Dr Andreas Tobias Keyser

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	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

This is the report of findings from our inspection of Dr Andreas Tobias Keyser's Practice, also known as Albion Surgery. Our inspection was a planned comprehensive inspection, which took place on 29 October 2014. Dr Keyser delivers services under a Primary Medical Services contract.

The service provided by Dr Keyser is rated as 'Good'.

Our inspection showed all aspects of care and treatment were safe, effective, caring, responsive and well-led.

Our key findings were as follows:

- