information about services and how to complain was available and easy to understand. We found openness and transparency about how complaints and concerns

Summary of findings

were dealt with. Lessons were learned from concerns and complaints, and appropriate action taken as a result to improve the quality of care. These lessons were shared with all staff.

- Patient's feedback for the new triage appointment system was mixed. Some reported concerns that this system was not always convenient and others stated they were happy to consult with the GP via telephone rather than a face to face appointment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken.
- While the practice had experienced a shortage of GPs the review of management systems had not been undertaken regularly. At the time of the inspection the practice was in the process of developing and implementing an assurance system and service performance measures, which we were informed, would be reported and monitored to improve performance.

There were also areas of practice where the provider should make improvements. The provider should:

- Improve the care plans in place for patients with complex health needs, who are at high risk of avoidable unplanned hospital admissions.
- The security of prescriptions should be reviewed as some were left in printers in rooms which were not locked.
- Encourage an interagency approach to safeguarding patients including regular communications and safeguarding meetings.
- Review the records made of the monthly multi-disciplinary meetings to ensure sufficient detail is made.
- Review the GP patient survey results that showed 43% of patients found it easy to get through to this practice by phone compared to the CCG average of 65% and the national average of 72%.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Staff learnt from significant events and this learning was shared across the practice. Staff were aware of their responsibilities to ensure patients received reasonable support, truthful information, and a written apology when things went wrong. The practice had systems, processes and practices in place to keep people safe and safeguarded them from abuse, however regular safeguarding meetings were not taking place. Risks were assessed and managed. For example, safety alerts were well managed and health and safety related checks were carried out on the premises and on equipment on a regular basis.

Procedures were in place to ensure appropriate standards of hygiene were maintained and to prevent the spread of infection. We looked at a sample of staff recruitment records and found that appropriate pre-employment checks had been carried out to ensure staff suitability. Systems for managing medicines were effective overall, however the storage of prescription pads required improvement. The practice was equipped with a supply of medicines to support people in a medical emergency.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence to confirm that the practice used these guidelines to positively influence and improve practice and outcomes for patients. Data showed that the practice was performing highly when compared to practices nationally. Audits of clinical practice were undertaken and widely discussed. The practice demonstrated how they ensured role-specific training and updating for relevant staff. We found that patients were signposted to the relevant service. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening and had achieved high results for performance.

Are services caring?

Good

The practice is rated as good for providing caring services. We saw staff treated patients with kindness and respect. Patients spoken with and those who returned comment cards were extremely positive about the care they received from the practice. They

Summary of findings

commented that they were treated with respect and dignity and that staff were caring, supportive and helpful. Results from the National GP Patient Survey showed patients felt they were treated with compassion, dignity and respect. Patients felt involved in planning and making decisions about their care and treatment.

Are services responsive to people's needs?

Good

The practice is rated good for providing responsive services. The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Services were planned and delivered to take into account the needs of different patient groups. Access to the service was monitored to ensure it met the needs of patients. The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. A range of appointments were available for patients.

Are services well-led?

Good

The practice is rated as good for being well-led. Staff were clear about the vision and their responsibilities in relation to it. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken. The practice proactively sought feedback from staff and patients, which it acted on. The practice had an active Patient Participation Group (PPG) and responded to feedback from patients about suggestions for service improvements. A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care. There was a strong focus on continuous learning and improvement at all levels.

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 offered proactive, personalised care and treatment to meet the needs of the older people in its population. The practice had a higher than average number of older people in its population. Up to date registers of patients with a range of health conditions (including conditions common in older people) were maintained and these were used to plan reviews of health care and to offer services such as vaccinations for flu. Nationally reported data showed that outcomes for patients for conditions commonly found in older people were similar to or in some cases better than local and national averages. General Practitioners and practice nurses carried out regular visits to local care homes to assess and review patients' needs and to prevent unplanned hospital admissions. Monthly multi-disciplinary meetings were held to discuss the care and treatment for patients with complex needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice held information about the prevalence of specific long term conditions within its patient population. This included conditions such as diabetes, chronic obstructive pulmonary disease (COPD), cardio vascular disease and hypertension. The information was used to target service provision, for example to ensure patients who required regular checks received these. Practice nurses held dedicated lead roles for chronic disease management. The practice employed a full time pharmacist also. As part of this they provided regular, structured reviews of patients' health. Data from 2014 to 2015 showed that the practice was performing in comparison with other practices nationally for the care and treatment of people with chronic health conditions such as diabetes. The practice held regular multi-disciplinary meetings to discuss patients with complex needs and patients receiving end of life care. Longer appointments and home visits were available for patients with long term conditions when these were required. Patients with multiple long term conditions were offered a single appointment to avoid multiple visits to the surgery.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Child health surveillance and immunisation clinics were provided. The practice had a reminder system for parents who did not bring children and babies for immunisation, sending these

