Ford Medical Practice

Quality Report

91-93 Gorsey Lane
Litherland
Liverpool
Merseyside L21 0DF
Tel: 0151 949 2000
Website: www.fordmedicalpractice.nhs.uk

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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

This is the report from our inspection of Ford Medical Practice. Ford Medical Practice is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on the 11 November 2014 at Ford Medical Practice. We reviewed information we held about the services and spoke with patients, GPs, and staff.

The practice was rated as Good overall.

Our key findings were as follows:

- There were systems in place to mitigate safety risks. The premises were clean and tidy. Systems were in place to ensure medication including vaccines were appropriately stored and in date.
- Patients had their needs assessed in line with current guidance and the practice promoted health education to empower patients to live healthier lives.
- Feedback from patients and observations throughout our inspection highlighted the staff were kind, caring and helpful.
- The practice was responsive and acted on patient complaints and feedback.
- The practice was well led. The staff worked well together as a team and had regular staff meetings and training.

We saw an area of outstanding practice:

The practice was responsive to the needs of older and vulnerable people. The practice offered an enhanced service by offering health checks carried out by the health care assistant or a practice nurse in the community for patients living independently and in residential and nursing homes. This was to promote good health and to monitor chronic and acute conditions. A review of this service indicated that unplanned admissions to hospitals had been reduced.

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. The practice had systems in place for monitoring safety and learning from incidents and safety alerts to prevent reoccurrences. For example the practice had a robust system in place to ensure learning from incidents was shared across all staff groups through practice meetings, clinical meetings and protected learning time.

The staff had received safeguarding training and the staff we spoke with were aware of the safeguarding vulnerable adults and children policies and procedures in place. The practice had a GP lead for safeguarding who liaised with other agencies when necessary.

There were systems in place to ensure medication, including vaccines, were safely stored and in date.

The practice was clean and tidy. All equipment was regularly maintained to ensure it was safe to use.

The practice had emergency medication available including oxygen and a defibrillator suitable for children and adults.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. The practice monitored its performance and had systems in place to improve outcomes for patients. For example the practice had carried out a breast screening audit in 2014 that resulted in breast screening uptake improving from 69% to 74%. A further example showed how the practice reviewed the effectiveness of the way in which referral letters were being monitored and managed. Following this review an upgrade to the IT system was fitted that monitored this system and had resulted in a significant reduction in delays in the system.

Staff had received training appropriate to their roles and any further training needs were being identified and planned from their appraisals. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for

Summary of findings

several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Patients also said that the staff were compassionate and thoughtful when they had experienced a bereavement. There was accessible information to ensure patients understood the services available. We observed that patients were treated with kindness and respect.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. We found that the practice had sought ways to improve their service for their local population and had acted on suggestions made by patients both individually and through the Patient Participation Group (PPG) .

The Practice had an emergency triage system whereby patients could contact the Practice to arrange a same day appointment. Children were offered same day appointments for urgent care. The practice carried out telephone consultations and home visits when necessary.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. The practice staff worked well together as a team and strove to always improve their systems of care by having a wide range of staff meetings.

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

Outstanding ☆

The practice is rated as outstanding for the population group of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. The practice kept a register of those patients 75 and over which was regularly updated and the practice offered a named GP for these patients in line with the new GP regulations. The practice was responsive to the needs of older and vulnerable people. The practice offered an enhanced service by offering health checks carried out by the health care assistant or a practice nurse in the community for patients living independently and in residential and nursing homes. This was to promote good health and to monitor chronic and acute conditions.

The practice held Gold Standard Framework meetings to discuss patients who required palliative care with other health care professionals to ensure patients received 'joined up' care appropriate to their needs.

Immunisations, such as the flu and shingles vaccinations, were offered to older patients and the Quality and Outcomes Framework (QOF) information indicated the percentage of patients aged 65 and older who had received such vaccination was higher than the national average.

