Langbank Medical Centre

Quality Report

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Date of inspection visit: 30 April 2015
Date of publication: 25/06/2015

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?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Langbank Medical Centre on 30 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services to older patients, patients with long term conditions, working age patients and those patients whose circumstances made them vulnerable. The practice required improvement for providing safe services. This had some impact on services provided to families, children and younger people, and those patients experiencing poor mental health.

Our key findings across all the areas we inspected were as follows:

- The practice used data and audits to check and gauge the effectiveness of treatments provided to patients.
- The practice was responsive to patients' needs; we found the practice listened to patient feedback and acted quickly to ensure their needs were met.
- The practice leaders promoted openness and transparency amongst staff and supported all staff appropriately
- Patients we spoke with told us they received a very caring service from the clinicians and staff at the practice. CQC comment cards completed by patients mirrored this.
- Administration processes in relation to safeguarding matters were incomplete. Patients who were subject to a safeguarding plan were not correctly identified and requests for reports from local authority safeguarding boards were not always met.
- The review of significant events was insufficient to provide learning for clinicians and staff involved.

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

Importantly, the provider must:

Summary of findings

- Improve processes in place for safeguarding of vulnerable children and adults. Sufficient checks must be in place for the receiving and correct recording of safeguarding information and for the sending of information to local authority safeguarding boards.

Action the provider should take to improve:

- Ensure review of significant events includes asking of key questions and has sufficient input from staff to identify areas for improvement and to promote learning.

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. Staff understood their responsibilities to raise concerns and to report incidents and near misses. However, when things went wrong, reviews and investigations were not thorough enough and lessons learned were not communicated widely across the practice to support improvement. The analysis of significant events was undertaken by clinicians but key questions of 'who, how, when, where, why and what' were not applied, so learning was limited. Administrative processes in relation to safeguarding failed to ensure all requests for reports were met and all information received was included in patient records.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff had received training appropriate to their roles. Any further training needs had been identified and training was planned to meet these needs. We saw appraisals and personal development plans were in place for all staff. Staff worked well with multidisciplinary teams to ensure people received care and treatment that met their needs. Effective communications were in place between GPs and the district nurse, who visited the practice on a daily basis to receive updates on those patients who required care, treatment and support within their home.

Are services caring?

Good

The practice is rated as good for providing caring services. We received 30 Care Quality Commission (CQC) comment cards completed by patients who wished to express their views. All comments were positive. Patients commented on the continuity of care they had received over a number of years and how they valued the staff at the practice. All feedback received from patients mirrored the results of the last NHS England GP Patient Survey (2013-14), where the practice had scored higher than or in line with national results for five key questions about the standard of care and treatment they received at the practice.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments

Summary of findings

available the same day. The practice policy was to see any child that was unwell on the same day. The district nurse, who liaised with the practice, was the case holder for 82 patients who required care, treatment and support in their own home. When we spoke to the district nurse they told us that GPs always made themselves available to answer any queries about a patient's condition or treatment and to provide further support as needed.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve the quality of care and treatment. The practice proactively sought feedback from staff and patients, which it acted on. The Patient Participation Group (PPG) was active. 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 providing services to older patients. The practice had a dementia 'care navigator' who regularly visited the practice. The care navigator was located in the waiting area with patients, seeking out those carers and patients with dementia, to help them access services available within the community. The practice GPs' and practice nurse support patients in two nursing homes, undertaking regular ward rounds for those patients. The practice had achieved its target for seasonal vaccination of patients over 65 years with the flu vaccine.

People with long term conditions

Good

The practice is rated as good for providing services to patients with long term conditions. The practice had worked with the local Clinical Commissioning Group (CCG), using data to identify and target areas for improvement. This included regular appointments with patients who had respiratory illnesses and coronary heart disease, delivering treatment that would help keep their conditions stable.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were deemed to be at risk and for those who were subject to a safeguarding plan. When we looked closely at systems to manage these patients, we found that there were gaps that caused some vulnerable patients to be overlooked. We also noted that requests from local authority social services departments, for submission of reports on the health and well-being of some of those children, were not always met due to administrative error. These errors had gone undetected.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people including those recently retired and students. The needs of this population group had been identified and the practice had developed services it offered to ensure they were accessible, flexible and met the needs of these patients. The practice worked with a local food bank, identifying patients and families in need of support, and issuing vouchers that could be used at food bank nearby. This service was confidential and we saw that all staff supported patients in a way that upheld their dignity.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for providing treatment to patients who may live in circumstances that may make them more vulnerable. The practice GPs supported a nearby residential facility for profoundly deaf patients. GPs conducted regular surgeries at the facility for patients who found visiting the practice more difficult. The practice staff were fully conversant with the 'Type talk' communication facility, which allowed patients to communicate their needs directly to GPs and staff at the practice. The second GP at the practice supported a centre for patients who had acquired brain injuries, again visiting the facility to provide services. The practice had worked with staff at both facilities to ensure all patients in this population group received the care and treatment they needed in a timely manner.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The practice used the services of a 'care navigator' who made themselves available in the practice waiting area, to any patients or their carer's. The role of the care navigator was to assist with access to community based support for those patients with dementia.

The practice maintained a mental health register, to enable them to interact effectively with patients and invite them for health checks and assessments. We found there were some gaps which were not addressed relating to the care of patients with acute mental health issues, and in how the practice worked with secondary care services to treat patients safely.

Summary of findings

What people who use the service say

We reviewed 30 CQC comment cards, completed by patients before our inspection. All comments were positive. Patients spoke highly of the GPs, nurse and administrative support staff. Patients commented on the continuity of service they had received over a number of years and of how valuable this had been to them. The practice had an active Patient Participant Group (PPG), who we met with on the day of our inspection. The group told us that they felt their voices were heard by the practice staff and that their opinions were genuinely valued.

We were able to speak with six patients on the day of our inspection. They told us they had received good care and treatment from the practice GPs and staff for many years. A patient was able to tell us how GPs had supported them as the carer of an elderly relative, meaning their relative was able to remain in their own home, which had been important to them. Patients told us access to GP and nurse appointments was good. A female GP had recently left the practice and patients had been made aware that another female GP would be joining the practice in May 2015. We saw a monthly newsletter was published and made available to patients in the waiting area of the practice.

Information we reviewed from the last NHS England GP Patient Survey, showed the practice performed well in key areas known to be important to patients. For example

- 88.64% of patients said their overall experience of their GP surgery was either good or very good. Nationally, the average practice score was just 85.76%.
- When asked, 85.74% of patients said their GP was good or very good at involving them in decisions about their care and treatment. Nationally, the average score on this question was just 81.84%.
- When patients were asked, 93.86% of patients said the practice nurse was good or very good at involving them in decisions about their care and treatment. Nationally, practices scored just 85.11% in response to this question.

This demonstrated that patients at Langbank Medical Centre experience care and treatment in a way that meets their needs but also took account of their wishes and preferences.

Areas for improvement

Action the service MUST take to improve

- Improve processes in place for safeguarding of vulnerable children and adults. Sufficient checks must be in place for the receiving and correct recording of safeguarding information and for the sending of information to local authority safeguarding boards.

Action the service SHOULD take to improve

- Ensure review of significant events includes asking of key questions and has sufficient input from staff to identify areas for improvement and to promote learning.

Langbank Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector, accompanied by a second CQC inspector and a GP Adviser.

Background to Langbank Medical Centre

Langbank Medical Centre ("the practice") is based in the Norris Green area of Liverpool. The practice is located in a building that had been adapted over many years since it was built in 1927. It has disabled access with all consulting and treatment rooms located on the ground floor. There is ramped access at the front of the premises. Located on the ground floor are three GP consulting and treatment rooms, a room available for use by locum GPs, a nursing and minor surgery room and a room for baby clinics with the health visitor. A number of professionals visit the practice on a weekly and monthly basis to deliver other services, such as midwives and health visitors. A dementia navigator also visits the practice to assist carers and those patients with dementia, to access other support services available within the community.

The second floor of the building is taken up by administration offices, a meeting room and a staff canteen area. The practice population at the time of our inspection was made up of 4, 679 patients. This represented a small increase on previous years which, GPs told us, was partially due to some re-development in the area and the closure of a neighbouring surgery.

Out of hours services are delivered by a separate provider, Urgent Care 24 (UC24).

Norris Green is one of the most deprived wards in the city of Liverpool. Although there have been considerable improvements in the ward in recent years, other issues that impact on health and well-being persist, such as housing, unemployment and income deprivation. Latest data shows the area has a higher proportion of children than the Liverpool average and lower numbers of working age adults. The practice has a higher rate of emergency hospital admission of cancer patients – 15.4% as compared to the national average figure of 7.4%. Data shows the management of patients with long term conditions for example diabetes, is good. Life expectancy for males in the area is 76 years, as compared with the England average of 79 years. Life expectancy for females in the area is 80 years as compared with the England average of 83 years.

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.

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?

Detailed findings

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. The practice sent us information before our inspection, such as policies and procedures and recent clinical audits conducted. We carried out an announced visit on 30 April 2015. During our visit we spoke with a range of staff including the two partner GPs, the practice manager and other administrative support staff. We also spoke with six patients and met with the Patient Participation Group (PPG). We received and reviewed 30 CQC comment cards completed by patients, expressing their views on the service. We also spoke with the district nurse, who worked with the practice in shared care of some patients, for example those who were housebound, recently discharged from hospital, or receiving palliative care.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice had a history of safe working and policies and procedures in place promoted and protected staff welfare, for example, when working alone or visiting patients in their own home. Staff were aware of systems in place for the reporting and recording of any safety incident, and spoke of an open culture at the practice in relation to addressing safety issues.

The practice had systems in place to ensure any alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) were received, reviewed and discussed with GPs, the practice nurse and other support staff.

Staff received training in health and safety and information to support this was readily available to staff, both in paper form and on the shared drive of the practice IT system. Clinicians and staff spoke of how they all had a responsibility to maintain a safe working environment for themselves and patients.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Following any significant event, the practice partners applied an analysis of each event to evaluate whether things could be done differently in future, and whether any learning could be drawn from the event.

In review of incidents we saw that the practice had produced a timeline, showing a patient's journey on their care pathway. The practice had concluded that there was nothing they would have changed or done differently, given the outcome of the significant event. The practice partners had access to a form which prompted key questions about the event, such as 'who, what, when, where, how and why'. However, this form was not used, so these questions had not been applied. As a result of this, detailed answers did not come from the analysis and 'red flags' were not addressed or commented on in the analysis. The system used for significant event analysis was not correctly applied in all cases, to always ensure learning from events.

Reliable safety systems and processes including safeguarding

The practice had systems in place to identify child and adult patients who may be vulnerable, at risk, or subject to a safeguarding plan. We saw the practice had regular meetings at practice level to review any needs of patients on the safeguarding register.

The practice reported to inspectors that they knew how many child patients were on their child safeguarding register. We reviewed an anonymised copy of the register. (A register which shows patients by their NHS number rather than by name). The register had notes next to each patient about checks that should be made to see whether a child was still subject to a safeguarding plan. There were also notes next to some NHS numbers that gave the date they were last seen at the practice. In one example, a child was last seen at the practice in early 2013 and had failed to attend a subsequent appointment in Spring of 2013. Notes made on the document we reviewed, which was dated 23 April 2015, said "contact XX to see if still active on register." In another example, it was annotated that a child on the register had "not been seen since re-registered on 20.03.14". From the notes on the register and records kept, the practice could not show that it kept an accurate up to date record of those children who were subject to a child safeguarding plan, or of those who were a looked after child as it could not demonstrate it had followed up the notes on individual patient records.

We tested processes in place at the practice for processing information requested by child safeguarding boards, and for recording information sent to the practice by local authority child safeguarding teams. In an example we case tracked, we found the practice had been advised by safeguarding teams that a child was to be made the subject of a safeguarding plan. The child was registered with the practice and seen by a GP, but had not been added to the safeguarding register. There were no markers on the records of the child to alert staff that the child was subject to a safeguarding plan. Another example we looked at involved a request to the practice for a report on a child whose safeguarding plan was being reviewed. The request and the form that required completion were date stamped and scanned on the patient record. However, the report was never completed. We made checks to see why this was not picked up and addressed. We found shortly afterwards the patient had moved out of the area. When responding to requests for the notes of this patient to be sent on, the

missing report had still not been picked up and addressed. This and the other examples we saw demonstrated that systems in place to protect children and vulnerable adults were not satisfactory.

The practice had a chaperone policy, which was available on request. Signs on the waiting room noticeboard and in consulting rooms advertised the availability of chaperones. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The practice nurse, health care assistant and administrative support staff had been trained to be a chaperone. When we asked staff about chaperone duties they could explain these and understood their responsibilities when acting as a chaperone.

Medicines management

The practice had policies in place for the safe management of medicines. Practice staff were able to describe and explain the practice cold chain policy and how they stored vaccines safely at the practice. We checked fridges used for the storage of vaccines and found they were well managed with vaccines stored in date order. Vaccines with similar names or in similar packaging were stored on separate shelves.

The practice had used data to target areas of prescribing that required improvement. The practice had worked with the local CCG to review prescribing of certain antibiotics. Data showed prescribing of some antibiotics had been higher than the national average (14.38% of antibiotic prescriptions, against an England average of just 5.57%) and above that of practices of similar size in the area. The practice had discussed this in meetings with all staff and how it could be addressed. Staff and GPs used each appointment with patients to discuss more effective antibiotic prescribing. A system of delayed prescribing was introduced whereby a prescription could be issued, but not collected from a pharmacist for 24 hours, to see if a condition had improved before using the medicine

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

Cleanliness and infection control

We saw that all areas of the practice were clean, tidy and free from clutter. Records were kept by the practice manager of cleaning checks carried out on a daily and weekly basis. Cleaning schedules were in place for the cleaner to follow, to ensure all areas of the practice were cleaned to the required standard.

The practice nurse led the practice for infection control. We saw that contracts were in place for the removal of clinical waste, and that waste was segregated and stored correctly. Sharps bins were available and stored on work surfaces where they could not be knocked over. All consulting and treatment rooms were fitted to the appropriate standard, with sealed flooring and work surfaces that were easy to clean and maintain. All rooms had sufficient stocks of personal protective equipment such as gloves, aprons and masks for use by the GPs, nurse and health care assistant. Soap dispensers were located close to sinks and paper towels were available for use. All items in treatment rooms were for single use only and disposed of safely after use. We reviewed the practice infection control policy. We saw that all staff were given training in infection control and could refer to the policy and the guidance it provided.

We reviewed the last infection control audit carried out by Public Health England at the practice. The practice had scored 96%. Any areas identified as requiring improvement had been addressed by the practice manager. We noted from an audit conducted on surgical procedures carried out at the practice, that in the year January 2014 – January 2015, 45 procedures were performed. There had been no instance of complication by way of wound infection, experienced by any of the patients. This supports the finding that the practice had good infection control procedures in place which were followed by staff.

The practice did not routinely conduct annual legionella testing to check for the presence of these bacteria. Exposure to these bacteria can be extremely harmful and steps should be taken to assess the risk of exposure to patients. The practice had taken advice from the Health and Safety Executive, in conducting a risk assessment on the practice premises and its water supply. Results of the risk assessment showed the practice to be at very low risk of harbouring these bacteria. As a precaution staff flushed all toilets and turned on all taps to let them run for at least 30 seconds each morning to clear any water that had been standing for a period of time, i.e. overnight or over weekends.

Requires improvement

Are services safe?

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 and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and blood pressure testing cuffs. Staff checked fridge temperatures were maintained at the levels required for the safe storage of medicines such as vaccines.

Staffing and recruitment

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with daily requirements. The practice manager was able to show that the training needs of staff were reviewed regularly to ensure that sufficient skills and cover was available within the practice team, to deal with unplanned absences.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. When we reviewed the staff files of the two most recently recruited staff members, we saw the recruitment policy had been followed.

The practice partners evidenced their commitment to providing services that mirrored the needs of its patients. A female GP had recently left the practice to take up another post. As a result of this the practice partners had recently recruited a new female GP who would start at the practice in May 2015.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was available for staff to review on the shared drive of the practice IT system. Staff received training updates annually on health and safety.

Practice policies promoted staff awareness of potential risks. One example we saw was the practice policy on the prevention of misuse of repeat prescribing. This was highlighted separately from the medicines management policy. Staff were warned about becoming accustomed to repeat prescription orders, without adequately checking each request. Attention was drawn to 'creeping time', where severe over use of 'as required' medications may be occurring.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to deal with emergencies and major incidents, such as unforeseen absence of key staff members, periods of high demand for GP appointments, medical emergencies and disruption to services due to extreme weather conditions.

Records showed that 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). Staff knew where the equipment was located and records confirmed that it was checked regularly and ready for use. Emergency medicines were available in a secure area of the practice and all staff knew of their location. Medicines available for use in an emergency included adrenaline, a GTN spray (used to treat a person experiencing chest pains), and oxygen. All the medicines we checked were in date and fit for use.

Contingency plans in place to deal with the absence of key staff were tested recently, when a GP left the practice. The flexibility of the two remaining partners, with ad hoc support from a locum, meant the practice could continue to deliver all services safely. The practice also had a buddy arrangement in place with a neighbouring practice, who could provide support if needed.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice is rated as good for providing effective treatment and services.