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letters out whenever possible. Appointments for young children were prioritised. Staff were aware of safeguarding matters related to children but the practice did We found the practice did not have regular safeguarding meetings with all professionals to discuss patients at risks and any developments to this. The staff we spoke with had appropriate knowledge about child protection and how to report any concerns. The practice provided a comprehensive and confidential sexual health and contraceptive service delivering the full range of contraceptive services.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice had an active website as well as noticeboards in reception advertising services to patients.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances in order to provide the services patients required. For example, a register of people who had a learning disability was maintained to ensure patients were provided with an annual health check and to ensure longer appointments were provided for patients who required these. The practice worked with relevant health and social care professionals in the case management of vulnerable people. The practice referred patients to local health and social care services for support, such as drug and alcohol services. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. Information and advice was available about how patients could access a range of support groups and voluntary organisations.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated good for the care of people experiencing poor mental health (including people with dementia). The practice maintained a register of patients receiving support with their mental health. These patients were mostly known by reception staff and we

saw they would call patients to remind them an appointment had been booked for them. Patients experiencing poor mental health were offered an annual review. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice referred patients to appropriate services such as psychiatry and counselling services. The practice had information in the waiting areas about services available for patients with poor mental health. For example, services for patients who may experience depression.

Summary of findings

What people who use the service say

Data from the National GP Patient Survey July 2016 (data collected from July-September 2015 and January-March 2016) showed that the practice was performing in line with local and national averages. The practice distributed 270 forms, 109 were returned which represents approximately 1% of the total practice patient population. Results showed that;

- 43% of patients found it easy to get through to this practice by phone compared to the CCG average of 65% and the national average of 72%.
- 61% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 75%.
- 88% of patients described the overall experience of this GP practice as good compared to the national average of 85%.

The practice was aware of the poor results for getting through on the telephone. This had been discussed with the Patient Participation Group and it was agreed that a new telephone line was to be added to the system. This had been completed at the time of inspection.

All of the 20 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. They also told us they were extremely happy with how caring the practice had been and how their dignity and privacy had always been respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required. Negative comments made by patients related to the new GP appointment system and waiting times when visiting the practice

Areas for improvement

Action the service SHOULD take to improve

- Improve the care plans in place for patients with complex health needs, who are at high risk of avoidable unplanned hospital admissions.
- The security of prescriptions should be reviewed as some were left in printers in rooms which were not locked.
- Encourage an interagency approach to safeguarding patients including regular communications and safeguarding meetings.
- Review the records made of the monthly multi-disciplinary meetings to ensure sufficient detail is made.
- Review the GP patient survey results that showed 43% of patients found it easy to get through to this practice by phone compared to the CCG average of 65% and the national average of 72%.

Park House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team also included a GP specialist adviser and a practice manager specialist advisor.

Background to Park House Surgery

Park House Surgery is responsible for providing primary care services to approximately 7295 patients. The practice has a General Medical Services (GMS) contract and offers a range of enhanced services such as flu and shingles vaccinations and timely diagnosis of dementia. The number of patients with a long standing health condition is higher at 65.2% when compared to other practices locally and nationally. The practice has one GP partner at the time of inspection, a number two practice nurse, health care assistant, administration and reception staff and a practice manager. At the time of inspection the practice had applied to CQC to register a number of other GP partners as part of a merger with a neighbouring practice.

The practice is open from 8am to 6.30pm Monday to Friday. Patients can book appointments in person, via the telephone or online. The practice provides telephone consultations, pre-bookable consultations, urgent consultations and home visits. The practice treats patients of all ages and provides a range of primary medical services. Home visits and telephone consultations are available for patients who require them, including housebound patients and older patients.

The practice treats patients of all ages and provides a range of medical services. This includes disease management such as asthma, diabetes and heart disease. Other appointments are available for maternity care, mental health and travel vaccinations.

