Park Road Group Practice

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	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 Park Road Group Practice. Park Road Group Practice is also known as The Elms Medical Centre and is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on 15 October 2014 at the practice location at the Elms Medical Centre, Dingle, Liverpool. We spoke with patients, relatives, staff and the practice management team.

The practice was rated as Good. They provided safe, effective, responsive and compassionate care that was well led and addressed the needs of the diverse population it served. However there were aspects of the service that needed to improve.

Our key findings were as follows:

- There were aspects of the service that needed improvement. There were systems in place to ensure safe patient care and that lessons were learnt from adverse events and incidents. The premises were clean and patients were protected from the risk of infection. Systems were in place to ensure medicines were appropriately stored and used. However improvements were required to ensure staff were safely recruited and required information was held in relation to staff.
- The practice was caring. Patients spoke highly of the practice. They said they were always treated with dignity and respect, listened to and staff were kind, compassionate and caring.
- The practice was responsive. The practice served patients in a deprived area of Liverpool. The practice provided good care to its population taking into account their cultural, religious, socio economic and language needs. The appointment system had been improved to enable good access to the patient population.

Summary of findings

- The practice was effective. Patient's needs were assessed and care was planned and delivered in line with current guidance and legislation. The practice promoted health education to empower patients to live healthier lives.
- The practice was well led. The practice worked hard to monitor, evaluate and improve services. They worked in collaboration with other practices and the Clinical Commissioning Group (CCG) within the Neighbourhood Team. Staff enjoyed working for the practice and felt well supported and valued.

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

Importantly, the provider must:

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

In addition the provider should:

- Follow up audits and undertake re audits to ensure the audit cycle is complete and improvements can be demonstrated. Review of actions taken following complaints should also be undertaken to demonstrate learning and improvements.
- Review and update fire risk assessments and the fire precautions policy and procedures to reflect the local situation and current guidance. Fire alarm checks should be recorded fully to ensure they demonstrate these have been undertaken appropriately.
- Risk assessments and risk management procedures should be reviewed to localise and update in order to reflect current guidance and legislation.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep people safe. However risk assessments and risk management procedures were not up to date and should be reviewed and localised. The practice recruitment policy and procedures did not include a policy and risk assessment for undertaking Disclosure and Barring Service (DBS) checks to ensure it reflected national guidance and legislation. Required information relating to staff and their suitability for their role was not available, checked or held by the practice.

Are services effective?

Good

The practice is rated as good for effective. Patient's needs were assessed and care was planned and delivered in line with good practice and current legislation. This included assessment of capacity and health promotion. Staff had received training that was appropriate to their roles and further training needs had been identified and planned. The practice had carried out appraisals and had personal development plans for staff. Multidisciplinary working was evidenced in various meetings and through referrals. National Institute of Health and Care Excellence (NICE) guidance was referenced and used routinely. It was evident in minutes of team meetings we saw that NICE guidelines were discussed and plans made for implementation.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to plan service improvements where these were identified. Patients

Summary of findings

reported good access to the practice with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded appropriately to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular meetings had taken place. There were systems in place to monitor and improve quality. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had a patient participation group (PPG), though support and improvements to the effectiveness of this group were needed. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care 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. GPs and other staff lead in different specialities common to older people. Patients aged 75 years and over had a named GP responsible for their care. The practice was responsive to the needs of older people, including offering home visits and urgent appointments for those vulnerable patients with additional needs.

People with long term conditions

Good

The practice had an average number of patients with long standing health conditions (55% of its population). There was a higher than average number of patients claiming disability allowance (9% of its population). Patients with long term conditions were supported by a healthcare team that cared for them using good practice guidelines and were attentive to their changing needs. There was proactive intervention for patients with long term conditions. Patients had health reviews at regular intervals depending on their health needs and condition. Patients had a lead GP and nurse for their condition and structured reviews to check their health and medication needs were being met. Registers of patients with long term conditions enabled the practice to monitor this population group's needs as a whole. Quality and Outcomes Framework (QOF) information indicated that patients with long term health conditions received care and treatment as expected for the national average including for example patients with diabetes having had regular screening and monitoring.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. Children were always given an appointment the same day or even more urgently within an hour if assessed as needing one. Vulnerable children were followed up if they did not attend their appointment. Immunisation rates were average or above for all standard childhood immunisations. The practice undertook their own six weeks baby checks and first childhood vaccinations (these are usually undertaken by the health visitor).

