Bootle Village Surgery

Quality Report

204 Stanley Road
Bootle
Liverpool
Merseyside
L20 3EW

Tel: 0151 933 7447
Website: www.bootlevillagesurgery.nhs.uk

Date of inspection visit: 4 November 2014
Date of publication: 22/01/2015

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?	Requires improvement

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 4

The six population groups and what we found 6

What people who use the service say 9

Areas for improvement 9

Detailed findings from this inspection

Our inspection team 10

Background to Bootle Village Surgery 10

Why we carried out this inspection 10

How we carried out this inspection 10

Detailed findings 12

Action we have told the provider to take 22

Overall summary

Letter from the Chief Inspector of General Practice

This is the report from our inspection of Bootle Village Surgery which is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on the 4 November 2014 at Bootle Village Surgery. We reviewed information we held about the services including patients comments and spoke with GPs and staff.

Bootle Village Surgery is rated as requiring improvement for providing safe and well led services. However, we had not seen any evidence to show that this had impacted on patient's welfare and therefore the practice has been rated good overall.

Our key findings were as follows:

- There were some 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.
- The practice was effective. Patients had their needs assessed in line with current guidance and the practice promoted health education to empower patients to live healthier lives.
- The practice was caring. 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 staff worked exceptionally well together as a team and had regular staff meetings.

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

Importantly, the provider must:

- Ensure that all records for management of the regulated activities are comprehensive to underpin the informal governance systems already in place. In particular, the practice must review and update all

Summary of findings

policies and risk assessments for the practice and ensure staff are aware of procedures and can access all policies. (Regulation 20 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Records)

- Ensure that records and checks pertaining to the employment of staff for the purposes of carrying out the regulated activity are updated to include any recruitment checks (or risk assessments as to why recruitment checks not carried out) and professional registration status. (Regulation 21 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers)

The provider should:

- Make patients aware there is a chaperoning service available.
- Make patients aware there is a complaints policy available and update the policy to give patients the correct contact details for who they should contact if they are not happy with the outcome of their complaint.
- Consider other ways to gain patients' feedback for example using a patient participation group.
- Should ensure the findings from audits are cascaded to the whole practice to improve patients' outcomes.
- Make sure there is a child safeguarding procedure and policy available for all staff.
- Ensure all staff receive infection control training suitable for their role.

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. The practice had not carried out any Disclosure and Barring recruitment checks for clinical staff which would ensure staff were suitable to look after patients.

The practice had a GP lead for safeguarding who liaised with other agencies when necessary. There were safeguarding policies available for vulnerable adults but not for children. However there was a documented guide available in consultation rooms. Clinical staff we spoke with were aware of their responsibilities for safeguarding but it was very unclear what training had been received by all staff and to what level. There were enough staff to keep people safe.

Bootle Village Surgery had systems in place for learning from incidents and safety alerts to prevent reoccurrences. For example the practice carried out significant event audits. There were systems in place to ensure medication including vaccines, were safely stored and in date. The practice also had emergency medication available and emergency protocols in place.

The practice appeared clean and tidy. However there were no policies available about safely disposing of sharps to prevent injuries. Equipment was regularly maintained to ensure it was safe to use.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed that the practice was performing reasonably in line with other local practices and took National Institute for Health and Care Excellence (NICE) guidelines into consideration. This included assessments of capacity and systems in place to promote good health. Some staff had received training suitable for their role and had received appraisals. The practice worked with other local multidisciplinary teams including pharmacy teams.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services. Information from surveys and comment cards indicated that staff were helpful and caring. 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.

The practice was in the middle of testing out new appointment systems and at the time of our inspection offered rapid access clinics twice a week. All appointments available in the morning sessions were bookable on the day. Afternoon pre-bookable appointments were available up to a week in advance for a GP and a month in advance for the practice nurses. The practice carried out telephone consultations and home visits when necessary.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for well led. The practice staff worked well together as a team and strove to always improve their systems of care by having weekly clinicians meetings and monthly practice staff meetings. However many policies and other records underpinning the governance systems in place were either out of date or not available.