The practice does not provide an out-of-hours service but has alternative arrangements in place for patients to be seen when the practice is closed. For example, if patients call the practice when it is closed, an answerphone message gives the telephone number they should ring depending on the circumstances. Information on the out-of-hours service is available on the practice's website and in the patient practice leaflet.

The practice is part of the St Helens Clinical Commissioning Group. The practice is located in a very deprived area of the borough area where people experience high levels of unemployment (12.% compared to 5.4% nationally) and a high number of the population (65% compared to 54% nationally) who are living with a long-standing health condition.

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 30 November 2016.

During our visit we:

- Spoke with a range of staff.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system which was completed by staff. A form was completed for each incident and reviewed by the lead GP. We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again. Staff gave us examples where they had reported incidents and the process that had been followed to ensure learning was shared. They confirmed that findings were discussed at three monthly significant event meetings (or sooner if required). Discussions with GPs confirmed their awareness and requirement to escalate incidents nationally, with clear guidance in place for all staff to follow. The practice carried out an annual analysis of the significant events and regular meetings were held to share this information with staff.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings incidents that had occurred were discussed. We tracked some of the systems to check that actions had been taken when safety alerts had been sent to the practice, we found that all required actions had been completed. These included when patients had reported a complaint to the practice. We found other examples where the significant event process had been followed and events had been investigated with appropriate actions taken to reduce the same incidents occurring again.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. We found the practice did not have regular safeguarding meetings with all professionals to discuss patients at risks and any developments to this. Staff we spoke with demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. Patient alerts were reported on the practice computer system and this included children who were identified as having a lower level of concern by the practice. The practice routinely following up children who did not attend for their practice appointment. We saw that staff took action when safe guarding concerns had been raised. Most of, but not all clinical staff had been trained to child protection or child safeguarding level three and administration staff to level two. Following inspection information was sent to us to show this level three training had now been completed.
- A notice was in place in each consultation room advising patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There were infection control procedures and protocol in place that had recently been reviewed by the nurse and staff had received up to date training. Bi-annual external infection control audits were undertaken and regular hand hygiene audits were undertaken by the nurse. Appropriate actions had been taken where improvements to infection control arrangements had been identified.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). The practice employed a full time pharmacist who provided support and reviews for staff and the patient population. In addition the practice had recently gained support from one of the senior GPs who was about to become a partner. Each Monday patient reviews were

undertaken and this included monitoring the processes for handling repeat prescriptions, including the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.

- Regular meetings were held also with the team to ensure safe and effective prescribing, as a result of this the practice the practice was aware of all the prescribing targets and were closely monitoring this for improvements. A recording was made of the receipt and allocation of prescriptions. However, the security of prescriptions should be reviewed as some were left in printers in rooms which were not locked.Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. We found that minimum, maximum and actual temperatures of the medicines fridge were recorded daily.
- We reviewed four personnel files and found satisfactory information relating to, for example, qualifications and registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. One of the files however did not show a DBS for a new member of staff who was on a probation period. We discussed this with the practice to identify the risks this posed to patients. Confirmation was received after the inspection that a new DBS had been applied for this member of staff.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Detailed rotas were in place for each staffing group to show that enough cover was in place each day. Staff told us they worked flexibly covering for each other when they were on leave or when staff were unexpectedly on sick leave.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the reception area.
- The practice had a defibrillator available on the premises and oxygen with adult masks but no children's masks. We were later informed the practice was to review the equipment for children in greater detail and arrangements had been put into place to access this equipment from another practice in the same building until new paediatric pads were delivered.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice did not however have daily or weekly clinical meetings to keep all clinical staff up to date due to the lack of GPs available for the previous 12 months. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. During our inspection we tracked a number of recent NICE guidelines and patient safety alerts to ensure appropriate actions had been taken and we found that the required changes to patient care and experience for example prescribing, had been changed.

Management, monitoring and improving outcomes for people

Patients care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation and this was closely monitored by the GPs. This included during assessment, diagnosis, when people were referred to other services and when managing chronic or long-term conditions, including for people in the last 12 months of their life. Patients had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing. The expected outcomes were identified and care and treatment was regularly reviewed and updated. Information about patient care and treatment, and their outcomes, was routinely collected and monitored.

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients, (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results in October 2016 (for the period April 2015 – March 2016) showed the practice had achieved 99.5% of the total number of points available (this was higher than the CCG and national averages). Exception reporting was 13.2% for the clinical domain and above the local CCG and national average. Systems were in place for the practice to monitor QOF performance.