Summary of findings

Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering a clinical telephone triage system which supported working patients to access the practice whilst causing minimal disruption to their working day. There was an extended opening hour's day offering appointments up until 8.30pm.

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 held a register of patients living in vulnerable circumstances including housebound patients and those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities. The practice offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and charity organisations such as the Citizens Advice Bureau and Addaction. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

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. 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 monitored patients with poor mental health according to clinical quality indicators and in line with good practice guidelines. The practice regularly worked with multi-disciplinary teams and the local mental health trust in the case management of people experiencing poor mental health including those with dementia

Summary of findings

What people who use the service say

We spoke with six patients including one member of the patient participation group (PPG). We reviewed the results of the GP national patient survey, the practice survey and comments left on NHS choices.

Patients told us that the staff were all nice and competent. Clinical staff gave them time, listened to them and fully explained their care and treatment.

All patients were very positive about the practice, the staff and the service they received.

They told us the staff were caring and compassionate, they were treated with dignity and respect and they had confidence in the staff and the GPs who cared for and treated them.

The main concern from speaking to patients and from the patient survey was getting through to someone on the phone with 30% of people saying it was not easy to get through. However the overall experience of making an appointment was rated as very good or good by 73% of survey respondents.

We spoke with a representative of the PPG. They told us all the staff were very good and caring. They told us they felt the group had a contribution to make in service improvement however both the practice and the group had identified the group was not functioning effectively and had identified improvements that needed to be made.

The results of the national GP patient survey published in July 2014 told us that 82% of respondents said the last GP they saw or spoke to was good at treating them with care and concern, 81% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care and 78% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern. Eighty seven percent described their overall experience of this practice as good. Eighty percent were satisfied with the surgery's opening hours.

Areas for improvement

Action the service MUST take to improve

The practice must ensure its recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 to ensure necessary employment checks are in place for all staff and these checks are relevant to the roles.

Action the service SHOULD take to improve

- Audits should be followed up and re audits undertaken to ensure the audit cycle is complete and improvements can be demonstrated. Review of actions taken following complaints should also be undertaken to demonstrate learning and improvements.
- Fire risk assessments and the fire precautions policy and procedures should be reviewed and updated to reflect the local situation and current guidance. Fire alarm checks should be recorded fully to ensure they demonstrate these have been undertaken appropriately.
- Risk assessments and risk management procedures should be reviewed to localise and update in order to reflect current guidance and legislation.

Park Road Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included two GP specialist advisors and an Expert by Experience. An expert by experience is someone who has personal experience of using or of caring for someone who uses a primary medical service.

Background to Park Road Group Practice

Park Road Group Practice is registered with the Care Quality Commission to provide primary care services. It provides GP services for approximately 8200 patients living in the Riverside neighbourhood area of Liverpool. The practice has five GP partners, four associate (salaried) GPs, an interim practice manager, a practice nurse manager, a practice nurse, healthcare assistant and IT, administration and reception staff. The practice is a GP training practice and has GP registrars working for them as part of their training and development in general practice.

The practice is open Monday to Friday from 8am to 6.30pm with extended opening hours until 8.30pm on a Monday. Patients can book appointments in person or via the phone. The practice provides triage and telephone consultations, pre bookable consultations, urgent consultations and home visits. The practice treats patients of all ages and provides a range of medical services. When the practice is closed patients can access the out of hour's provider for Liverpool, Urgent Care 24 (UC24).