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 was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs. GPs from the practice also carried out visits to care homes in the area.

The practice had a register for patients who had dementia and also for patients requiring palliative care. The practice held three monthly Gold Standard Framework meetings to discuss patients who required palliative care with other health care professionals. This ensured patients received 'joined up' care appropriate to their needs. In addition, the practice participated in a local initiative called a 'Virtual Ward' which aimed to treat elderly patients at home with the help of other healthcare professionals such as district nurses to avoid admission to hospital.

The practice proactively encouraged older people to receive immunisations such as the flu and shingles vaccines.

People with long term conditions

Good

There were registers of patients with long term conditions which enabled the practice to monitor and arrange appropriate medication reviews. The Practice Nurse supported patients with a variety of long term conditions such as chronic obstructive pulmonary disease. The practice had an in house phlebotomist to avoid the need for patients to attend hospital clinics.

The practice used the Quality and Outcomes Framework to monitor patient outcomes and worked on local initiatives.

Families, children and young people

Requires improvement

There were aspects of the practice for this population group that required improvement. The practice had a system for ensuring that children requiring prompt care were seen as a priority. Although, GPs and one of the practice nurses we spoke with knew how they would report any potential safeguarding issues, there were no safeguarding children policies in place and it was unclear what training staff had received. There was therefore a risk that correct procedures would not be followed.

Maternity care was given at ante-natal clinics which operated every Wednesday afternoon. Mothers and babies at 6 weeks old were routinely checked by the Health Visitor and GP. After this

Summary of findings

appointment, appointments were made for the babies to have immunisations with the Practice Nurse. The Baby clinic for immunisations and weighing was provided every Thursday afternoon.

The practice had a system in place for flagging up those children who had not received their vaccinations and the practice was encouraging follow up visits. The Practice Nurse had recently received refresher training on immunisations.

Working age people (including those recently retired and students)

Good

The practice had plans in place to provide an additional weekly evening clinic that ran until 8pm to mainly accommodate patients who could not attend during the day due to their work commitments. In addition, the practice had introduced a rapid access clinic on Monday and Friday mornings whereby the patient attended the surgery rather than call. This was to deal with urgent new illnesses such as chest infections. Appointments were given at five minute slots to allow more patients to be seen.

People whose circumstances may make them vulnerable

Good

The practice kept a list of patients with learning disabilities and arranged support and an annual health check. Some of the staff were able to partially sign using Makaton for those patients requiring support with communications.

One GP took the lead responsibility for looking after patients with drug and alcohol addiction problems. They liaised with the local drugs and alcohol team and reviewed patients regularly.

The practice was in the process of sourcing interpreter assistance. An advisor from The Citizen's Advice Bureau also held sessions at the surgery once a week to help more vulnerable people, for example, with understanding their benefits.

People experiencing poor mental health (including people with dementia)

Good

There were aspects of the practice which required improvement and related to all population groups.

The practice maintained a register of patients who experienced poor mental health. The register was used by clinical staff to offer patients an annual physical health check and medication review. Patients had a comprehensive care plan agreed with the patient or family/ carer where appropriate.

Summary of findings

The practice liaised with local services for example, Inclusion Matters. Patients where necessary were referred to this service and patients were followed up on the outcomes of their treatment.

Quality and Outcomes Framework data for 2013-2014 showed the practice performed above average for patients with mental health conditions compared with other GP surgeries in the area and in England

Summary of findings

What people who use the service say

The latest national GP patient survey results from July 2014 showed that, 86% of patients described their overall experience of this surgery as good (from 110 responses); 84% were able to get an appointment to see or speak to someone the last time they tried but only 48% found it easy to get through to the practice by phone.

Results from the national GP patient survey also showed that 89% said the last GP they saw or spoke to was good at explaining tests and treatments and 83% said the last GP they saw or spoke to was good at involving them in decisions about their care. 91% said the last GP they saw or spoke to was good at treating them with care and concern. 89% found the receptionists helpful.

The practice's in-house survey results for 2014 indicated that patients found staff and GPs very good and caring but there were on going problems trying to access appointments and seeing a GP on the same day.