This practice was not an outlier for any QOF but our information showed that performance for the prescribing of non-steroidal anti-inflammatory drugs required improving. The practice was aware of this and had taken actions to improve these clinical targets. Other data showed:

- Performance for diabetes related indicators was similar to or lower than the local and national average. For example the percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 68% compared to 82% across the CCG and 88% nationally. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less was 78% compared to 81% across the CCG and 78% nationally.
- Performance for mental health related indicators was above or comparable to the national and local averages. For example, 91% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2014 to 31/03/2015), compared to the CCG average of 92% and national average of 88%. The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months (01/04/2014 to 31/03/2015) was 81% compared to 85% across the CCG and 84% nationally.

Information about outcomes for patients was used to make improvements. We looked at the processes in place for clinical audit. Clinical audit is a way to find out if the care and treatment being provided is in line with best practice and it enables providers to know if the service is doing well and where they could make improvements. The aim is to promote improvements to the quality of outcomes for patients. There were two full cycle audits that had been carried out. This included an audit to improve the management of patients with atrial fibrillation in reducing the risk of the development of a stroke. Another audit was undertaken in response to a medicines safety alert relating to the use of proton pump inhibitors for the treatment of dyspepsia. The practice undertook a patient search on their web system, contacted patients by letter inviting them in

Good

Are services effective?

(for example, treatment is effective)

for a review with their GP, during which time any changes to medications were discussed with patients and benefits explained. The findings were used by the practice to improve services.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety, infection control, bullying and harassment and complaints.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. This included ongoing support during sessions, clinical supervision and facilitation. All staff had received an appraisal within the last 12 months, while GPs had completed appraisals through NHS England. The nursing team received additional supervision from the provider's lead nurse.
- Staff received appropriate training to meet their learning needs and to cover the scope of their work. They had access to and made use of e-learning training modules to complete training in safeguarding, fire procedures, basic life support, information governance, dignity and respect, and confidentiality. In-house training, external training events, seminars and conferences were also available.
- Nursing staff told us they had completed training specific to their roles including management of long term conditions such as high blood pressure, diabetes and lung diseases. Records confirmed this.
- Staff who administered vaccines stayed up to date with changes to the immunisation programmes by accessing online resources and engaging in discussion at clinical meetings.
- Protected learning time was provided for all staff so they could maintain their training and development.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff through the practice's patient record system and their intranet system. This included assessments, care plans, medical records and test results. We noted that some care plans were brief in detail and required improvement. All paper and electronic records relating to people's care was well managed. Staff could easily access the information they needed to assess, plan and deliver care to patients in a timely way. This included information being shared between day time general practice and GP out-of-hours services. When different care records systems were in place for different teams and services, these were coordinated as much as possible.

Monthly meetings were encouraged with other healthcare professionals to discuss the on-going needs of patients with long term conditions and those at risk of hospital admissions. The records made of these meetings were brief however. Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan on-going care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information such as NHS patient information leaflets was also available. There were systems in place to ensure relevant information was shared with other services in a timely way, for example when people were referred to other services and the out of hours services.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example, patients receiving end of life

Good

Are services effective?

(for example, treatment is effective)

care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. We saw that patients were signposted to the relevant service.

The practice's uptake for the cervical screening programme was 95%, which was higher than the CCG average of 83% and the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test also. There were systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening and had achieved high results for performance. For example, females, 50-70, screened for breast cancer in last 36 months was just lower when compared to other practices across the CCG (practice was 66%, CCG was 74%, national was 72%). Childhood immunisation rates for the vaccinations given were good when compared to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 85% to 100% and five year olds ranged from 96% to 97%. The practice was aware of their performance and were taking action to try to improve uptake.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed throughout the inspection that members of staff were courteous and helpful to patients both attending at the reception desk and on the telephone. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations to promote privacy. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. Staff we spoke with recognised the diversity, values and human rights of patients that attended the practice and good examples were shared with us for how they had shown caring and compassionate care to patients and their families.

All of the 20 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. They also told us they were extremely happy with how caring the practice had been and how their dignity and privacy had always been respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required. Negative comments made by patients related to the new GP appointment system and waiting times when visiting the practice.

Results from the National GP Patient Survey showed patients felt they were treated with compassion, dignity and respect. Results were similar to local and national averages, for example:

- 90% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 89% and the national average of 88%.
- 82% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 86%.
- 95% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 92% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 95%.
- 88% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 90%.
- 80% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 86%.