The practice is part of Liverpool Clinical Commissioning Group (CCG). The practice is situated in an area of high deprivation. The practice population is made up of a predominately younger population between the ages of 15-64 years old and a lower than national average of patients aged over 65 years. Nine percent of the population claim disability allowance and 21 % have a caring responsibility. Fifty five percent of the population has a long-standing health condition and a slightly higher than national average number of unemployed.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

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?

Detailed findings

- 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
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before our inspection we carried out an analysis of the data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas. We carried out an announced inspection on 15 October 2014 and spent seven hours at the practice.

We reviewed all areas of the practice including the administrative areas. We considered the views of patients both from face-to-face interviews and via patient surveys. We spoke with the interim practice manager, registered manager, GPs, practice nurse, a healthcare assistant, administrative staff and reception staff on duty. We spoke with patients who were using the service on the day of the inspection and with a member of the patient participation group.

We observed how staff handled patient information, spoke to patients face to face and talked to those patients ringing the practice. We discussed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

Are services safe?

Our findings

Safe Track Record

Reports from NHS England indicated that the practice had a good track record for maintaining patient safety. We saw that any significant or serious events were identified, recorded and significant event analysis (SEA) had been completed when these incidents had occurred. We saw that appropriate and safe action had been taken. Staff were encouraged by the management team to share information when incidents and untoward events occurred. We spoke to staff who demonstrated knowledge and awareness of their responsibilities to raise concerns, and how to report incidents and near misses.

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. We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw the records of significant events that had occurred during the last 12 months. A slot for significant events was on the practice meeting agenda. The practice closed for half a day each month for training and learning to take place with all staff. At this event significant events and complaints were reviewed, actions planned and lessons learnt disseminated. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We saw incident forms were available on the practice intranet. Staff were aware of where to locate these and would seek advice from their line manager if they needed to complete them. The interim practice manager and registered manager oversaw that these were managed and monitored.

National patient safety alerts were cascaded by email from the interim manager to all relevant practice staff. Staff told us alerts were discussed at clinical team meetings or at the half day training and development meetings if necessary to ensure all were aware of any relevant to the practice and where action was needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible. Safeguarding guidance flowcharts were displayed in all clinical areas. However there was no flowchart displayed in the office where reception staff took telephone calls from patients and put them on the triage list.

The practice had a dedicated GP appointed as lead in safeguarding vulnerable adults and children. This GP had been appropriately trained and could demonstrate they had the necessary skills to enable them to fulfil this role. All staff we spoke to were aware of who the lead was and who to speak to in the practice if they had a safeguarding concern.

There were systems in place on the electronic records to highlight vulnerable people including those with poor mental health, learning disabilities, substance and alcohol abuse. The system enabled calls and recall for patients to be reviewed, have their medication reviewed and for health checks to be undertaken. This also included information so that staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

A chaperone policy was in place and visible on the waiting room noticeboard and in all consulting rooms. Chaperone training had been undertaken by all nursing staff, including health care assistants. If nursing staff were not available to act as a chaperone receptionists had also undertaken

Are services safe?

training and understood their responsibilities when acting as chaperones. However these staff had not had a Criminal Records Bureau (CRB) or Disclosure and Barring Service (DBS) check undertaken.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We saw audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

The practice told us about the newly introduced clinician led triage system. This system increased uptake of appointments and in particular clinicians felt that vulnerable children and young people were seen appropriately and with timeliness. For example an unwell child or vulnerable person would be seen within an hour of triage. Evidence in the monitoring of A & E attendances during practice hours demonstrated a reduction of inappropriate attendances since the introduction of this triage system. This triage system enabled follow up of vulnerable people, so for example if someone who was registered as having a mental illness did not attend for their appointment this was pursued and referred to appropriate services where applicable.

Clinicians attended child protection case conferences and reviews if they were able. If they were not able to attend then written reports were submitted.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

Processes were in place to check medicines were within their expiry date and suitable for use. We established the practice nurse undertook all checks of the various medicines that were required however they did not check medicines in the doctors' bags. This was the responsibility of the individual GPs. We found that one GP's bag contained out of date medicines. This was immediately disposed of and we were told that a system would be implemented to ensure medicines in doctors' bags were checked and safe.