We asked patients to complete comment cards prior to our inspection. We received 28 comment cards. All comments received indicated that patients found the reception staff helpful, caring and polite and the GPs provided excellent care and treated them with dignity. Patients' experiences of getting through to the surgery on the telephone and waiting times and being able to see the same GP were mixed. There were a few comments relating to privacy at the reception desk as patients felt they could be overheard or had to give more details to staff over the telephone than they would prefer.

Areas for improvement

Action the service MUST take to improve

- Ensure that all records for management of the regulated activities are comprehensive to underpin the informal governance systems already in place. In particular, the practice must review and update all policies and risk assessments for the practice and ensure staff are aware of procedures and can access all policies. (Regulation 20 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Records).
- Ensure that records and checks pertaining to the employment of staff for the purposes of carrying out the regulated activity are updated to include any recruitment checks (or risk assessments as to why recruitment checks not carried out) and professional registration checks. (Regulation 21 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers).

Action the service SHOULD take to improve

- Make patients aware there is a chaperoning service available.
- Make patients aware there is a complaints policy available and update the policy to give patients the correct contact details for who they should contact if they are not happy with the outcome of their complaint.
- Consider other ways to gain patient's feedback for example, using a patient participation group.
- Complete audits, not just for the benefit of the individual GP's revalidation scheme, but for the whole practice to improve patient's outcomes.
- Make sure there is a child safeguarding procedure and policy available for all staff.
- Ensure all staff receive infection control training suitable for their role.

Bootle Village Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and the team included a GP specialist advisor and a practice manager specialist advisor.

Background to Bootle Village Surgery

Bootle Village Surgery is located near the main shopping area of Bootle, Liverpool. The practice is in a deprived area of the country with approximately 13% of the patient population unemployed.

The practice has four GP partners (two male and two female), a Foundation 2 trainee GP, a registrar, three practice nurses, a Phlebotomist, reception and administration staff. The practice is open 08.30 to 18.30 Monday to Friday. The practice has two morning sessions (Monday and Friday) for rapid access whereby patients do not need to make an appointment but have to wait to be seen. We were told that there were plans to open one evening per week to accommodate patients who could not attend during normal hours due to working commitments.

The practice has a PMS contract and also offers enhanced services for example; various immunisations (for example, MMR), Alcohol, Learning Disabilities, Dementia, Minor Surgery and Avoiding Unplanned Admissions. The practice is a training practice and also offers community placements to medical students from the University of Liverpool School of Medicine.

There were approximately 6100 patients registered at the practice at the time of our inspection. The practice treated all age groups but the majority of the patients seen at the practice were between 15-65 years of age.

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
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)

Detailed findings

- 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 Bootle Village Surgery provided before the inspection day. We carried out an announced visit on 4 November 2014 and spent nine hours at the practice.

We spoke with a range of staff including five of the GPs, a Practice Nurse, administration and reception staff, the Business Manager and the Practice Manager on the day. We sought views from patients via comment cards and reviewed survey information.

Requires improvement

Are services safe?

Our findings

Safe Track Record

The Practice did not have an up to date policy in place for reporting incidents. Staff we spoke with were unsure about the process of reporting incidents and what constituted an incident other than to report anything to the Practice Manager. One GP told us there was an incident recording form which was accessible to all staff. The practice did carry out an analysis of significant events and this also formed part of GPs' individual revalidation process.

Learning and improvement from safety incidents

We looked at a summary of the practice's significant events for 2014. There were details of the investigations (root cause analysis) and learning outcomes briefly recorded. However there was no clear framework for actions to be taken by designated staff within set time frames with a date for the review of the effectiveness of any action taken. Minutes from weekly clinicians' meetings demonstrated that discussions about any incidents took place but all documentation lacked detail. We looked at one incident that had occurred and found appropriate actions had been taken and new procedures and a policy had been implemented to reduce the risk of the same type of incident happening again.