Care planning and involvement in decisions about care and treatment

We looked at a number of patient care plans for example end of life care plans however, those that were in place to avoid hospital admissions for patient who were vulnerable and at risk were brief in detail and required improvements. Other care plans were reviewed also for patients with long term conditions. We considered these to be thorough and effective and each were being closely monitored by the GPs at the practice.

Results from the National GP Patient Survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were similar to local and national averages and these aligned with the comments made in our cards. For example:

- 84% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and the national average of 86%.
- 77% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 81%.
- 87% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care. For example, there were translation and interpreting services available.

Patient and carer support to cope emotionally with care and treatment

Good

Are services caring?

Patient information leaflets and notices were available in the patient waiting area and in the GP consulting rooms, which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. This information was used to support carers and direct them to appropriate resources. Written information was available to direct carers to the various avenues of support available to them. We found that clinical staff referred patients on to counselling services for emotional support, for example, following bereavement. The practice told us that cards and letters were often written to families when bereavement had been experienced.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local Clinical Commissioning Group (CCG) to improve outcomes for patients in the area. For example**,** the practice offered a range of enhanced services such as flu and shingles vaccinations, and the timely diagnosis of dementia. Throughout the year the practice undertook a number of searches to target individual patient groups with a view to addressing specific needs. For example, the pharmacist employed at the practice regularly ran a programme of reviews for patients aged 75 years and older, as a result of this many of this patient group had a medication review.

The practice was responsive in terms of seeking and acting upon patients views. We saw in reception there were publicised comments forms and a box for patients and public to contribute views. The practice had completed an action plan for the less positive results for the National GP Survey and they had met with the practice PPG to discuss the results. Actions where they had agreed to improve were, to review the number of telephone lines coming into the practice due to negative comments made by patient about how difficult it had been getting through on the telephone.

We were told that patient experience feedback was discussed at staff meetings and appropriate actions taken. Other examples of how the practice responded to meeting patients' needs were as follows:

- Same day appointments were available for children and those with serious medical conditions. Longer appointments were available for patients with specific needs or long term conditions such as patients with a learning disability.
- There were longer appointments available for patients who needed them, for example, for patients with a learning disability.
- There was also an online service which allowed patients to order repeat prescriptions, book appointments and access medical records.
- There was an automated booking-in system in the reception area for patients to record their arrival for their appointments.
- Home visits were available for patients who were too ill to attend the practice for appointments. Routine home visits were carried out by GPs for housebound patients to monitor their health and care needs.
- The practice treated patients of all ages and provided a range of medical services. This included a number of disease management clinics such as asthma and heart disease.
- All patients had a named GP.
- Annual reviews were carried out with patients who had long term conditions such as diabetes; lung diseases; for patients with learning disabilities; and for those patients who had mental health problems including dementia. We saw anonymised records to confirm this.
- Translation services were available for patients.
- The practice referred patients who were over 18 and with long term health conditions to a well-being co-ordinator for support with social issues that were having a detrimental impact upon their lives.

Access to the service

The practice was open from 8am to 6.30pm Monday to Friday. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them. The practice had a mix of male and female clinicians.

The practice operated a GP triage system for appointments. We found that patients telephoning who requested a GP appointment were asked to confirm their telephone number. The number was passed to the on call GP who then telephoned the patients back at a later time that morning to discuss the problems with them. We heard that in many cases it was hoped that the matter would be resolved on the telephone without the need for the patient to visit the surgery. In those instances where the patient and doctor agree that an appointment was necessary, the practice aimed for this to be made later on the same day. At the time of inspection this new system had yet to be evaluated. The patients we spoke with had mixed feelings for the effectiveness of the new system, some believing it suited their life style and others commenting on having to wait long periods of time for a call back and sometimes this came at an inconvenient time.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Results from the National GP Patient Survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages apart from being able to get through easily on the telephone. Results were;

- 82% of patients were satisfied with the practice's opening hours compared to the national average of 79%.
- 43% of patients said they could get through easily to the practice by phone compared to the national average of 72%.
- 93% of patients said the last appointment they got was convenient compared to the CCG average of 92% and the national average of 91%
- 62% feel they don't normally have to wait too long to be seen compared to the CCG average of 59% and the national average of 57%

The practice had a system in place to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. These assessments were done again by the telephone triage system. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns. A complaints policy and procedures was in place. We saw that information was available to help patients understand the complaints procedure and how they could expect their complaint to be dealt with. The information on the practice's website informed patients of their right to make a complaint directly to NHS England if the so wished and that the second stage of a complaint managed locally was to refer to the Parliamentary and Health Service Ombudsman.