People with long term conditions

Good ●

The practice is rated as good for the population group of people with long term conditions. The practice held information about the prevalence of specific long term conditions within its patient population such as diabetes, chronic obstructive pulmonary disease (COPD), cardio vascular disease and hypertension. This information was reflected in the services provided, for example, reviews of conditions and treatment, screening programmes and vaccination programmes. The practice had a system in place to make sure no patient missed their regular reviews for long term conditions and to follow up unplanned hospital admissions in a timely manner. Clinical staff kept up to update in specialist areas which helped them ensure best practice guidance was always being considered. The practice had achieved and implemented the gold standards

framework for end of life care. One of the GPs took the lead for this group of patients. They had a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Child health surveillance and immunisation clinics were run on a weekly basis. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns. The staff were very responsive to parents concerns and ensured parents could readily bring children who appeared unwell into the practice to be seen. Staff were knowledgeable about child protection and a GP took the lead for safeguarding. Staff put alerts onto the patient's electronic record when safeguarding concerns were raised. Regular meetings were held with the health visiting service to discuss any children who were at risk of abuse and to review if all necessary GP services had been provided.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age people (including those recently retired and students). The practice was open Monday to Friday from 8am – 6:30pm and 8am - 8pm every Thursday which provided flexibility to working patients and those in full time education. We found the practice had a range of appointments available including pre-bookable on the day and telephone consultations. Staff told us they would try to accommodate patients who were working to have early or late appointments wherever possible. Appointments could be booked and repeat prescriptions ordered on line. The practice monitored patient satisfaction with access to the service through patient feedback. Patient feedback indicated patients were satisfied with the range of appointments available. Health checks were being offered to patients who were 40 – 74 years of age to promote patient well-being and prevent any health concerns.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice was aware of patients in vulnerable circumstances and ensured they had appropriate access to health care to meet their needs. Staff were knowledgeable about interpreter services for patients where English was their second language. Patients' electronic records contained alerts for staff regarding patients requiring additional assistance in

Summary of findings

order to ensure the length of the appointment was appropriate. For example, if a patient required interpreting services or had a mental health need a double appointment was offered to the patient to ensure there was sufficient time for the consultation. Staff told us they would ensure homeless people received urgent and necessary care. They were aware of local support services for the homeless to which patients could be signposted. Staff were knowledgeable about safeguarding vulnerable adults. They had access to the practice's policy and procedures and had received training in this.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). GPs worked with other services to review care, implement new care pathways and share care with specialist teams. The practice maintained a register of patients who experienced poor mental health. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. The practice referred patients to appropriate services such as psychiatry and counselling services. Referrals were made to Child and Adolescent Mental Health Services (CAHMS) to support younger patients. The practice had information for patients in the waiting areas to inform them of other services available. For example, patients who may experience depression or those who would benefit from counselling services for bereavement.

Summary of findings

What people who use the service say

As part of our inspection process, we asked for CQC comment cards for patients to be completed prior to our inspection.

We received 34 comment cards and spoke with four patients. The majority of the comments indicated that patients found the reception staff helpful, caring and polite and described their care as excellent. Five patients indicated that at times making appointments could be difficult.

For the practice, our findings were in line with results received from the national GP patient survey. For example, the GP survey results for 2013/2014 showed 78.42% of patients stated that the last time they saw or spoke to a GP, the GP was good or very good at involving them in decisions about, this is in line with the national average. The survey also showed that 93.24% of patients stated that the last time they saw or spoke to a nurse, the nurse good or very good at involving them in decisions

about their care their care. This is significantly higher than the national average.

Results from the national GP patient survey also showed that 99.43% of patients stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern.

Outstanding practice

The practice offered older and vulnerable patients living independently in the community or in residential or nursing homes regular visits from the Health Care Assistant/ Practice Nurse. This was to promote good health and to monitor chronic and acute conditions. This service supported positive relationships with practice staff and allowed early diagnosis and treatment for patients. A review of this service indicated that unplanned admissions to hospitals had been reduced.

Ford Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) inspector and the team included a GP specialist advisor and a practice manager specialist advisor.

Background to Ford Medical Practice

Ford Medical Practice is located in the Litherland area of Liverpool which is one of the most deprived areas of the country. There are approximately 6024 patients registered at the practice at the time of our inspection. The practice treats all age groups but there was a larger than average proportion of patients 18 years and under.

