Parkfield Medical Centre - EM Hawthornthwaite

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?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Parkfield Medical Centre. Our inspection was a planned comprehensive inspection which took place on 8 January 2015.

The service provided by Parkfield Medical Centre is rated as requires improvement. We found care and treatment delivered to patients was safe, caring and responsive to patients' needs. We found some improvements were required to make services more effective and to embed leadership.

Our key findings were as follows:

- Care and treatment delivered by the practice was safe. Clear systems and procedures to protect and maintain patient safety were in place at the practice.
- Safeguarding protocols were adhered to. Practice staff researched and checked information for accuracy. Updated information was accessible to all clinicians, including GPs on training placement with the practice.
- The practice staff were caring and considerate towards patients. Practice staff recognised the importance of patient confidentiality and treated patients with dignity and respect.
- The practice was responsive to patients' needs. Services delivered by the practice met the needs of the various population groups and access to appointments was good.

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

- Staff training, supervision and appraisal should be timely and must be in place for all staff

Importantly, the provider must:

- Ensure that all staff employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard. This

Summary of findings

includes opportunities for all staff to receive appropriate training, professional development, supervision and appraisal, and audit of the work of practice nurses.

In addition the provider should:

- Have effective systems to regularly assess and monitor the quality of the services provided.

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. We saw that the practice followed national best practice guidance in relation to treatment of patients and that prescribing protocols were followed. The practice had systems in place to safeguard children and vulnerable adults and all staff demonstrated their knowledge of these systems. Infection control policies and procedures were in place and regular checks to ensure standards were observed and maintained were in place. A comprehensive schedule of health and safety checks in relation to the premises was in place. We saw that equipment used by GPs and nurses was subject to regular maintenance checks to ensure its safety for use.

Are services effective?

Requires improvement

The practice is rated as requiring improvement for providing effective care and treatment. The practice showed us two examples of clinical audit but these were incomplete, which meant conclusions as to the outcomes for patients could not be drawn and discussed at practice meetings. The practice had identified all vulnerable patients and those over 75 years old. Each patient had a care plan in place, with details of a named GP. Arrangements in place for staff training required improvement; we noted some staff training required updating and refreshing, but this had yet to be organised. Staff appraisal and performance review required improvement; the practice managers had not had an annual appraisal recently, despite additional duties being added to their role during a period of significant change for the practice. There were no arrangements in place for appraisal of the nurse prescriber at the practice, or peer review or audit of the work carried out by the nurse prescriber. The practice had a lower than expected uptake of cytology screening, but no effective plan to address this had been put in place.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients commented that they were always listened to and that GPs and nursing staff gave them sufficient time within a consultation to discuss their health conditions.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice delivered patient led disease management clinics which accommodated those patients who would not be able to commit to

Summary of findings

attending a clinic at a specific time or date. We saw that the practice responded immediately to any patient complaints about waiting times in the reception area, informing patients when a GP was running behind with scheduled appointments.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had recently become a training practice. The partners had contributed significantly to the support of two GP registrars placed with the practice. Succession planning since the retirement of two partners was in place and clear lines of accountability were in place and working on a day to day basis.

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 care of older patients. Patients who were vulnerable to unplanned hospital admission had been identified. Each patient had details of their named GP and a copy of their care plan. Older patients we spoke to told us they had good access to their named GP and that the practice was responsive to their needs.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for treatment of patients with long term conditions. Clinical audit and benchmarking of patients treatment over time, required some improvement. Demand led clinics for treatment of patients with long term conditions such as asthma and COPD were in place. Data we reviewed before our inspection showed that the rate of diagnosis of patients with respiratory illnesses had increased in the past 12 months. The practice partners confirmed that 98% of those patients diagnosed with respiratory conditions were subject to spirometry testing. Evidence of clinical audit or review of patients, was in place. However, these audit cycles had not been completed to see if treatments provided by clinicians delivered the expected results for patients.

We saw that patients had good access to the practice nurse for help in management of their conditions and up to date registers were kept of those patients with long term conditions.

Families, children and young people

Good

The practice is rated as good for the services provided to families, children and young people. Patients we spoke with from this population group commented that access to GP and nurse appointments was good, and met their needs, especially for those patients who were in full time education. This mirrored the high score achieved in the last NHS England GP Patient Survey, where 96.8% of patients said they were satisfied with the practice opening hours, compared with 79.8% of patients nationally who were satisfied with opening hours of their GP practice.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for services provided to working age patients and those recently retired. We found lower

than average levels of uptake of cytology screening. No effective system to follow up patients who had failed to attend for screening had been put in place and this issue was not highlighted by leaders as being significant.