Each newly registered patient with the practice was offered a full health check. Patients' needs were assessed and a comprehensive review of their medicines was conducted. Where necessary, patients were added to registers to ensure that their condition was regularly monitored by the practice nurse and GPs.

GPs at the practice could clearly explain their assessment of patient's needs, and how this related to National Institute of Health and Care Excellence (NICE) guidance. Treatment of patients followed this guidance and the prescribing protocols of the local Clinical Commissioning Group (CCG). We saw minutes of practice meetings where new guidelines were disseminated and discussed. If any patient treatments did not follow guidance, the rationale and explanation for this was clearly documented in patient records.

The practice had conducted reviews of the patient register to identify patients aged 75 years and over, as well as those vulnerable to unplanned hospital admission. Each of these patients had been seen by the GP or nurse and had their needs assessed. A care plan was in place that focussed on health care designed to reduce the risk of unplanned hospital admission.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits we reviewed included an audit of patients being treated for rheumatoid arthritis and an audit of minor surgery carried out between January and December 2014. The audit of minor surgery carried out at the practice looked at any complications experienced, such as infection following surgery, and any follow up treatment required. Conclusions were documented. We saw that all patients had received follow-up appointments with the GP delivering surgical procedures at the practice and that there was a zero infection rate following surgery. Ages of patients were also recorded as part of the audit. This showed the youngest patient was 36 weeks old and the oldest was 88 years old.

The report concluded that use of a particular piece of equipment was key in reducing any bleed experienced by the patient, and that this contributed to zero infection rates. We saw that the findings of the audit were shared with practices locally at neighbourhood meetings.

The purpose of the audit conducted of patients treated for rheumatoid arthritis was to correctly identify all patients and to monitor and review the effectiveness of their treatment over time. One significant finding was the number of patients who were incorrectly entered on the practice computer system as having rheumatoid arthritis. In response to this finding, the register was reviewed and updated to show only those patients with a confirmed diagnosis of rheumatoid arthritis with the correct read code assigned, and who were receiving treatment for the condition. The audit had been through one complete cycle. A follow up cycle would be required to show the impact of treatment on the patients' condition, over time.

Effective staffing

Practice staff included two GPs, a practice nurse, a practice manager and administrative staff. We reviewed staff training records and saw that all staff were up to date with mandatory courses such as annual basic life support and safeguarding. The skill mix of the GPs had been considered when recruiting a new female GP, to replace a GP who had recently left. The lead GP partner had been revalidated in January 2015, and the second GP partner was due for revalidation within the next 12 months. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The practice manager kept a copy of the up-to-date nursing registration of the practice nurse.

Administrative support staff were trained in a number of duties to ensure that there was enough flexibility and knowledge within the practice team to provide cover for colleagues.

We saw arrangements were in place for all staff to receive annual performance appraisal. The practice nurse received regular one to one sessions with the lead GP and was appraised annually by the GPs. This helped in identifying any areas of professional development for the nurse, and to pinpoint any training updates required.

Good

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

The district nurse that supported the practice in the shared care of patients in the community visited the practice to speak with us during our inspection. The district nurse told us they visited the practice on almost a daily basis to receive updates on particular patients, or to give details to the practice staff about changes made to care regimes following a patient's discharge from hospital. There was a very effective communication system in place between the practice and the district nurse, and between the practice and the hospital. The district nurse, who liaised with the practice, was the case holder for 82 patients who required care, treatment and support in their own home. Good working relationships and lines of communication between the GPs and community district nurses, who then cascaded this information to other nursing colleagues and professionals across the patch, for example, those from occupational health, supported and upheld patient recovery and well-being.

The practice used the chose and book system to refer patients to secondary care (hospital appointments and referrals). Some referrals were still made by letter from the GP to the appropriate consultant at the hospital. We case tracked a patient (using an anonymised record) through this system and saw that it was managed to ensure that there was no unnecessary delay to patient treatment. The referring GP asked to see each patient referred in this way, seven days after their hospital appointment. This provided a way of GPs following up referrals and reviewing any treatment decisions by the hospital clinicians.

Information sharing

The practice held computerised patient records. The system allowed a summary of patient's records to be accessed by Out of Hours Services, which ensured safe communication of patient's conditions and on-going treatments. We saw that information from the Out of Hours service was received promptly at the practice. Letters from hospital consultants and other care providers were received electronically and by post. Incoming paper communications were reviewed by GPs and annotated with any follow up action required. These documents were scanned by staff onto each patient record. The practice shared information with Out of Hours services and updated this regularly. For example, registers of patients receiving palliative care or end of life care were updated daily and shared with the Out of Hours provider. Updates were also given by phone and email to the district nurse and support teams that worked in the community. The district nurse that worked with the practice in the shared care of patients told us that working arrangements and communications were of a very good standard.