The practice has four GP partners (three male and one female), one GP registrar, two practice nurses, a health care assistant, Practice manager, reception and administration staff. The practice is open 8.00am to 6.30pm Monday to Friday and offers extended evening opening hours one day per week for nurse appointments. Patients requiring a GP outside of normal working hours are advised to contact an external out of hours service provider called Go to Doc. The practice has a GMS contract and also offers enhanced services for example; various immunisation and health check schemes.

This is a training Practice and usually has a GP Registrar as part of its team.

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

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

How we carried out this inspection

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

Detailed findings

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

Before visiting the practice we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the Practice Manager for Ford Medical Practice provided before the inspection day. There were no areas of risk identified across the five key question areas. We carried out an announced visit on 11 November 2014.

We spoke with a range of staff including three GPs, two practice nurses, the healthcare assistant reception staff, administration staff and the Practice Manager on the day. We sought views from patients and representatives of the patient participation group and looked at comment cards and reviewed survey information.

Are services safe?

Our findings

Safe Track Record

South Sefton Clinical Commissioning Group (CCG) and NHS England Area Team reported no concerns to us about the safety of the service. GPs told us they completed incident reports and carried out significant event analysis as part of their on going professional development in order to reflect on their practice and identify any training or policy changes required. These were shared within the practice. We looked at a sample of significant event reports and saw that significant events were appropriately analysed, a plan of action had been formulated following analysis of the incidents and appropriate action taken.

Staff were able to describe the incident reporting process and were encouraged to report in an open, no blame culture. They told us they felt confident in reporting and raising concerns and felt they would be dealt with appropriately and professionally. Staff were able to describe how changes had been made to the operation of the practice as a result of reviewing significant events and complaints.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring safety incidents. Staff told us and we saw evidence that significant events, incidents and complaints were investigated and reflected on by the clinical staff and non-clinical staff as appropriate. Records showed that significant events were discussed at weekly clinical meetings and at monthly governance meetings.

Staff we spoke with told us they felt able to report significant events and that these incidents were analysed and learned from and changes to practice were made as a result. For example, following the analysis of an incident of a patient who had both chronic and acute medical needs and the poor communication between services. Meetings with other stakeholders had been arranged and information was shared with the CCG to highlight the patient journey and to ensure optimisation of the patient's health journey. Following the analysis of an incident where there was a data protection breach information sharing protocols were reviewed.

A protocol around learning and improving from safety incidents was available for staff to refer to. A central log/ summary of significant events was maintained that would allow patterns and trends to be easily identified and enable a record to be made of actions undertaken and reviewed.

Reliable safety systems and processes including safeguarding

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

Records and staff we spoke with confirmed they had received training in safeguarding at a level appropriate to their role. Staff we spoke with demonstrated good knowledge and understanding of safeguarding and its application.

One of the GPs took the lead for safeguarding. The GP lead told us that whenever possible they attended safeguarding meetings and always provided reports when asked to do so.Staff put alerts onto the patient's electronic record when safeguarding concerns were raised. Regular meetings were held with the health visiting service to discuss any children who were at risk of abuse and to review if all necessary GP services had been provided. Staff were proactive in monitoring if children or vulnerable adults attended Accident and Emergency or missed appointments frequently. These were then brought to the GPs attention.

We found that there were systems and processes in place to keep patients safe. This included systems and processes around infection prevention and control, medicines management, equipment and building maintenance. A chaperone policy was on display in the waiting area that advised patients that this service could be requested at reception. Training records showed staff who carried out this role had received appropriate training.

Medicines Management

There were systems in place for medicine management. Annual reviews of medication for patients took place. The GPs re-authorised repeat medication on a six monthly basis

or more frequently if necessary. A system was in place to ensure that any changes made to medication by the out of hours service or following hospital discharge were actioned without a delay.

GPs worked closely with pharmacy support from the Clinical Commissioning Group (CCG) to review prescribing trends and medication audits. Members of the CCG pharmacist team visited the practice weekly to support the GPs with medicines optimisation to ensure patients received the best outcomes from their prescribed medication. GPs reviewed their prescribing practices as and when medication alerts were received and in accordance with good practice guidelines.