The practice offered extended hours services between 6.00pm and 8.00pm, Monday to Thursday each week. Responses to questions about patient access, asked of all patients attending practices across the Wirral, showed that Parkfield Medical Centre recorded the highest score in this area, with 96% of patients saying they were satisfied with opening hours of their practice.

We noted that one of the partners worked with patients who had been off work for extended periods of time, to support them in returning to work.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for services provided to patients whose circumstances may make them vulnerable. The practice did not use a telephone triage system when assessing whether a patient needed to see a GP. Practice managers recognised that this helped to capture more vulnerable patients who may otherwise be deterred from visiting the practice. The practice shared a building with a minor injuries unit. Patients who were homeless or those with more unsettled lifestyles who were seen at the minor injuries unit were often referred to GPs at the practice for treatment. The practice rarely turned any of these patients away.

We were told that the practice had patients on their register who did not speak English as a first language. Staff had access to interpreting services and information leaflets in a number of different formats, to enable patients to communicate their health care needs.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated good for providing services for patients experiencing poor mental health including dementia. The practice showed us work that they had recently started on identifying patients who may have previously complained of some forgetfulness, but had not had sufficient follow up activity. These patients were being invited to attend the practice to be re-assessed and in some cases, to carry out mental capacity assessments. This meant those patients who required further tests could be referred to a memory clinic, and/or receive treatment and regular follow-up that helped manage their condition. One of the GP's had a particular interest in this area of clinical practice.

Summary of findings

What people who use the service say

On the day of our inspection, we collected 25 completed CQC comment cards. These documented positive comments about the GPs, nurses and staff. Some patients commented that they could be kept waiting for a long time to see the GP – i.e. past the time of their appointment, but commented that when they saw the GP they were very happy with the care and treatment they had received.

When we asked some patients about their care and treatment, they confirmed they had a named GP. Older patients told us they had good access to their GP and that the practice responded well to their needs.

We spoke to some patients with family members who were all registered with the practice. We were told that nurses led clinics for patients with long term conditions such as asthma. We were told that access to nurses was good and that patients had not experienced any problems making appointments with the nurse. Patients who were parents commented that they could book appointments on-line and valued this service. A patient who was a parent commented that they had left their previous practice to register with Parkfield Medical Centre as the services had been recommended to them by friends.

Results of a patient access survey, collated by the NHS England area team, showed the practice scored significantly higher that other practices in the Wirral area and higher than the England average, on issues such as overall patient experience at the surgery – 95% positive experience compared with England average of 85.7%, and the Wirral average of 91.1% positive experience. Other notable results included:

Overall patient experience of making an appointment at the practice: 82% positive experience, compared with 74.6% England average and 81.6% Wirral average positive experience;

Patient experience of getting through to the practice by telephone: 94% positive experience, compared with Wirral average of 79.9% positive experience.

Patient experience of being able to get an appointment to see or speak to someone: 93% positive experience, compared with England average of 85.7% and Wirral average of 89.9% positive experience.

Feedback from six patients we spoke with mirrored these findings.

Areas for improvement

Action the service MUST take to improve

- Ensure that all staff employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard. This includes opportunities for all staff to receive appropriate training, professional development, supervision and appraisal, and audit of the work of practice nurses.

Action the service SHOULD take to improve

Have effective systems to regularly assess and monitor the quality of the services provided.

Parkfield Medical Centre - EM Hawthornthwaite

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The inspection team included a GP and a practice manager.

Background to Parkfield Medical Centre - EM Hawthornthwaite

Dr Hawthornthwaite who was the lead partner at the practice had recently retired. The partnership in place at the practice had yet to apply to have Dr Hawthornthwaite's name and another recently retired partner, removed from the partnership registration with the Care Quality Commission (CQC). This is why Dr Hawthornthwaite still appears in the name of the practice, as the lead partner.

Parkfield Medical Centre is based in New Ferry, Wirral, Merseyside. The practice currently serves approximately 6,000 patients. All services are delivered under a Primary Medical Services (PMS) contract. The partnership is made up of three GPs, two male and one female. There are also three salaried GPs and two nurses, one of whom is qualified to prescribe medicines. The practice employs two practice managers, an office manager and a range of administrative support staff. The practice falls within an area rated as being the fourth highest on the social deprivation measurement scale used by NHS England. Life expectancy of male patients registered with the practice is 74.9 years of age and 79.97 years of age for females. The practice has recently become a training practice and had one GP registrar placed with them at the time of our inspection.