The practice also shared information with neighbouring practices, at formal meetings and within sub groups. Discussions were held to support the successful take over and implementation of practice level delivery of all baby and childhood vaccination and immunisations. Information was also shared to promote patient well-being. For example, on how a scheme to reduce the instance of falls by older people would work in practice and how the practice could make referrals to this service.

Consent to care and treatment

All staff at the practice had received training in patient consent to care and treatment. The practice had a policy in place to support this. The policy covered definitions of expressed consent (when verbal permission is given); implied consent (when consent is indicated, for example by a patient offering their arm and rolling up their sleeve to have their blood pressure checked); and informed consent (when a patient is given information about something, for example the side effects of any treatment and what long term effects may be, before consenting to that treatment). Staff were clear on how the requirement for patient consent impacted on their daily roles, for example, when they offered and performed the services of a chaperone, or when the health care assistant took blood from a patient.

The practice nurse and GPs could evidence training they had received, and their understanding of The Mental Capacity Act 2005, the Children Act 1989 and 2004 and the use of Gillick competency (a way of testing a younger patient's capacity to understand their treatment and make choices about their treatment). The practice had produced a summary document to support all staff when dealing with consent, capacity to consent and how this should be recorded. We noted that staff communicated with patients in an age appropriate manner.

Health promotion and prevention

The practice had developed a number of patient registers that helped monitor and support those patients who may require regular health checks. For example, patients who were also a carer of a person who was ill, and those patients who had learning difficulties. We saw that these

Good

Are services effective?

(for example, treatment is effective)

patients had good access to GPs, were invited to attend regular health checks, and offered longer appointments if necessary to ensure they had sufficient time to discuss their health concerns.

The practice GPs and nurse attended all neighbourhood meetings. We saw from minutes of meetings how each practice intended to provide support for nurses in the transfer of responsibility to practice level, for the delivery of all baby and childhood vaccination and immunisations. This service had historically been provided by health visitors and Liverpool Community Health. Information was also shared to promote patient well-being. For example, on how a scheme to reduce the instance of falls by older people would work in practise and how the practice could make referrals to this service.

Practice managers attended meetings between practices to share good practice and ideas for effective health promotion. We reviewed the minutes of a recent neighbourhood meeting which showed, amongst other things, how the practice focussed on effective engagement with smokers. This included making a request to the local CCG to develop a code assigned to patient records that showed if a patient was using electronic cigarettes. This would allow the practice to monitor the effectiveness of this form of smoking cessation.

The practice could offer advice on prescription. This scheme worked by referring patients to specialist teams who could help with social problems that impacted on patients health, for example housing issues, debt counselling and advice on home security initiatives.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with patients during the day of our inspection. We asked them if they felt the service they received from clinicians and staff at the practice was caring. All patients told us they valued the level of compassion and empathy afforded to them by the GPs, nurse and practice staff. All patients said that treatment was provided in ways that respected their cultural and religious beliefs and upheld their dignity. Comment cards completed by patients before our inspection mirrored this feedback. Patients had reported that reception and administrative staff were supportive, compassionate and sensitive to their needs.

In our observations throughout the day, we noted that consultation and treatment room doors were closed during when patients were with the GP and that conversations taking place in these rooms could not be overheard.

Staff working at the practice reception desk ensured that any patient information was not left on display, for example incoming letters, faxes or paper records. We observed that staff spoke with patients in a tone that could not be overheard. Staff told us there was a separate room available if patients needed to share information, or required a more private discussion. We saw this was advertised to patients in the waiting room.

In consultation rooms, curtains were provided so that patients' privacy and dignity was maintained during examinations, investigations and treatments. Patients were offered a chaperone routinely for any intimate examinations. The chaperone service was advertised in each consulting and treatment room and in the patient waiting area.

Data from the last NHS England GP Patient Survey showed that when asked 85.28% of patients said their GP was good or very good for treating them with care and concern. This score is in line with the England average. The survey also showed that when asked 91% of patients from this practice said the practice nurse was either good or very good at treating them with care and concern. This result compared favourably with the England average score, which was only 85.11%.