We looked at how the practice stored and monitored emergency drugs and vaccines, to ensure patients received medicines that were in date and ready to use. Vaccines were securely stored and were in date and organised with stock rotation evident. We saw the fridges were checked daily to ensure the temperature was within the required range for the safe use of the vaccines. A cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was in place for the safe management of vaccines and a recent cold chain audit had been undertaken and had identified no concerns.

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

Cleanliness & Infection Control

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

The four patients we spoke with commented that the practice was clean and appeared hygienic. We looked around the premises and found them to be clean. The consultation rooms and treatment rooms, waiting areas and toilets were in good condition and supported infection control practices. Surfaces were intact, easy to clean and the premises were uncluttered. Staff had access to gloves and aprons and there were appropriate segregated waste disposal systems for clinical and non-clinical waste. We observed good hand washing facilities to promote good standards of hygiene. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms and the patient waiting area.

A cleaning schedule was in place and a log of cleaning works undertaken was maintained.

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

Legionella testing was carried out.

Equipment

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

Staffing & Recruitment

The practice had a procedure for the safe recruitment of staff. This included guidelines about seeking references, checking qualifications/clinical registration, checking an applicant's physical and mental fitness and obtaining Disclosure and Barring service (DBS), formerly Criminal Records Bureau (CRB) checks (these checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post).

We looked at a sample of recruitment files for two GPs, a practice nurse and three reception and administrative staff. We found that the recruitment procedure had been followed and the required checks had been undertaken to show the applicants were suitable for their posts.

Are services safe?

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

Monitoring Safety & Responding to Risk

Staffing levels were reviewed to ensure patients were kept safe and their needs were met. In the event of unplanned absences staff covered from within the service. Reception and administrative staff were multi-skilled which meant they could cover each other's duties if necessary. Clinical leads and the practice manager had an identified member of staff who could cover their absence. Duty rotas took into account planned absence such as holidays. Staff we spoke with felt staffing levels and the skill mix of staff were appropriate and met the needs of the service and patients. GPs and the practice manager told us that patient demand was monitored through the appointment system and staff and patient feedback to ensure that sufficient staffing levels were in place.

The practice had other systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the fire fighting equipment, medicines management, dealing with emergencies and monitoring the safety of equipment. Health and safety information was displayed for staff to see around the premises. A health and safety policy and procedure was available. The practice manager was the lead for health and safety and these issues were discussed at staff meetings.

Arrangements to deal with emergencies and major incidents

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

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

A disaster recovery and business continuity plan was in place. The plan included the actions to be taken following loss of building, loss of telephone system, loss of computer and electrical equipment and loss of utilities. Key contact numbers were included for staff to refer to. Staff we spoke with confirmed that they were aware that their practice had buddy arrangements in case of an emergency affecting the building occurred.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

GPs and nurses attended weekly clinical meetings. These meetings provided the opportunity to discuss new clinical protocols, review complex patient needs and keep up to date with best practice guidelines and relevant legislation. Clinical staff we spoke with told us how they accessed best practice guidelines to inform their practice, for example, they had access to National Institute for Health and Care Excellence (NICE) guidelines on their computers. GPs and nursing staff also attended training and educational events provided by the Clinical Commissioning Group.

GPs we spoke with used national standards for the referral of patients for tests for health conditions, for example patients with suspected cancers were referred to hospital and the referrals were monitored to ensure an appointment was provided within two weeks. We found that audits of referrals were regularly undertaken to ensure that referrals were being completed in a timely manner that protected the welfare of patients.

GPs specialised and lead in clinical areas such as prescribing, chronic condition and child health. They also specialised and took the lead with different patient groups such as dementia, diabetes, chronic kidney disease and maternity. Staff meetings and other clinical meeting minutes demonstrated that staff discussed patient treatments and care and this supported staff to continually review and discuss new best practice guidelines. Records viewed of a clinical multi-disciplinary meeting showed the needs of patients and their relatives were considered.