The practice is located in a purpose built building, which it shares with a minor injuries unit. The practice partners, salaried GPs and nurses deliver services from a suite of 11 consulting rooms, three of which are dedicated to nursing services at the practice. All rooms are equipped to, and meet the specification required for delivery of surgical procedures. The practice patients benefit from extended hours of opening above that of normal GP practices, due to the opening times of the minor injuries clinic which shares the building. As a result of this, GP and nurse appointments were available to patients between the hours of 8.00am and 8.00pm between Monday and Thursday of each week. The value patients placed on this was reflected in the Wirral Patient Access Survey, which showed 93% of those patients asked, said they were able to get an appointment with a GP at Parkfield Medical Centre.

The practice does not deliver out of hours services; these are delivered by an alternative provider.

We reviewed data from a number of sources before our inspection. The CQC intelligent monitoring placed the practice in band six. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one

Detailed findings

of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. 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.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 8 January 2015. During our visit we spoke with a range of staff including three GPs, a nurse, two practice managers, an office manager and a member of reception staff. We were able to speak with two patients who used the service. We observed how people were being cared for and talked with carers and/or family members. We reviewed 25 CQC 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 are provided for specific groups of people and what good care looks like for them. The population groups are:

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

Good

Are services safe?

Our findings

Safe track record

We saw that the practice considered national best practice guidance in relation to treatment of patients and that prescribing protocols were followed. The practice had recently become a training practice and at the time of our inspection there was one GP registrar placed at the practice. We saw from staffing rotas that there was always a partner available to provide mentor support to the registrar.

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. Reports from NHS England indicated the practice had a good track record for maintaining patient safety and during our inspection we found systems to monitor this.

The practice manager and GPs discussed significant events and showed us documentation to confirm that incidents were appropriately reported. We saw how these were discussed at practice and GP partner meetings to ensure patient safety lessons were disseminated to all staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We observed from minutes of practice meetings, that safety incidents and investigation and analysis of these were discussed at staff meetings, which demonstrated that learning from such events was shared amongst staff and used to prompt discussion at meetings.

We reviewed two examples of serious event analysis. Both cases had been openly discussed with staff, and findings from the investigation had given rise to action points. For example, in one case the incident analysis resulted in further medicines being added to the emergency medicines held at the practice. Findings from the second incident we reviewed had helped to inform the local Clinical Commissioning Group (CCG) on the instance of falls in nursing homes, and whether GPs supporting those homes were called to attend in a timely manner.

Where any incident had involved a patient, the patient was offered a full explanation of findings from the investigation and where required, an apology. Staff we spoke with told us the practice partners promoted an open 'no blame' culture. Staff told us they were happy to report or raise concerns to any of the partners and recognised how this contributed to safety within the practice.

Reliable safety systems and processes including safeguarding

The practice had a range of policies and procedures in place for staff to read and follow which helped promote safe working practices.

All GPs and staff had received training to the required level in the safeguarding of children and vulnerable adults. When we checked staff records, we saw some of this training (for five staff in total) required refreshing as it was over three years old. Staff we spoke with were able to relate a recent example of when they had raised a safeguarding alert; from review of this we could see that the policy in place at the practice supported the efficiency of the local authority safeguarding processes. One of the partners was the lead in safeguarding and met with health visitors every six weeks. This GP was able to say, without referring to records, how many patients on the practice register were subject to a safeguarding plan. When we checked this information later in the afternoon with the practice managers, we found it was correct. This meant that communication between staff on safeguarding matters was likely to be effective and updated on IT systems in a timely manner. The lead partner on safeguarding also told us that safeguarding was discussed at every practice meeting.

We reviewed the minutes of a staff safeguarding meeting, which took place in June 2014. At this meeting staff were reminded of the location on the computer of safeguarding policies and flowcharts with contact details of safeguarding leads within the local authority. It was also stressed to staff that any child or vulnerable adult that was subject to a safeguard marking on their patient record must be seen by a partner or salaried GP, and not by a locum GP. The patient also had to be seen on the day, rather than be given a booked appointment for several days later. Staff were reminded of the particular areas on patient notes that should be updated at each visit to the practice. For example, the name of the school or college a safeguarded

child attended, and whether a child or vulnerable adult had failed to attend any pre-booked appointment, for example for a vaccine or immunisation, or routine health check with a nurse or health visitor.

The practice provided a chaperone service to patients and this was clearly advertised in the practice waiting areas. We were told by practice managers that nurses and the health care assistant would assist if a patient required a chaperone. We were able to confirm that these staff had undergone enhanced background checks, which confirmed they were suitable for this work.