We saw records of practice meetings that noted the actions taken in response to review of prescribing data and medicines audits. For example, an audit on the pattern of antibiotic prescribing identified a training and education need for GP registrars.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance (Patient Group Directives). The health care assistant also administered vaccines under these directions which had been reviewed and approved. We saw evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance. Appropriate action was taken based on the results.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Are services safe?

The practice had a lead for infection control (this was the practice nurse) who had undertaken training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and there after biannual updates.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these in order to comply with the practice's infection control policy, for example reception staff when handling specimens. There was also a policy for needle stick injury, a flow chart of what to do in the event of a needle stick injury was displayed in clinical rooms.

Hand hygiene technique signs were not displayed in areas where hand washing took place. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

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, however we did not see any equipment maintenance logs or other records that confirmed this. We saw evidence that clinical equipment was routinely tested and calibrated by dated and signed stickers on the equipment. We saw evidence of calibration of relevant equipment; for example weighing scales, blood pressure monitoring machines, fridges and the fridge thermometers.

Staffing & Recruitment

Records we looked at contained evidence that mostly appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. However the recruitment policy was out of date. Non clinical staff did not have a Criminal Records Bureau (CRB) or Disclosure and Barring Service (DBS) check carried out prior to employment. Neither was there a policy for these employment checks to identify which roles required which checks and at what level. Non clinical staff undertook chaperone duties on occasions when clinical staff were not available. There was no risk assessment in place to understand the reasons for these checks not having been carried out

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure they was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were enough staff on duty to ensure patients were kept safe. However we were told that there were some vacancies across administration and reception staff and the practice manager post was currently being covered by an interim manager. Some of the staff told us the practice was actively trying to recruit to these vacancies however they were having difficulty recruiting suitable staff, this may lead to increased stress for staff trying to cover roles and workload.

Monitoring Safety & Responding to Risk

The practice had a health and safety policy, last reviewed in 2012 and was due for review two months ago. Health and safety information was displayed for staff to see around the premises. There was a generic risk assessment tool for the environment, clinical and human resources risks, however this was not localised to the practice. The risk management strategy and procedures identified environmental risks; however this needed to be reviewed as we found hazardous clutter including stepladders and boxes at the bottom of a staircase and next to a fire exit. Risk assessments and risk management procedures should be reviewed to localise and update in order to reflect current guidance and legislation.

The practice had other systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual checks of the fire fighting equipment, medicines management, staffing, dealing with emergencies and equipment. However the fire alarm test procedure was out of date and the fire safety log did not demonstrate that these essential checks had been undertaken weekly. We were told by the interim practice manager that weekly fire alarm checks had been undertaken but these were not fully documented.

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check emergency medicines were within their expiry date and suitable for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice and included power failure, adverse weather and unplanned sickness. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners (Liverpool CCG). We saw minutes of practice meetings where new guidelines were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. These guidelines were used extensively in the training of the GP registrars working at the practice also.

GPs lead in different specialist areas such as diabetes, heart disease and asthma as did the practice nurses whose support in this work allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support and discussed patients and conditions regularly in clinical meetings.

We saw data from the local CCG of the practice's performance dashboard. Although there were areas for improvement, generally it showed the practice was better than the target threshold across many of the indicators for example cancer screening and management and cardio vascular disease.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for example patients with suspected cancers referred and seen within two weeks and management of mental health conditions. We saw minutes from meetings where regular review of elective and urgent referrals were made and that improvements to practise were shared with all clinical staff.

Management, monitoring and improving outcomes for people

The practice showed us several clinical audits that had been undertaken in the last two years. Some of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit, however some of these required a follow up audit to ensure actions taken had been effective and the audit cycle was complete. Some of the audits seen included rescue medications used in chronic obstructive pulmonary disease (COPD), antimicrobial prescribing guidelines in urinary tract infections, and an audit of preferred place of care in the palliative care register according to the Gold Standards Framework.