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

The practice provided a service for all age groups. They provided services for patients in the local community including those patients living in nursing or residential care services. The practice offered an enhanced service by offering regular health checks carried out by the health care assistant or a practice nurse in the community for patients living independently and in residential and nursing homes. This was to promote good health and to monitor chronic and acute conditions. A review of this service indicated that unplanned admissions to hospitals had been reduced.

We found GPs and nursing staff were familiar with the needs of patients and the impact of the socio-economic environment. For example, the practice had access to language translator services and provided health promotion services in accordance with the needs of patients.

Management, monitoring and improving outcomes for people

There were systems in place to evaluate the operation of the service and the care and treatment given. The practice had a system in place for completing clinical audit cycles. We saw that audits of clinical practice were regularly undertaken and that these were based on best practice national guidelines. Examples of clinical audits seen included an audit of breast screening, an audit of chronic kidney disease and childhood immunisation and audits relating to medication prescribing. The GPs told us clinical audits were often linked to medicines management information, safety alerts, clinical interest or as a result of Quality and Outcomes framework (QOF) performance. All the clinicians participated in clinical audits. We discussed audits with GPs and found evidence of a culture of communication, sharing of continuous learning and improvement. For example we found that as a result of one of the audits we looked at the uptake for breast screening had increased in the practice from 69% to 74%.

The practice had systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. The practice kept up to date disease registers for patients with long term conditions such as asthma and chronic heart disease which were used to arrange annual health reviews. They also provided annual reviews to check the health of patients on long term medication, for example for mental health conditions.

The practice used the information they collected for the QOF and their performance against national and local screening programmes to monitor outcomes for patients. The practice identified what was working well and where improvements were needed. A development plan was in

Are services effective?

(for example, treatment is effective)

place to address any areas where the outcomes for patients needed to be improved. The practice worked with the CCG to ensure prescribing practices promoted patient safety and met current clinical guidelines.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included managing long term conditions, safeguarding, unplanned admissions to hospital, education and training and information governance. The practice had achieved and implemented the gold standards framework for end of life care. One of the GPs took the lead for this group of patients. They had a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families. There was a clear process in place for informing the out of hours services of any particular needs of patients who were coming towards the end of their lives.

Effective staffing

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

An appraisal policy was in place. Staff were offered annual appraisals to review performance and identify development needs for the coming year. We looked at a sample of records for administrative/reception staff which indicated they had received an annual appraisal and that a personal development plan had been drawn up as a result which identified any training needed. We spoke to two reception/administrative staff who told us the practice was supportive of their learning and development needs.

We looked at the records relating to one nurse which indicated they had received an annual appraisal. We spoke to three GPs, two nursing staff and the health care assistant who told us they had annual appraisals and we saw records to demonstrate that they undertook training/ learning to inform their practice. GPs told us they had protected learning time and met with their external appraisers to reflect on their practice, review training needs and identify areas for development. Revalidations of GPs had either taken place or were due. Revalidation is the process by which all registered doctors have to demonstrate to the General Medical Council (GMC) that their knowledge is up to date, they are fit to practise and are complying with the relevant professional standards.

The staff we spoke with told us they felt well supported in their roles. Clinical and non-clinical staff told us they worked well as a team and had good access to support from each other. Regular developmental and governance meetings took place to share information, look at what was working well and where any improvements needed to be made. For example, GPs and nursing staff met weekly to look at new protocols, to review complex patient needs and keep up to date with best practice guidelines and relevant legislation. Clinical governance meetings were held regularly.

The practice manager kept a record of training carried out by clinical and administration staff. The GPs and nurses also kept a record of their own training. Clinical and non-clinical staff told us they had the training they needed to support them in their roles and in any specialist roles.

Working with colleagues and other services

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

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

Information Sharing

There was a confidentiality policy and data sharing policy which gave clear guidance to staff. Information about

Are services effective?

(for example, treatment is effective)

access to records and data protection was available for patients to refer to. Staff spoken with confirmed they had undertaken training around promoting patient confidentiality.