The practice collected any information with regards to national patient safety alerts. For example we could see the alert regarding the Ebola outbreak in Africa had been actioned and notices were on display in the waiting room. Minutes from clinicians' meetings showed that alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) were discussed such as issues with the combined contraceptive pill back in January 2014. However the minutes from meetings were very brief and not detailed enough to show precisely any actions to be taken and who would have responsibility.

Reliable safety systems and processes including safeguarding

The practice had a safeguarding vulnerable adults policy but we were not shown a safeguarding children policy. However GPs did have guidelines available in their consultation rooms. There was a safeguarding vulnerable adults leaflet produce by the local authority on display in the treatment room containing contact telephone numbers.

The practice had a computer system for patients' notes and there were alerts on a patient's record if they were at risk or subject to protection. There was a GP lead for safeguarding. We spoke with the GPs and Practice Nurse who were aware of their safeguarding responsibilities and discussed various examples of cases of safeguarding both for children and vulnerable adults and what action they had taken. The GP lead and other GPs had attended training about safeguarding arranged by the local clinical commissioning group. The GPs were unaware of what level of training they had attained. There was no clear practice overview of staff training received and there was no evidence to suggest that other members of staff had received training suitable for their role.

A chaperone policy was available in the Practice Manager's office but there was no notice in the waiting room to advise patients the service was available should they need it. We were told the Practice Nurse acted as the main chaperone.

Medicines Management

The practice had two fridges for the storage of vaccines available in the treatment room. The Practice Nurse took responsibility for the stock controls and fridge temperatures. We found vaccinations to be in date. There was a cold chain policy in place and fridge temperatures were checked daily. Regular stock checks were carried out to ensure that medications were in date and there were enough available for use. The Practice Nurse carried out vaccinations for children and told us they had recently received immunisation training updates.

Emergency medicines such as adrenalin for anaphylaxis and benzyl penicillin for meningitis were available. The Practice Nurse had overall responsibility for ensuring emergency medication was in date and carried out monthly checks. Emergency drugs were also available in GP bags for home visits. All the emergency medication was in date.

Prescription pads were securely stored and a log was kept of serial numbers of prescriptions available. GPs had to sign out any prescriptions used. There was a prescribing policy in place and systems were in place to check on patients

who had not collected their prescriptions. There were clear guidelines available to patients both in the practice information leaflets and the practice web site on how to order and collect prescriptions.

The practice worked with pharmacy support from the local Clinical Commissioning Group to complete medication audits.

Cleanliness & Infection Control

The Practice Manager had responsibility for ensuring the overall safety of the building which included the cleanliness of the premises. A Legionella (a bacteria found in water supplies) risk assessment had not been carried out. The practice carried out monthly checks to ensure hygiene standards were maintained.

All areas at the practice appeared to be hygienic and the practice used a cleaner who came in twice a day. Treatment rooms had the necessary hand washing facilities and personal protective equipment (such as gloves) was available. Sharps bins were appropriately stored. However there were no policies available about safely disposing of sharps to prevent injuries. Clinical waste disposal contracts were in place and spillage kits were available.

A recent infection control audit had been carried out by the local infection control team which demonstrated a high compliance with infection control standards. There was an infection control policy and decontamination policy in place and the designated member of staff for infection control was the Practice Nurse. The infection control policy outlined that staff would receive infection control training at induction and annually. However the lead for infection control had not received any training suitable for their role in their current employment nor had attended any local meetings with the infection control team to be able to cascade best practice guidelines to other staff. We could not find any evidence to suggest that other members of staff had received training about infection control suitable for their role.

Equipment

The Practice Manager ensured all electrical equipment had received a portable appliance check to ensure the equipment was safe to use.

We saw evidence to support that all clinical equipment in use had received an annual calibration check for example blood pressure monitors, to ensure the equipment was in working order. The practice did have oxygen for use in emergencies but there were no records of any checks for the equipment available.

Staffing & Recruitment

The practice had four GPs, a registrar and a foundation 2 GP, three Practice Nurses and a Phlebotomist. The clinicians were supported by reception and administration staff led by the Practice Manager and a Reception Supervisor. The practice also employed a Business Manager. The practice had made a decision not to employ locums. We saw a staff rota for the current week. Staff covered for each other when necessary using a buddy system. Staff members within the reception and administration team displayed versatility in being able to cover each other's roles and therefore reducing problems if any member of staff was absent.