Medicines management

We looked at systems in place to manage, order and store medicines safely. All reception staff had undergone training in the receipt and storage of vaccines. These were kept in a dedicated, temperature controlled fridge. Regular temperature checks were carried out and records kept of these. The practice clinicians used cool bags for the transport of any vaccines when visiting patients. The time the vaccines were removed from the fridge and in some cases returned were recorded. This ensured that any vaccine returned, was put back in to stock within a safe timescale.

The practice had a protocol in place for the safe management of repeat prescriptions. This was aimed at reducing the possibility of error in issue of prescribed medicines. Patients could order repeat prescriptions in person or on-line. Telephone requests for repeat prescriptions were only available to those patients who were housebound or receiving end of life care. We found there were no uncollected prescriptions held by reception staff which suggested that this system was monitored and worked well.

We carried out checks on emergency medicines held by the practice. We found all medicines were in date and suitable for use. Those medicines identified following analysis of the findings of a recent serious event were also stocked as part of the emergency medicines stock.

GPs at the practice did not routinely carry medicines with them on any home visits. However, the practice manager showed us a system in place to book any medicines, taken from the emergency medicine kit, out of the practice and to book back in if not used. From review of these records, we could see that medicines were safely carried and stored, for example in cool bags, and that the shelf life of medicines was not unduly compromised. GPs had access to emergency medicines to take on home visits, if required.

Cleanliness and infection control

We looked at infection prevention and control procedures. The practice premises were cleaned by an external contractor. We saw cleaning schedules were in place and observed that these were regularly checked to ensure all cleaning was carried out to the required standard. When we checked the cleaning store cupboard for availability of equipment we saw this was well ordered with all products clearly labelled. All mop heads were for single use only and disposed of after each evening cleaning session.

We observed a system in place for the safe handling and collection of specimens; all staff had received guidance on this and could refer to the policy in place to support this process.

We conducted a visual inspection of the premises. We found all areas of the practice to be clean, well ordered and free of clutter. Corridors were kept clear and we found all fire doors were kept closed as required. Treatment rooms had the correctly segregated waste bins in place, and all bins operated on a foot opening pedal. We saw that supplies of personal protective equipment such as aprons, gloves and masks were available in each consultation and treatment room. Hand washing facilities were also available in each room. Dispensers with hand sanitizing gel were placed throughout the building, for use by patients and clinicians. Sharps bins were in place in all rooms, and we saw that these were not overfull, labelled with the date on which they were brought into use and placed on work surfaces, away from danger of being knocked over. Needle stick injury instructions were on display in treatment rooms for staff to refer to immediately if needed.

Equipment

All equipment at the practice, clinical and electrical was subject to a maintenance plan and had undergone recent checks to ensure it safety and suitability for use. All clinical equipment was tested annually and calibrated to ensure its safety and accuracy. Portable appliances and IT equipment had been safety tested; we saw that these tests were conducted on an annual basis. The practice shared a defibrillator with the other GP practice located in the building. Checks had been made on the maintenance and

battery charge of the defibrillator, ensuring its readiness for use in an emergency. Contracts were in place for the checking of oxygen cylinders at the practice, and weekly checks were made to see if they needed re-filling or replacement. The practice used spirometry equipment and an ECG machine; both pieces of equipment had records of checks made on them for safety in use.

Fire extinguishers had been tested and checked and a contract was in place for the regular servicing of these, or replacement if necessary.

Staffing and recruitment

The practice had a recruitment policy in place. The practice managers were able to show through record keeping that the policy was followed when recruiting and appointing staff. We noted that turnover of administrative and support staff was low.

The practice partners told us that the practice was undergoing a period of significant change; the long term lead partner had recently retired. Earlier last year, another long standing partner had also retired. This had left two partners who then recruited a salaried GP who had worked at the practice for a number of years, as an additional partner. The new partnership had become a training practice and had one GP registrar with them at the time of our inspection.

We reviewed the GP staffing rota for the month of January 2015. We could see from this that there was sufficient cover available to offer patient appointments in line with demand. We also noted that cover by the partners was available to offer mentoring and support to the GP registrar on placement with the practice. When drawing up the GP working rota, consideration had been given to meetings the GPs were required to attend and any tutorials and training events. Planning of GP cover in this way meant the practice could respond to an emergency if required.

Reception and administrative support staff were sufficient in number to allow for any unplanned absences. The practice had an office manager who liaised closely with the two practice managers, to pinpoint any peaks in demand for services.

At the time of our inspection, two nurses were working at the practice. One of these nurses was due to leave at the end of January. The practice had begun to take steps to replace this nurse, who was also qualified to prescribe medicines to patients. The partners were keen to ensure that any new recruit had the skills set required to serve the needs of patients seen by the nurse, i.e. those in disease management clinics.