Care planning and involvement in decisions about care and treatment

Data from the last NHS England GP Patient Survey showed the practice scored highly on questions around patient involvement in decisions about their care and treatment. When patients were asked how good their GP was at involving them in decisions about their care and treatment, 85.74% of patients responded positively. This compares with just 81.84% of positive responses nationally. When patients were asked how good their GP was at treating them with care and concern, 85.28% of patients responded positively, which was in line with the England average score of 85.31% of positive responses. When patients at the practice were asked how good the nurse was at involving them in decisions about their care and treatment, 93.86% of patients responded positively, compared to the England average of just 85.11% of positive responses.

Patients we spoke with 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. Patient feedback on the comment cards we received was also positive in relation to patient involvement on decisions about their treatment.

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

Notices and leaflets in the patient waiting area gave information on and details of support organisations within the area. Details of bereavement services were available, as well as carer support groups. We saw a copy of a booklet that was given to patients and carers who had been recently bereaved. This gave practice advice and a step by step guide as to what needed to be done in the event of the death of a person.

When we spoke with patients, they gave us a number of examples of how the practice staff had supported them when they were undergoing intensive treatment, for example, chemotherapy and radiotherapy. We were told how, when a patient was taken into hospital, the practice dealt with all matters in relation to the person the patient

Good

Are services caring?

was a carer for. This level of understanding and support had meant the person who was cared for by the patient, could stay in their own home rather than be admitted to respite or longer term nursing and social care. Although not a common occurrence, patients we spoke to said it was a good demonstration of how the practice and staff were prepared to 'go the extra mile' in supporting patients through periods of illness.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The NHS England Area Team 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 saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. One example of this was the way in which patient access to information was improved at the practice. The practice had a diverse population, which included patients who did not speak English as a first language. To ensure these patients had access to information, the practice had downloaded an application that enabled patients visiting its website, to convert the information on screen, into their chosen language. This ensured access to health promotion information as well as important messages about opening times of the practice and where healthcare could be accessed over holiday periods.

The practice had a Patient Participation Group (PPG). The group had been started over ten years previously, but had dwindled in number during 2013-14. The practice had worked to re-establish the group and meetings had started again in 2015. We met with the PPG who told us of initiatives the practice wanted to involve them in, for example, their help with ideas to improve services and to publish a newsletter following meetings on the practice website.

Tackling inequity and promoting equality

The practice was responsive to patients who may find explaining their health care needs more difficult. We saw several examples of this. One of the GP partners supported patients who were profoundly deaf, who lived in a residential facility in the neighbourhood. The GPs visited the facility to ensure all patients' health needs were met and also to ensure they received continuity of care. Those patients who wished to see a GP at the practice premises were offered longer appointments to ensure they had sufficient time and opportunity to discuss their health care needs. Staff were proficient in use of the 'Type talk' facility, used by deaf patients. This could also be used to offer initial telephone consultations to some deaf patients who may have required a home visit. All steps taken by the practice promoted the independence and autonomy of this patient group.

The practice had recently recruited a female GP to provide clinics at the practice. The partners considered this was essential to meet the needs of their patient population. In the short gap between when the previous female GP had left, and the new female GP would start, the nurse had been available to provide some services. We asked patients we spoke to during our inspection day, how they had found not being able to access a female GP for a period of time. All patients said they did not view this as a problem and that the practice had kept patients informed on the subject through the website and practice newsletter, available in the waiting area.

Access to the service

We reviewed the patient appointment system at the practice. We found this met patient demand. Patients we spoke with, and feedback left on comment cards from patients, was positive on the availability of GPs. Practice policy was to see any child that was ill, on that day. Also, any patient deemed as being vulnerable, would also be seen on the day if required.

Patients could book appointments by phone and in person. The practice offered a small number of appointments that could be booked on-line and were looking to increase this following evaluation of how well it worked in practise.

The premises and services had been adapted to meet the needs of patients with restricted mobility. All patient consultation and treatment rooms were accessible on the ground floor and accessible to wheelchair users. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams. Disabled toilets were also accessible on the ground floor.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. However we noted it

Good

Are services responsive to people's needs?

(for example, to feedback?)

was not immediately accessible and patients had to request a copy from the reception area. A copy of the complaint policy, or any complaint form for patients to use, was not available on the practice website.