We looked at complaints received in the last 12 months and found that these had been logged, investigated and responded to in a timely manner and patients had been provided with a thorough explanation and an apology when this was appropriate. Complaints were discussed at practice meetings and an annual review of complaints was carried out. We found that lessons had been learnt from the sample of complaints we looked at and action had been taken to improve the quality of care and patients' experience of the service.

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

At the time of inspection the practice was near completion of a GP partner merger with a neighbouring practice in St Helens. We were told that for the previous 12 months there had seen a number of GP partners leaving the practice and with the difficulties of recruiting a new GP partner, this meant the practice was led by one GP partner only. Across the year support for GP cover had been given by the practice soon to merge with Park House Surgery. As part of the new merger the practice developed a new business plan which included how they intended to deliver high quality care and promote good outcomes for patients. The practice did not have a formal mission statement but all staff shared the same ethos to provide patient centred care to all patients across their community.

The GP partners had knowledge of and incorporated local and national objectives. They worked alongside commissioners and partner agencies to improve and develop the primary care provided to patients in the locality.

Governance arrangements

The practice had appropriate systems in place for gathering, recording and evaluating accurate information about the quality and safety of care, treatment and support they provided and the outcomes. The practice did not have an overarching governance framework which supported the delivery of the strategy and good quality care but we were told that this would be developed as part of the arrangements with the merger of the new practice. a number of structures and procedures were in place and at the time of inspection these were under review as part of the merger. We found the following:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. There were clear systems to enable staff to report any issues and concerns.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- The GPs used evidence based guidance in their clinical work with patients. The GPs had a clear understanding of the performance of the practice. The practice used the Quality and Outcomes Framework (QOF) and other performance indicators to measure their performance. The QOF data showed that the practice achieved results comparable to other practices locally and nationally for the indicators measured.
- A programme of clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- The GPs had been supported to meet their professional development needs for revalidation (GPs are appraised annually and every five years they undergo a process called revalidation whereby their licence to practice is renewed. This allows them to continue to practise and remain on the National Performers List held by NHS England).

Information was gathered about the safety and quality of their services from a number of sources as follows:

- Feedback from patients
- Adverse incident monitoring
- Comments and complaints made by patients and members of the public
- Use of information from national and local clinical sources

Leadership and culture

Meetings took place on a monthly basis to share information, to look at what was working well and where any improvements needed to be made. The practice closed one afternoon per month which allowed for learning events and practice meetings. Clinical meetings were not in place to demonstrate that GPs and nurses formally met to discuss clinical issues such as new protocols or to review complex patient needs. We were told that clinical meetings were to be introduced on a weekly basis and these would also include the practice nurses and advanced nurse practitioners working at the practice. Plans were in place to

Are services well-led?

Good

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

reintroduce full practice team meetings. Bi- monthly meetings had recently been developed with all staff to discuss significant events and complaints and how they had been managed.

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 or as they occurred with the practice manager, registered manager or a GP partner. Staff said they felt respected, valued and supported. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. The practice had policies in place to ensure there was a confidential way for staff to raise concerns about risks to patients, poor service and adverse incidents. A Whistle Blowing policy was in place and staff said they would use this without fear of recrimination.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The GPs encouraged a culture of openness and honesty.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. The practice had a proactive Patient Participation Group (PPG) and we met with four of its members who spoke positively about the management team.

At the time of inspection the practice was reviewing the leadership structure in place and we found that staff were now well supported by management. The practice had recently reinstated regular all staff team meetings and business meetings. There was an evident open culture within the practice and staff had the opportunity to raise any issues at appraisals and meetings. Staff were respected, valued and supported, particularly by the partners and management in the practice. Some staff had worked at the practice for long periods of time with a low staff turnover rate. We were told that the development of staff was supported by the management team. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We found that mandatory training was undertaken and monitored to ensure staff were equipped with the knowledge and skills needed for their specific individual roles.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. Clinicians kept up to date by attending various courses and events. The lead GP was involved with the local CCG and the practice participated in local pilots. A business development plan was in place which covered the future aims and objectives of the practice in relation to patient services, clinical care, the premises, staffing and finances. The plan detailed future aspirations and how they intended to achieve these.