Monitoring safety and responding to risk

When we reviewed how the practice partners communicated any significant information between clinicians, we saw they used a day book as well as messaging through the in house computer systems. Whilst one of the partners told us communicating between clinicians could be a challenge, another told us that use of the day book, the internal computer messaging system and the fact that 'we talk to each other' meant that staying in touch whilst out of the practice was not an issue.

The practice managers had several risk assessments in place in relation to staff duties, for example, for lone working in the community or at the practice, a risk assessment for expectant mothers working at the practice, and a display screen and work station ergonomic assessment. All of these contributed to the protection of staff safety and welfare. We saw how these had been completed and reviewed when staff had returned to work, for example, following birth of a child. We saw examples of how the practice managers had checked that desk equipment was re-configured or adjusted to suit the needs of the user.

Arrangements to deal with emergencies and major incidents

The practice had plans in place to deal with major incidents, for example, loss of IT function, power supply or access to the practice building. Also covered was the response to a local incident such as an epidemic/ pandemic. The business continuity plans to address these scenarios were highly detailed, giving details of 'buddying' arrangements with neighbouring practices.

Staff had received training to enable them to respond quickly to a patient emergency, for example, in the delivery of cardio-pulmonary resuscitation and in the use of emergency equipment such as a defibrillator and the administration of oxygen. Staff we spoke to were able to tell us immediately where this equipment was stored and confirmed their ability and competence in its use.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We saw how the practice had used a risk profiling tool to identify those more vulnerable patients, such as those over 75 years of age and those with complex conditions, who were at greater risk of unplanned admission to hospital. These patients had their needs assessed and a documented care plan was put in place. Individual care plans were developed which included access to community services and these where shared with the patient and their families.

The practice worked hard to meet the needs of all its patients. Although the patient register was very stable, there were small numbers of patients from different ethnic backgrounds. For those who did not speak English as a first language, interpreter services were available. Patients with less stable living arrangements were offered access to a GP when needed. The practice worked closely with the minor injuries unit which shared the building. Any homeless patients who needed additional GP care, were referred to the practice by the minor injuries unit. These patients were seen 'on the day' wherever possible.

The practice provided enhanced services under its Primary Medical Services (PMS) 2014-15 contract which included a number of initiatives including childhood influenza vaccinations, minor surgery, shingles catch-up vaccinations, screening and identification of dementia and referral onwards for timely diagnosis of dementia. One of the practice partner's special areas of interest was consent and mental capacity assessment. We saw examples which demonstrated how recognised guidance on assessment was used and how any assessment was corroborated with district nurses.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. We saw examples of clinical audit conducted in 2013-14 and examples of clinical audits given by the partners for this year (2014-15), which included an audit on dementia and an audit on antibiotic prescribing. The work behind these audits was explained in detail. We saw that recognised tools for each audit had been used, for example, in the identification of patients with dementia. However, the dementia audit cycle commenced in November 2014 and had not been completed. With regard to the audit on antibiotic prescribing, one cycle of review of prescribing had been completed, but this had not been revisited and repeated so that results could be compared to establish the adherence to Wirral CCG prescribing guidelines or the appropriateness of medicines prescribed.

Practice staff told us that they used the Choose and Book system of referring patients to secondary care (hospital appointments). Office staff checked the work lists each day to ensure that patients completed the booking of their appointment, if not completed with the GP.

We noted that the practice had a relatively low uptake on cytology screening (smear tests), which was reported as being 72.7%. The partners described this as a 'Wirral wide issue'. We saw that follow up of non-attenders was not effectively carried out. There had also been a lower than expected level of spirometry used for diagnosis of patients with respiratory illness in 2013. The practice partners pointed to the more recent increase in use of spirometry. Of those patients diagnosed with respiratory conditions, 98% were subject to spirometry testing. However, the practice nurse responsible for delivery of disease management clinics confirmed that there had been no audit or peer review of work they had carried out with these patients to assess the effectiveness of patient treatment over time.

Effective staffing

The practice had been through a period of significant change. Two long term partners had recently retired, one of whom was the lead partner. The remaining partners had expanded the practice by recruiting a further partner and three salaried GPs. The practice had also recently become a training practice and much of the work of the partners had been around supporting this.

On inspection, we found arrangements in place for staff training required improvement. The practice arranged training for staff to ensure that mandatory training was completed and refreshed. However, on checking we noted some staff training required updating and refreshing, but this had yet to be organised. Staff appraisal and performance review also required improvement; there were no arrangements in place for appraisal of members of the nursing team at the practice. When we spoke with the nurse prescriber, they confirmed that there had been no formal review of the work they carried out and there were no arrangements in place to provide regular one-to-one

Requires improvement

Are services effective?