Staff had been working for years at the practice and the last newly employed member of staff was one of the practice nurses who had been in post for 18 months. The practice had recently put a recruitment policy in place but this did not contain any up to date information relating to the Disclosure and Barring Scheme (DBS) or reference the need for risk assessments if no checks were completed. We looked at the staff file for one of the practice nurses. There was no evidence to support a DBS check or professional registration check with the Nursing Midwifery Council (NMC) had been undertaken. The Practice Nurse confirmed they had shown the Practice Manager their confirmation of registration and had supplied the practice with references.

Monitoring Safety & Responding to Risk

The Practice Manager told us all new employees working in the building were given induction information for the building which covered health and safety and fire safety. However there were no records available to confirm this.

The Practice Manager did not have a clear schedule for monitoring safety of the premises but ensured repairs were carried out when necessary. We saw there were log sheets of all repairs carried out and a monthly check sheet regarding the hygiene of the premises.

Fire equipment was checked annually and fire safety information was clearly displayed throughout the building.

Arrangements to deal with emergencies and major incidents

Requires improvement

Are services safe?

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. In addition, the premises were fitted with panic buttons.

All staff received basic life support training and there were emergency drugs available in the practice and in GP bags such as adrenalin. The practice had pulse oximeters and oxygen.

The practice had an emergency protocol in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and was available on notice boards for staff to refer to.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Once patients were registered with the practice, one of the practice nurses carried out a full health check. We looked at the information covered in a routine health check and found it to be very comprehensive including information about the patient's individual lifestyle as well as their medical conditions. The Practice Nurse referred the patient to the GP or other clinic within the practice when necessary.

The practice had a system of registers for patients who had greater needs for example learning disabilities register. This helped the practice identify patients who required specific appointments such as annual health checks or medication reviews. The practice used a risk stratification tool to ensure that patients had their needs assessed to proactively manage their care and avoid unplanned admissions to hospital.

We spoke with GPs who were aware of their professional responsibilities for keeping up to date with guidance for best practice such as National Institute for Health and Care Excellence (NICE) guidance. One GP we spoke with gave us an example of how patients had been reviewed following the issue of recent NICE guidance.

Management, monitoring and improving outcomes for people

Bootle Village Surgery participated in the Quality and Outcomes Framework system (QOF). This is a system for the performance management of GPs intended to improve the quality of general practice and reward good practice. GPs from the practice met monthly with the local Clinical Commissioning Group (CCG) to discuss performance.

The GPs we spoke with carried out their own individual audits. However, the audits were for individual use and results did not seem to be cascaded for the whole practice to utilise and hence potentially improve outcomes for their patients. However, the GPs did carry out medication audits for the whole practice in conjunction with the pharmacy lead for the local clinical commissioning group.

Effective staffing

A trainee GP confirmed they received induction training and mentoring from other GPs. The Practice Manager told us there was an induction programme for other newly appointed members of staff that covered such topics as fire awareness and health and safety. However we did not find any records relating to any induction training for these staff.

Staff attended local Clinical Commissioning Group training days including training about safeguarding vulnerable adults and children. There was no record of training staff received overall apart from computer training for administration and reception staff. Staff told us they had basic life support training annually. We were given a list of training which covered fire safety awareness, safeguarding vulnerable adults, equality and diversity, risk health and security but it was unclear whether this training was given just at induction or held at regular intervals. It was also unclear if the practice held training for infection control.

The practice had an appraisal system in place for administration and reception staff overseen by the Practice Manager. However, not all staff had completed appraisals and we only saw documentation completed by the member of staff and not the appraiser and there was no timetable in place for appraisals to be completed. The Practice Manager had not received an appraisal. One practice nurse confirmed they had received an informal appraisal but again we did not see any record to verify this.