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

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. 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. They gave examples in their practice of when best interest decisions were made and mental capacity was assessed prior to consent being obtained for a surgical procedure. All clinical staff demonstrated a clear understanding of Gillick competencies, (these help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was obtained and documented in the electronic patient notes.

Health Promotion & Prevention

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

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

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

Health promotion advice was provided to patients. This included smoking cessation, obesity management and travel advice.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone.

CQC comment cards we received and patients we spoke with all indicated that they found staff to be helpful, respectful, caring, friendly and polite and that they were treated with dignity. Results from the national GP patient survey also showed that 85% of patients said the last GP they saw or spoke to was good at treating them with care and concern and 89% said the last GP they saw or spoke to was good at listening to them which is higher than the national averages.

Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The practice had a confidentiality policy in place and all staff were required to sign this annually at their appraisals.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey also showed that 86% said the last GP they saw or spoke to was good at explaining tests and treatments and 89% said the last GP they saw or spoke to was good at involving them in decisions about their care. 97% said the last nurse they saw or spoke to was good at treating them with care and concern. The local CCG average was 90%

Comments received from patients highlighted that they felt listened to by GPs, were referred appropriately and were supported in terms of managing either long term or acute illnesses.

Patient/carer support to cope emotionally with care and treatment

Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed that they would offer them a private room to discuss their needs. The Practice Manager told us that patients with emotional issues were contacted, offered support and signposted to various counsellors and support organisations to ensure their needs were being met.

There was a variety of supporting information to help patients who were carers which was available on the noticeboards in the waiting room. The practice also kept a list of patients who were carers and alerts were on these patients' records to help identify patients who may require extra support.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the practice population were understood and systems were in place to address identified needs. The practice engaged with NHS South Sefton Clinical Commissioning Group (CCG) to address local needs and service improvements that needed to be prioritised.

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

Referrals for investigations were carried out by the GPs with patients. A computer system monitored referrals to ensure all referral letters were completed in a timely manner. Records indicated this system worked well with all referrals receiving prompt attention.

The practice worked to the National Gold Standard Framework in end of life care (The National Gold Standards Framework (GSF) Centre in End of Life Care provides training to enable generalist frontline staff to provide a gold standard of care for people nearing the end of life). The practice had a palliative care register and had tri monthly multidisciplinary meetings to discuss patients and their families' care and support needs. They regularly updated shared information to ensure good communication of changes in care and treatment.

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

The practice offered patients a chaperone prior to any examination or procedure. Staff we spoke with said they had received sufficient guidance around carrying out this role. Records demonstrated that staff who acted as chaperones had received training in this.

The practice had an established Patient Participation Group (PPG). The purpose of the PPG was to meet with practice staff to review the services provided and to be part of the development of the practice action plan. Records showed the changes were made to the practice as a result of feedback from surveys and meeting with the PPG, for example, the introduction of a practice based phlebotomy clinic to reduce the traveling and waiting times for patients.

Tackling inequality and promoting equality

The practice provided disabled access in the reception and waiting areas, as well as to the consulting and treatment rooms. There was a comfortable waiting area for patients attending an appointment and a small car park was available at the rear of the building. There were disabled toilet facilities.

The surgery had access to interpreter services (language line) but staff told us they had rarely had to use this facility.

Patients' electronic records contained alerts for staff regarding patients requiring additional assistance in order to ensure the length of the appointment was appropriate. For example, if a patient required interpreting services or had a learning disability then a double appointment was offered to the patient to ensure there was sufficient time for the consultation.

Staff we spoke with told us there was a low incidence of homeless people accessing the practice. They told us they would ensure that patients received urgent and necessary care whatever their housing status. They were also aware of local support services for the homeless to which patients could be signposted.

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

Access to the service

Ford Medical Practice was open 8.00am to 6.30pm Monday to Friday. Patients requiring a GP outside of normal working hours are advised to contact an external out of hours provider (Go To Doc). The practice operated a triage system in order to offer emergency appointments each day. Reception staff would triage calls in order to signpost to the most appropriate healthcare professional.