The GPs told us clinical audits were often linked to medicines management information (from the local CCG), safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example we saw an audit regarding the prescribing of analgesics and non steroidal anti-inflammatory drugs. Following the audit the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how at group meetings they reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar practices in the area. The Liverpool CCG organised themselves into Neighbourhood Teams. The practice belonged to the Riverside Neighbourhood Team and met regularly with the CCG and other practices. These meetings shared information, good practice and national developments and guidelines for implementation and consideration. They were monitored through performance indicators and each

Are services effective?

(for example, treatment is effective)

practice was benchmarked. We saw evidence of performance monitoring with action plans developed for areas needing improvement. This benchmarking data showed the practice had outcomes comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that mostly staff were up to date with attending mandatory courses such as annual basic life support. A matrix for mandatory training requirements identified training undertaken by staff role, frequency required and was monitored to ensure staff were skilled and trained to undertake their role. A good skill mix was noted amongst the doctors with various additional training courses having been undertaken by most of them for example management of skin disease, GP training and child health. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and supported other role relevant courses, for example the practice nurse was enabled to undertake further training to enhance her role. As the practice was a training practice, doctors who were in training to be qualified as GPs had access to a senior GP throughout the day for support.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, administration of vaccines and cervical cytology.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X-ray results, letters from the local hospital including discharge summaries and out of hours providers were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. We observed that not all results were filed daily and we saw some examples where a GP had left some reports unfiled from the previous day. It was unclear if these had been actioned, however we spoke with the practice GPs and management who agreed they would look at introducing a system to ensure actioned results were filed in a timely manner.

The practice held monthly multidisciplinary team meetings to discuss the needs of patients with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented. These meetings and discussions gave evidence that the Gold Standard Framework protocols were implemented.

The practice worked closely with other health care providers in the local area. The principal GP and the practice manager attended various meetings for management and clinical staff involving practices across Liverpool CCG and in their Riverside Neighbourhood team. These meetings shared information, good practice and national developments and guidelines for implementation and consideration.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals and we saw that these were used appropriately.

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 system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 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. Staff

Are services effective?

(for example, treatment is effective)

gave examples of how a patient's best interests were taken into account if a patient did not have capacity. 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 held with a record of the relevant risks, benefits and complications of the procedure.

Health Promotion & Prevention

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

QOF information showed the practice performed average or good when compared to GP practices nationally regarding health promotion and ill health prevention. For example, the provider had just a 1% higher than target of patients who were recorded as smokers in the last 24 months and a lower than target threshold for children's immunisations. They performed well and were above the threshold for some of the screening targets such as bowel, cervical and breast screening. The practice had regular meetings with the Neighbourhood Team and CCG management and had developed an action plan to address those issues where they were not meeting their targets.

The practice had a health promotion room located in the reception of the practice. This was open to all patients attending the practice and had equipment including blood pressure monitor and weighing scales. Patients could record their own weight, height and blood pressure and take it to their appointment or read about how healthy they were in this respect. The room also included numerous health promotion information leaflets to read and take away such as various cancer screening tests, smoking cessation, obesity, diabetes and coronary heart disease.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and the majority were offered an annual physical health check. Similar mechanisms of identifying at risk groups were used for patients who were obese and those receiving end of life care. Ninety three percent of patients with diabetes had a record of foot examination and risk classification. All these groups were offered further support in line with their needs.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance and is performing well. QOF data demonstrates that for example 98% of patients who have diabetes have had an influenza immunisation.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the recent national patient survey. The evidence from this showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data showed the practice was rated 'among the best' for patients rating the practice as good or very good. Seventy one percent would recommend the practice to someone who has just moved into the area. The practice also scored well for its satisfaction on consultations with doctors and nurses with 86% of practice respondents saying the GP was good at listening to them and 91% rated the GP as very good or good at explaining tests and treatments.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located in a separate office which helped keep patient information private. There was access to a quiet / private room if someone presented at reception and wished to speak in private. Staff knew about this and told us how they would offer patients the opportunity to use this room if they felt it would help.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. The survey showed 81% of practice respondents said the GP involved them in care decisions.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

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

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection told us staff were compassionate and understanding when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. There was written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us families who had suffered bereavement were called by their usual GP. A sympathy card was also sent out to the family.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs.

The practice provided a service for all age groups. They provided services for people in the local community with diverse cultural and ethnic needs, patients living in deprived areas and those experiencing poor health with a lower than average life expectancy . GP's and other staff had the overall competence to assess each patient, were familiar with the individual needs of each patient and the impact of the socio-economic environment.

The practice proactively addressed the risk of unplanned admissions. Each of the patients at risk of unplanned admissions were identified and had a nominated GP with regular meetings held to minimise risks and investigate any episodes of unplanned admissions.

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We were told by the CCG that action plans had been agreed to implement service improvements.

There had been very little turnover of staff during the last few years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. There was a register of housebound and nursing home patients and home visits were made to local care homes and to those individual patients who needed one.

The practice had achieved and implemented the Gold Standards Framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

The practice worked collaboratively with other agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment.

The practice had a population with higher than average mental health needs. They had a high incident of patients suffering from depression and worked with local support services to aid better care for these patients. Diagnostic tools were used by the practice to identify those patients at risk. The practice also worked collaboratively with the local mental health trust and had joint meetings to discuss patient care every three months.

The local specialist drug and alcohol charity (Addaction) held a clinic at the practice once a week and the practice worked closely with them in treating these vulnerable patients.

The practice had a higher than average population group of younger patients including women. For mothers and babies the practice undertook their own six weeks checks and first immunisations. This is usually something usually the community health visitor did. This meant continuity of care post-natal with the GP.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. It monitored and was aware of patients various needs physically, psychologically and socio economically. For example joint working took place with local mental health services and drug and alcohol addiction charities to plan and deliver care and treatment to patients. Those patients with a learning disability were identified and able to access services designed for them.

Staff were found to be dedicated to the practice ethos; they respected patients and valued their diversity. Staff knew how to access language translation services and Citizens Advice Bureau support.

The practice provided equality and diversity at work training. The training matrix showed that most of the clinical staff had undertaken this, however the clerical staff needed to be updated in this training.

The premises met the needs of people with disabilities. The doors were wide enough for wheelchair users, there was a lift to the first floor and the consultation / treatment rooms were on the ground floor. There were disabled toilet

Are services responsive to people's needs?

(for example, to feedback?)

facilities on the ground floor. The provider may find it useful to note that access through the front door was restrictive for wheelchair users in that it was not easy to negotiate the two doors due to the lack of an electronic opening system.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had a population of over 80% white British ethnicity patients. Access to translation services was available for patients whose first language was not English.

Access to the service

Appointments were available from 8am to 6.30pm on weekdays. An extended service was offered on Mondays with appointments available up until 8.30pm. Home visits were available to those housebound patients and those living in nursing homes. The practice operated a telephone triage system for appointments which meant that all urgent cases were seen usually within an hour and the majority of patients were seen the same day as ringing. All unwell children were seen the same day and usually within two hours.

Comprehensive information was available to patients about appointments on the practice website and in the practice information leaflet. This included how to arrange urgent appointments and home visits and advised that they did not offer an online booking service. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed they would be automatically transferred to the local out of hour's service.