Working with colleagues and other services

The practice had access to patients' blood tests and X-ray results from local hospitals and had a system in place for recording information on to patients' medical records. All letters were scanned initially and then passed onto the GP to read and action as necessary. If the GP was absent, then the letters were shared among the other GPS. Each GP could access their patients' follow up requirements and allocated time throughout the day was given to GPs to deal with administrative issues such as hospital letters and test results so that actions were taken in a timely manner. Urgent information was given directly to the GP. Patients were contacted as soon as possible if they required further treatment or tests.

Patients had previously been referred to hospital using the 'Patient Choose and Book' system. However on monitoring this system, the practice management and administrators had found that patients often re-contacted the surgery as appointments were not always available and had found that patients were seen more rapidly if the practice simply

Good

Are services effective?

(for example, treatment is effective)

directly referred the patient to hospital either by letter or fax. Those who were booked under the two week rule for urgent referrals were asked to contact the practice if they had not received their appointment within ten days.

Information Sharing

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. All members of staff were fully trained on the system, and could demonstrate how information was shared.

Systems were in place to ensure information regarding patients was shared with the appropriate members of staff. For example, information about individual clinical cases was shared at weekly clinicians meetings.

The practice shared information with the out of hours care provider for example; the practice would fax any relevant information for patients who were on end of life care who may require attention over a weekend.

Consent to care and treatment

We spoke with GPs about their understanding of the Mental Capacity Act 2005. They provided us with examples of their understanding around consent and mental capacity issues. One GP gave us an example of a case that had required a best interests meeting.

The practice carried out occasional minor surgical procedures and we saw consent forms in place which were completed prior to patients being treated. The practice had an up to date consent policy in place.

Health Promotion & Prevention of ill health

The Practice Nurse looked after patients with long term conditions such as diabetes. A member of the administration team managed the lists of people who had chronic diseases such as diabetes, heart disease, asthma, hypertension and chronic obstructive pulmonary disease to ensure patients were given appropriate recall appointments or treatment.

The Practice Nurse carried out children's vaccinations and there were systems in place to ensure that any children who may have missed a scheduled vaccination were recalled.

We observed there were adverts to patients to ensure they received their flu jabs and any patients who were considered to be at risk because of their health were invited to make an appointment.

There were health promotion and prevention advice leaflets available in the waiting rooms including information on alcohol awareness, smoking cessation and immunisations. There was also information available on local health trainers who offered advice on healthy lifestyles. The Practice Manager brought all the latest signposting information to weekly GP partner meetings so that everyone was kept up to date on the local services available and there was a provision of lifestyle information policy.

The lead GP had an interest in acupuncture therapies and ran a clinic for patients with stress related conditions.

Good

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.

We received 28 CQC comment cards which indicated that patients found staff to be helpful, caring, and polite and that they were treated with dignity. Results from the National GP survey for Bootle Village Surgery showed that 91% of patients said the last GP they saw or spoke to was good at treating them with care and concern and 89% found the receptionists helpful.

We noted that consultation and treatment room doors were closed during consultations to ensure patient's privacy. We did find that due to the layout of the reception and waiting room that conversations between patients and receptionists could be overheard. Patients also made reference to the lack of privacy on the CQC comment cards. However, results from The GP national survey showed that 61% of patients were satisfied with the level of privacy when speaking to receptionists at the surgery. The practice did have a confidentiality policy in place.

Care planning and involvement in decisions about care and treatment

Results from the National GP patient survey showed that 89% said the last GP they saw or spoke to was good at explaining tests and treatments and 83% said the last GP they saw or spoke to was good at involving them in decisions about their care.

73% of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care. The Practice Nurse showed us how they printed off health information leaflets for patients for example those patients newly diagnosed with diabetes so that the treatments and services available could be explained to them.

The practice staff helped patients who had difficulties with communications for example some staff could use Makaton signing to help support patients understand treatment.

Patient/carer support to cope emotionally with care and treatment

The practice had a system for alerting staff that certain patients may require extra care such as patients suffering with cancer or patients who had bereavement issues. The Practice Manager and Practice Nurse told us that patients with emotional issues could be sign posted to various bereavement counsellors and support organisations to ensure their needs were being met. In addition, the practice always sent a condolence card to bereaved families or telephoned them to let them know they could come to the practice for support.