(for example, treatment is effective)

sessions to discuss and review progress in the key areas of work carried out by the nurse. For example, the management of chronic diseases and effective delivery of clinics to meet the needs of those patients.

The practice managers had supported the GPs through the period of change. We particularly noted that neither of the practice managers had undergone formal review and appraisal in recent times, for example in the last three years. As the practice had developed through the period of change, practice managers tasks, roles and responsibilities were not clearly defined and had not been subject to recent performance review. Also the effectiveness of the practice managers as the practice developed had not been appraised. Key areas of work were split between the two practice managers. One of these areas related to managing the performance of other staff, such as the office manager and other administrative and support staff. As a result of this, aspects of key deliverables the practice would be judged on, for example the follow up of patients failing to attend cytology screening could not be properly assessed by the management team.

The practice arranged training for staff on protected learning days. However, as the practice shared premises with the minor injuries clinic, they could not close, which presented problems when arranging training. We were told that staff attended training sessions facilitated by the CCG. As one to one discussions between practice managers and staff were not documented, we were unable to establish if learning needs of staff were effectively identified, and whether the training delivered by the Clinical Commissioning Group (CCG) met those needs.

Working with colleagues and other services

One of the practice partners' special area of interest was palliative care. This partner led the multi-disciplinary team meetings for the management of care of palliative patients in the community, and of patients receiving end of life care.

The results of tests for patients referred to secondary care (hospital appointments) were sent to the practice electronically. The practice had an effective system in place to ensure that these were reviewed by a GP, who would annotate with details of further action required, for example, to organise an appointment for that patient to be seen by a GP. Any referrals of patients by GP registrars or locums were reviewed by the practice partners. We saw how notification of a patient's discharge from hospital was received by the practice and how any follow up of this was organised by practice staff.

The practice held regular clinical meetings. Attendees included all GPs at the practice, health visitors and district nurses. However, we found the practice nurse did not attend these meetings. Staff and practice managers had their own meetings, which the practice nurse would attend. We did ask about the rationale for this. We were told that in the past, one of the GP partners would attend the staff meetings but this had ceased, for no apparent reason. We asked the practice nurse why they did not attend practice clinical meetings. We were told they had never been asked to attend and when they started at the practice the system was already in place whereby they would attend the staff meetings rather than clinical meetings. This meant that a further opportunity for the practice nurse to discuss clinical matters with the GPs was missed.

The practice referred patients and carers to a number of community resources for support and advice. One initiative currently available for Wirral based practices was a support facility for carers of patients. When referred the carer could receive up to £200 to spend as they wished to improve their own well-being as a carer. We also saw information given to carers which gave details of respite services they could call, who could provide a short break from caring duties. There was also a Home from Hospital service run by Age UK which could support patients by personalizing their care and support on return from hospital. Staff demonstrated a good awareness and knowledge of other organisations that could offer support to patients of all population groups.

Information sharing

Practice staff showed us how they shared information with district nurses who visited patients in their homes. Staff were able to print off a copy of a care plan if required, and also a patient summary sheet which gave a list of recorded health conditions and detailed the medication taken by patients on a regular basis.

When we asked the nurse practitioner to show us care plans devised for those people at risk of hospital admission, they were unable to say where they were kept, and were unable to find one for us to review. We asked one of the practice managers to show us how the care plans worked in an everyday situation. We observed that the care

Requires improvement

Are services effective?

(for example, treatment is effective)

plans were kept in paper form in the reception area office. Electronic copies were also available. Staff told us that should a care plan be reviewed following feedback from a district nurse, updates would be added to the care plan and

the updated copy would be made available to any visiting clinician. Staff were unclear how the patient would be given an updated copy to be kept by them.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and delivery of their duties in line with this. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. One of the partner's special areas of interest was consent and mental capacity. The practice used evidence based guidance to assess a patients capacity to consent and this was corroborated with evidence from district nurses who would be treating the patients in the community. We were given an example of a patient who required 24 hour care in a home setting who had refused intervention of clinicians. A multi-disciplinary team meeting, which included relatives and carers, was held and the capacity of the patient determined. Clinicians had documented the patient's capacity to make a decision and this was recorded and shared.

Health promotion and prevention

The practice offered all newly registered patients a full health check with a member of nursing staff. Patients completed a form that asked for details of any long term conditions, any medications currently being taken and for details of any illnesses that run within the family. Lifestyle questions such as whether the patient smoked and how much alcohol a patient took within a week were also asked. When the patient had been seen by a nurse, they could be referred on to a GP if required. The practice nurses used the information on the form and from the health check to update disease registers, for example, in relation to patients being treated for asthma or diabetes.