The practice had implemented a clinician led telephone triage system to improve access to appointments. They had identified access to appointments was an issue and patients were waiting up to two weeks for an appointment. Telephone triage meant that patients needing to be seen on the same day could be identified and therefore the practice was responding to the needs of the most vulnerable patients quickly. For example patients with poor mental health, at risk of admission to hospital or an acutely unwell child. Data demonstrated there had been a reduction in attendance of practice patients to A & E departments since the introduction of the triage system. A recent survey showed that 78% of respondents said they could see a doctor on the day they rang for an appointment. In addition all vulnerable children were seen, usually within two hours of the phone consultation. Vulnerable patients who did not then attend an appointment they had made that day were immediately followed up and if at risk of harm other agencies were contacted.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Seventy eight percent of patients responding to the national GP patient survey said they could see a doctor on the day they rang for an appointment. Eighty nine percent of respondents said the appointment they got was very or fairly convenient for them. Both patients and doctors told us they were pleased with the telephone triage system. Those patients who worked were able to speak to a doctor at a convenient time for them during the working day and did not necessarily need to visit the practice for a consultation. Extended hours were available on a Monday which gave access for those working during the day also. Text message reminders were also sent for appointments to try to help reduce the number of patients who did not attend.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated person who handled complaints in the practice and liaised with staff to undertake investigation and reporting for complaints.

We saw that information was available to help patients understand the complaints system. This was contained in the practice information leaflet, on the website and on posters displayed in the reception area. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at nine complaints that had been received in the last twelve months and found these were handled satisfactorily. We reviewed a complaint that had been

Are services responsive to people's needs?

(for example, to feedback?)

upheld by the Parliamentary and Health Service Ombudsman, this dated back to 2012. An action plan was developed, however we did not see any evidence of review or monitoring of the action plan to ensure lessons were learnt and incidents such as this did not recur.

The practice reviewed complaints regularly at monthly meetings and this involved looking at themes or trends. Staff told us they found these meetings useful and they imparted information from lessons learnt from 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 had a clear vision to deliver high quality care and promote good outcomes for patients. These values were clearly displayed in the waiting areas and in the staff room and formed part of their statement of purpose. The practice vision and values included providing high quality, evidenced based care, working with patients to understand their individual needs and supporting staff to deliver high quality care.

We spoke with nine members of staff including GPs, nurses, reception and administration staff. They all knew and understood the vision and values and knew what their roles and responsibilities were.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at a selection of these policies and procedures. Most of them were current and up to date, however some of them, in particular recruitment and risk management procedures needed reviewing to ensure they reflected current guidance and legislation.

The practice held various meetings weekly and monthly. We looked at a selection of these and found that performance, quality and clinical risks were discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice participated in a local peer review system with neighbouring GP practices within the local CCG. At these meetings the practice had the opportunity to benchmark their service against others and identify areas for improvement. Local action plans were developed and the practices were supported by the CCG.

The practice had completed a number of clinical audits, for example rescue medicines used in COPD exacerbations, adherence to antimicrobial guidelines in urinary tract infections and an audit of the preferred place of care in the palliative care register in accordance with the Gold Standards Framework. We found some of these audits required a follow up to ensure completion of the audit cycle.

Leadership, openness and transparency

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

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

There were a number of human resource policies and procedures in place including disciplinary procedures, harassment and bullying at work and management of sickness absence. Some of these policies required updating. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. As a result of previous surveys the telephone triage and consultations system was introduced.

The practice had an active patient participation group (PPG). We spoke to a member who told us they felt ineffective as a group and felt doctors from the practice attended their meetings infrequently. We discussed this with the practice who acknowledged they needed to work better with the PPG and were looking at re-establishing regular meetings with the group and helping the group to promote itself and work more effectively with the practice.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Are services well-led?

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

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at seven staff files and saw that regular appraisals took place. Staff told us that the practice was very supportive of training and that they had staff half day learning events which promoted learning and development.

The practice was a GP training practice. GP registrars were supported to learn by GP partners who were accredited trainers and advisors.

The practice had completed reviews of significant events and other incidents and shared the results with staff via meetings and half day learning events to ensure the practice improved outcomes for patients.

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 Family planning services Maternity and midwifery services Termination of pregnancies Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **People who use services and others were not protected against the risks associated with unsuitable staff because the provider did not have an effective procedure in place to assess the suitability of staff for their role. Not all the required information relating to workers was obtained and held by the practice.**