There were a variety of information leaflets available in the waiting room and corridors outside the consultation and treatment rooms for various support groups. An advisor from The Citizen's Advice Bureau also held sessions at the surgery once a week to help more vulnerable people understand for example, any changes to their benefits which could cause patients to become anxious.

Good

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. For example, 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.

The practice did not have a patient participation group. The practice had however responded to patients' complaints and feedback from surveys. In particular the practice had recognised the need for altering appointment systems and had recently implemented a rapid access clinic. The Practice Manager told us they went into the waiting room during this time to gain patient's verbal feedback and told us that 80% of patients thought the system was a good idea.

Tackling inequity and promoting equality

Many of the staff had been working at the practice for many years and lived in the area and knew the patients well. The practice ethos was not to be judgemental towards any patient irrespective of their circumstances and to show respect.

The practice was in the process of seeking new interpreter services and worked closely with link workers from the community to strive to improve equal access to health care and health promotion services in the area.

The practice had an equality policy. Staff received training about Equality and Diversity. The practice also respected the rights of its staff and operated a zero tolerance policy and had anti bullying and harassment policies in place.

Access to the service

Bootle Village Surgery is open 08.30 to 18.30 Monday to Friday.

The practice was working hard to test out new methods of making appointments for all its patients. The practice had recently altered the appointment systems in response to patients concerns and was in the process of evaluating what worked well.

The practice carried out telephone consultations and home visits when necessary. Pre-bookable appointments were available for afternoons with the GP up to a week in advance and appointments all day with the nurse up to a month in advance. Some appointment systems were reserved for children after school and for the elderly in the mornings. The practice had introduced a rapid access clinic on Monday and Friday mornings whereby the patient attended the surgery rather than call. This was to deal with urgent new illnesses such as chest infections. Appointments were given at five minute slots to allow more patients to be seen. The Practice Manager told us they were considering having more rapid access sessions and the GP partners were deciding on whether there should be cut off times for this service.

All morning appointments had been changed to book on the day and this had reduced the failure rate of patients attending their appointments which in turn made appointments accessible for patients who wanted to be seen. In addition, the practice had considered the needs of patients who could not attend during the day due to work commitments and had planned to start an evening clinic once a week which was commencing the day after our inspection. During the evening there would be one GP and one Practice Nurse available to see patients until 20.00.

However, telephone access to the surgery was limited as the phone lines close 12.00-15.00 every day except Thursday when the lines were closed at 12.00 noon. The practice did have an answering service with an emergency mobile number in place and a dedicated mobile telephone number for those patients identified as being at high risk who might require immediate treatment.

Patients were advised to contact the surgery after 15.00 for non-urgent appointments and test results. Repeat prescriptions could be ordered by sending an email request and the turnaround for this was very quick -24hours.

Listening and learning from concerns & complaints

The practice had a complaints policy in place but this was kept in the Practice Manager's office and was not available at reception. Reception staff we spoke with simply told us that all patients with formal complaints were advised to speak or write to the practice manager. The complaints policy clearly outlined a time framework for when the

Good

Are services responsive to people's needs?

(for example, to feedback?)

complaint would be acknowledged and responded to. In addition, the complaints policy outlined who the patient should contact if they were unhappy with the outcome of their complaint but did not give any contact details or details of the Parliamentary Ombudsman.

We looked at a review of an annual summary of formal complaints received by the practice from April 2013 to March 2014. Complaints were broken down into different categories such as whether the complaint was a clinical issue or about administration in order to identify any trends. The review outlined whether patients' complaints had been dealt with in an appropriate timescale and highlighted whether the patient was happy with the outcome of the complaints process. Complaints were discussed at staff meetings and we saw action had been taken to attempt to reduce complaints about appointment systems. For example, by using two surgery mobiles to prevent blocking the lines at 8.30am for outbound calls, use of more staff at busier times, an extra phone line and a call queuing system.

Are services well-led?