There were notices in the waiting room to advise patients that if they had more than one medical problem that needed attention, they should book a longer appointment. The practice carried out telephone consultations and home visits when necessary.

Pre-bookable appointments for those patients who found it difficult to attend the practice during working hours were also available one evening a week with a practice nurse.

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns & complaints

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

We saw that the complaint policy was displayed in the waiting area and reference was made to the policy on the practice's website. The policy included contact details for NHS England and the Health Service Ombudsman, should patients wish to take their concerns outside of the practice.

We looked at the record of complaints and found documentation to record the details of the concerns raised and the action taken. There was a central log/summary of complaints to monitor trends and ensure any changes made were effective. Staff we spoke with were knowledgeable about the policy and the procedures for patients to make a complaint. We found that changes to the service had been made as a result of patient complaints.

Are services well-led?

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

Our findings

Vision and strategy

The practice statement of purpose stated that 'Ford Medical Practice aims to provide to a high standard a full range of General Medical Services to it's registered patients at all times. Our objective is to ensure that we are promoting health and wellbeing to all by working to best practice and guidance provided by the Department of Health and NICE'. The Practice is a training practice which means that each year we welcome to our team trainee doctors. We have been a training Practice for a number of years now and pride ourselves in providing a modern and fully equipped building as well as an excellent knowledge of General Practice life'. Comments we received were very complimentary of the standard of care received at the practice.

All staff were engaged in producing a high quality service and each member of staff had a clear role within the structure of the practice. For example, there were leads for safeguarding and infection control.

The practice was engaged with the local Clinical Commissioning Group (CCG) to ensure services met the local population needs.

Governance arrangements

The practice had policies and procedures to support governance arrangements which were available to all staff on the practice's computer system. The policies included a 'Health and Safety' policy, safeguarding policy and procedure and 'Infection Control' policy. All policies were in date and regularly reviewed.

Policies and procedures were discussed regularly through staff training events and the regular staff meetings that took place. Personal development was encouraged and supported by training days and appraisals for all staff.

Leadership, openness and transparency

The practice had a clear leadership structure which had named members of staff in lead roles for oversight of the performance and monitoring of the practices. For example there were lead GPs for information governance, QOF and GP training.

All GPs had specific clinical lead roles such as mental health, coronary heart disease, palliative care and child health. Staff we spoke with told us they were well supported and knew who to go to in the practice with any concerns.

The practice held a variety of staff meetings to ensure all staff had an opportunity to be involved in the running of the practice. Minutes for all meetings were kept on the practice's computer systems which all staff could access. Members of staff we spoke with said they all worked well together as a team and there were good communications between them.

Members of staff were supported at the practice, for example there was a 'zero tolerance policy' to prevent and cope with any untoward behaviour from patients against the practice staff. Staff we spoke with thought they were well supported and the culture within the practice was supportive, open and honest.

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

Results of surveys and complaints were discussed at staff meetings. There was a patient participation group in place and minutes from meetings and results of surveys demonstrated actions were taken when necessary. We spoke with a member of the PPG who told us there were no concerns at present and felt that the practice was responsive to any issues raised by the group.

The practice website encourages patient feedback on the services provided.

Staff we spoke with were aware there was a whistleblowing policy in place and were confident that any concerns raised would be acted upon.

Management lead through learning and improvement

GPs were all involved in revalidation, appraisal schemes and continuing professional development and were a teaching practice. All staff received annual appraisals.

The practice had a comprehensive meeting schedule with set agendas. Minutes were available for all meetings and cascaded to staff. The practice held weekly clinicians' meetings. Where gaps or improvements could be identified meetings were held with other stakeholders, for example

Are services well-led?

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

social services and community health trusts. Weekly non-clinical meetings took place to ensure best practice development and the clear dissemination of information and feedback.

One GP was part of the Local Medical Committee and used this involvement as a driver for learning and development within the practice and the South Sefton CCG area.

The practice held monthly half day training sessions for both clinical and non-clinical staff which included a mix of training both in house and by external trainers/facilitators.

The practice was also involved in meetings with the local CCG, multidisciplinary meetings for the Gold Standard Framework and Neighbourhood meetings.