The practice notice boards contained a number of posters and leaflets were available to patients on various health promotion initiatives. We observed that practice staff had grouped information together on each notice board, to make messages to patients clearer. The initiatives available for health promotion and overall patient well-being were many and varied and included chair based exercise classes, health walks, befriending services, fire safety services – even information on a service that could look after pets if a patient was in hospital. GPs could refer patients to a tele health service. This service was available to suitable patients with Chronic Obstructive Pulmonary Disease, (COPD) and used technology to monitor a patient's condition.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We received 25 CQC comment cards completed by patients, which gave their views of the service they received. All comments were positive. Patients commented particularly that they appreciated continuity of service from the GPs and that waiting times when booking an appointment were not overly long. Patients commented that staff treated them with dignity and respect. Results from the NHS England GP-Patient Survey for 2013-14 showed almost 90% of patients who were asked, said the nursing staff treated them with care and consideration. 94% of patients asked, said the last time they saw a GP, they were treated with care and concern. We asked two patients about the chaperone service available at the practice. Both responded that they were aware they could ask for a chaperone and felt comfortable asking for this service. Both patients were able to point to notices advertising this service at the practice.

Care planning and involvement in decisions about care and treatment

Data we reviewed before our inspection indicated that patients were happy with the degree of involvement and information they were given about their care and treatment. The lead partner at the practice told us that some recent patient feedback reflected the changes at the practice and how the make-up of GP and nursing staff had changed in the past 12 months. This was evident in one of the areas of patient response in the NHS England GP-Patient Survey 2013-14. Patients had expressed some dissatisfaction at not being able to see their GP of choice; this had improved more recently with the appointment of three permanent salaried GPs and an additional partner. Certainly, feedback from patients on CQC comment cards completed in the two weeks leading up to our inspection reflected this improvement.

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

Patient/carer support to cope emotionally with care and treatment

The practice staff and clinicians worked to ensure patients and their family members and carers were adequately supported in terms of their physical and mental well-being. The practice did not keep a register of those patients who were also carers, but these carers were clearly identified on the computer system. Double appointments were offered to these patients to ensure their time with the GP was sufficient to meet their needs. Practice staff were able to show us a number of useful information booklets that they would give to carers or family members, should the need arise. For example a Community Information Bereavement Book. Notice boards held details of a variety of support organisations. The practice had arrangements in place to refer patients for counselling services, which could be delivered in the practice building by external providers.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had an active Patient Participation Group (PPG). We were able to spend some time talking with two members of the group who came to the practice on the day of our inspection. The group told us how additional services were hosted by the practice, which improved access for some patients who were not able to make journeys further afield for these services. For example, the practice hosted, audiology, physiotherapy, ultrasound scanning services, rheumatology clinics, counselling services and cognitive behaviour (CBT) clinics. The practice nurse delivered INR (international normalized ratio) testing for patients who required Warfarin, in patients' homes, for those patients that were unable to attend the practice or where housebound. We saw an example of how a range of services were planned to be delivered to a patient within one visit from the practice nurse, and how regular provision for these home visits had been planned into the nurse's working day.

Tackling inequity and promoting equality

The practice staff were aware of the needs of more vulnerable patients who may not normally have easy and regular access to GP services, for example homeless or transient patients. Any patient referred to the GPs by the minor injuries unit based in the same building would be seen on the day, as quickly as possible by any of the available GPs. Staff working in reception understood that by asking this patient group to return later in the day or the following day, may effectively prevent them from receiving care and treatment.

The practice had a stable register of patients. The practice manager told us they had very small numbers of patients from different ethnic backgrounds, namely Chinese people and a small number of patients from European countries. Most of these patients could speak English but interpreting services were available if required. The practice had a hearing loop system in place for use by patients with hearing difficulties.

We observed the practice did not use 'easy read' letters when sending out details of appointments to those patients with a learning disability. The practice also used text reminders for these patients. The nurse who conducted some of the health checks for people with learning disabilities told us they would wait in the reception area to greet these patients. We were unable to gauge any failure to attend rate of this patient group within the time we spent at the practice, so where unclear of the effectiveness of the appointment letters in use.

Access to the service

We observed that access to the service for all patients was good. The patients of the practice benefited from extended hours provision, with the practice being open from 8.00am to 8.00pm Monday to Thursday, and 8.00am to 6.00pm on Friday of each week. We spoke to two patients who told us getting an appointment to see a GP was not a problem. The practice did not use a triage system, which meant patients were seen when needed.