Requires improvement

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

Our findings

Vision and Strategy

Bootle Village Surgery had the following mission statement:

"We at Bootle Village Surgery aim to provide a safe environment and a holistic approach for all patients, enabling them to manage both acute and chronic illness, and promote positive health prevention models. We aim to do this whilst remaining committed to develop medical service via innovation and education to allow provision of high quality care for our patients to continue into the future."

In discussions with the lead GP for the practice they told us that the practice mission was to look after patients. Results from the National GP survey and comment cards we reviewed indicated that patients felt they were well looked after.

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

Governance Arrangements

There was no clear formal documented clinical governance structure in place and many arrangements were informal relying on the good team working relations between staff and informal staff meetings. Records relating to the education and training of staff and HR management were poor. For example, records pertaining to staff employment checks or risk assessments, immunisation details, induction, training and appraisals were incomplete. In particular there were no documents available to demonstrate a clear overview of appraisals, training and levels of attainment achieved or future planned training for all the staff team. There was a minimal risk to patients that not all staff would be appropriately skilled.

Records relating to the risk management of the practice were also incomplete. For example, there were no policies available for staff to refer to about how to report safety incidents, child safeguarding or sharps injuries policies. In addition, there was a lack of risk assessments such as a Legionella assessment. We saw the practice had some policies and procedures to support governance arrangements which were available to all staff in files in the Practice Manager's office. However we found that many policies had only been updated since the announcement of our inspection and many were still out of date. For example there was a Grievance policy which was in date but an Inoculation Accident policy dated 2009 and an Equal Opportunities policy with no date. We saw that there were minutes from clinician's meeting kept but not from other staff meetings and it was not clear how learning from safety incidents or complaints was cascaded to members of the staff team. Although we had not seen any evidence to show that this had impacted on patient's welfare, there was a minimal risk to patients and staff that correct procedures may not be followed as there was insufficient guidance in place.

Leadership, openness and transparency

The practice was overseen by a lead GP partner and there was also nominated clinicians within the practice to act as leads for example, safeguarding and infection control.

Staff we spoke with told us they were well supported and knew who to go to in the practice with any concerns. It was clear from discussions with staff that the practice operated an 'open door policy' to allow staff to discuss any issues. The practice operated a 'no blame culture' to allow staff to feel confident to raise concerns about poor performance.

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

There was no patient participation group in place. We saw a comments and suggestions box was available at reception but this had only been put there since announcing our inspection. The practice had carried out a patient survey.

Results of surveys and complaints were discussed at staff meetings and actions had been taken as a result of patient feedback for example changes to the appointment system. The Practice Manager told us that they had spoken with patients in the waiting room to gain their feedback on the new appointment systems in place.

Staff told us that they could always raise any concerns with the Practice Manager and could meet with them every afternoon to discuss any problems on an informal basis.

Management lead through learning & improvement

GPs were all involved in revalidation, appraisal schemes and continuing professional development. The Practice

Are services well-led?

Requires improvement

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

Manager told us they were in the process of carrying out appraisals for administration staff and we saw some documentation to demonstrate that staff had been asked about their performance but we did not see any completed appraisal processes or any timetable for planned appraisals. One of the Practice Nurses and trainee GPs told us they had received an informal appraisal and were clinically supported to carry out their role. However we did not see any records to support this.

All staff attended a variety of staff meetings. The clinicians and Practice Manager held weekly meetings and often invited other healthcare professionals affiliated to the practice to attend. We looked at minutes for meetings held over the year. Agendas for clinician's meetings included any incidents or complaints and any patient safety or medication alerts but the minutes for the action needed lacked detail.

There was monthly staff meetings arranged for other staff but we did not see any minutes for the meetings. The Practice Manager and staff confirmed they attended meetings which included protected learning time. Some staff told us they attended training sessions provided by the local commissioning group (CCG) and one of the GPs and practice manager attended local Clinical Commissioning Group meetings on a monthly basis.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **Evidence regarding information specified in schedule 3 was not available. In particular there were no Disclosure and Barring checks available for any staff.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Records pertaining to the management of the practice were incomplete. This included risk assessments and general operating policies and procedures. Patients who used the service were at a minor risk of staff not following up to date procedures to ensure patients' welfare.**