We looked at four complaints received in the last 12 months. We found they had been dealt with in a timely way and the complaints policy had been followed, for example, in timescales for responding to any complainant and for providing a detailed response following investigation of a complaint. We saw that the practice acted in an open and transparent way, offering an apology immediately if any distress had been caused to a patient. Where appropriate, patients were offered the opportunity to discuss any concerns with the GPs at the practice. Any learning from analysis of complaint was shared between all staff at the practice.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice manager described a clear vision to deliver good quality care and promote good outcomes for their patients. All staff at the practice spoke of the importance of genuine respect and care for their patients. We spoke with eight members of staff. All staff knew and understood the vision and values held by the practice, and their responsibilities in relation to these.

Governance arrangements

There was a leadership structure with named members of staff in lead roles. For example, the nurse led the practice for infection control and one of the GP's was the lead for safeguarding. Staff had their own practice meeting, which was led by the practice manager. The practice nurse, GPs and other community clinicians, such as the district nurse, had their own meeting. We did note that the staff where well supported and communicated openly with GPs, the practice nurse and community nurse. However, there was no system in place to share any learning between the clinical team and the administrative support team, for example, learning from significant events. The practice could not show that there was a system in place to review minutes of each teams meetings, which would have ensured shared learning and understanding of any action points made at each meeting.

The practice had policies and procedures in place to govern activity and these were made available for us to review. Staff had access to all policies on the shared drive of the practice IT system. Staff records showed that all policies had been read, the date they had read them and when any policy was updated this was raised at staff meetings. For example, changes to lone working policies, or updated health and safety policies.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. We saw that QOF data was regularly discussed at practice meetings for support staff and action plans were produced to maintain or improve outcomes. For example, the correct read coding of certain conditions of patients to ensure registers produced were up to date, and interventions were successfully recorded and reported.

The practice manager took the lead on governance processes to maintain the safety of the working environment, building and facilities at the practice. We saw that risk assessments were updated. For example, we saw that the practice had contacted the Health and Safety Executive to ask for advice on Legionella testing at the practice, and a risk assessment had been carried out on the need for an annual test.

The practice kept accurate staff records in respect of each staff member. We saw that the recruitment of each staff member had been carried out in line with the recruitment policy. The practice manager also maintained a training matrix to ensure all training was completed and updated in a timely manner.

Leadership, openness and transparency

All staff we were able to speak with told us they felt confident in approaching any of the leaders at the practice to voice concerns they may have. Our observations of working relationships on the day of our inspection, and in checking information following our inspection, supported this. The practice leaders had ensured that all staff had received equality and diversity training, relevant to their role. Staff we spoke with told us this helped them understand the needs of patients from diverse backgrounds, such as those from Russia, Poland, Somalia and other African nations. Staff told us the clinical team were supportive and that they felt valued.

The practice had a whistle blowing policy. Staff could refer to this and confirmed their understanding of the term whistle blowing. We saw examples of how poor performance had been identified and addressed. Leaders encouraged positive behaviours from all staff. Staff told us their working atmosphere was friendly, professional and supportive.

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

The practice was responsive to patient feedback and input from colleagues across the area. For example, the experiences of other GP practices that were shared at neighbourhood meetings, were discussed at practice staff meetings. The practice had recently started to apply the friends and family test at the practice. This asks patients to say whether they would recommend their practice to their family and friends. Results from February, March and April of 2015 showed that patients who visited the practice were

Are services well-led?

Good

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

either very likely or likely to recommend the practice to family and friends. Only five patients seen within these three months said they were neither likely nor unlikely to recommend the practice to family and friends. Patients we were able to speak to on the day of our inspection mirrored these results.

In the last NHS England GP Patient Survey, the practice had achieved a score lower than the England average when asked about the privacy of conversations with staff in the reception area. There were no plans in place to try and address this but the Patient Participation Group confirmed it was something that would be raised on behalf of patients.

Management lead through learning and improvement

The practice manager and GPs identified areas for improvement using a number of data sources. For example, information on new patients registering at the practice showed a rise in patients that were from more diverse ethnic and cultural backgrounds, such as Polish, Russian, and Somalian patients. The practice manager and GPs identified that patients and children of these patients could be more difficult due to engage with due to language and cultural barriers. To address this, the practice manager had increased the information that was available in a number of languages, on the practice website. Staff had been trained on how to engage with these patients, for example ensuring they had access to a female GP or the practice nurse. Staff had received Equality and Diversity training and promoted the availability of interpreter services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Administration processes in relation to safeguarding matters were incomplete. Patients who were subject to a safeguarding plan were not correctly identified and requests for reports from local authority safeguarding boards were not always met.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.