The practice was fully compliant with the Equality Act 2010. We found ramp access to the main doors of the practice. All internal doorways were wide enough to accommodate any patients using a wheelchair or walking aide. We also noted that all consultation and treatment rooms were at ground floor level. Disabled toilets, baby changing and breast feeding rooms were also available.

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Listening and learning from concerns and complaints

The practice used various initiatives to reach out and canvass patient opinion on the service provided by the practice. We saw there was a suggestion box in the waiting area; the practice was waiting on results of the recently introduced friends and family test. This asked patients if they would recommend their practice to their friends and family.

The practice had commissioned an external company to conduct a patient survey. Results of the survey were collated and sent back to the practice in December 2014 and these were due to be discussed with the patient participant group. The survey was comprehensive. The practice has just over 6,000 patients and 193 patients had completed the survey. The survey focused on questions

Good

Are services responsive to people's needs?

(for example, to feedback?)

around patient access to services, the service delivered by the GP, their ability to listen, give explanations and reassurance when needed, respect and consideration shown by the GP and the level of patient confidence in their GP. Questions around waiting times and service provided by reception staff were also included in the survey as well as questions about the complaints process at the practice and how well this worked. The survey results showed the practice had performed well in areas that patients had expressed as being important to them. The only area that indicated improvements were needed was in seeing the practitioner of choice, being able to speak to a practitioner on the phone and waiting time once at the practice. It was worthy of note that the survey targeted questions in this area, to see if improvements had been made on answers to similar questions in the last patient survey. This underlined the commitment of the practice to listening and acting on patient opinion in order to focus areas for improvement.

The practice had a system in place for handling complaints and concerns. Its 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. The practice had sent a summary of all complaints received in the past 12 months. When we reviewed the practice response to these we could see that response time was within the timescales set out in the complaints policy.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a mission statement which was printed on their communications, which read 'Looking after you and your family.' When we asked staff about the vision for the practice they were able to refer to this.

The two principal partners had recently recruited a third partner, which they felt was needed following the retirement of two long term partners in 2013-14. The partners had also recruited three salaried GPs. The partners explained that over time, they hoped the patients would experience the continuity of service and access to GPs which patients had rated as being so important to them. The partners were clear that their recruitment strategy was key to being able to develop the practice further.

Governance arrangements

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

The practice used a number of data sources including QOF data to target improvements in delivery of care and treatment. We questioned some results which were lower than expected. For example, we asked about the lower than expected risk assessment for patients with osteoporosis, but were told this could be a read code issue. The practice managers told us that exercises' to ensure all staff applied read codes correctly were on-going. Staff and clinicians were encouraged to use specific codes and less free text to record interventions, to ensure greater accuracy of QOF data.

Leadership, openness and transparency

We spoke with staff in different roles and they were clear about the lines of accountability and leadership. They spoke of good visible leadership and full access to the senior GP and practice managers.

The practice manager used the services of an external human resource support service and was responsible for human resource policies and procedures. We could see these were updated as required, due to changes in the law, for example health and safety regulation or regulations on limits to working times. We saw that staff team meetings took place regularly and minutes of these were available for review. Whole practice meetings did not take place, although a GP would on occasion attend the staff meetings.

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

The patient participant group felt they played an active part in helping to feedback the needs of patients to practice staff. They expressed their desire to try and engage further with the population through other means, such as social media. As yet there had been no move by the practice to launch this initiative.

The practice had commissioned an external company to carry out a patient survey. Patients were asked for their views on a number of key areas, for example access to the practice GPs, and how long they had to wait to see their preferred GP. Analysis of the survey responses showed 84% of patients said the practice was good, very good or excellent. The practice partners confirmed that areas identified within the survey results as needing improvement, would be the subject of discussion with staff and the PPG, to generate ideas on how to deliver those improvements.

Staff we spoke with during our inspection told us they had good access to the partners at the practice and that management were receptive to feedback. Staff recognised that the practice had undergone a period of change and understood that as the practice grew further, this would present new challenges. Staff said they felt supported but as inspectors, we felt this support could have been wider and more comprehensive, for example, role specific training for staff.

Management lead through learning and improvement

The lead partner of the practice discussed with us their plans to step away from wider duties within the CCG to spend a greater amount of time at the practice, to provide greater leadership and support. The lead partner openly acknowledged that this was needed to steer the practice through its recent changes and to support the partners to meet the future challenges of delivering primary medical

Are services well-led?

Good

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

services. The partners were responsive to feedback we gave at the end of our inspection; there was a clear indication from the partners and staff that were aware of some of the areas we had highlighted for improvement.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Regulation 23(1)(a) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010** **The practice must ensure that all staff employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard. This includes opportunities for staff to receive appropriate training, professional development, supervision and appraisal.**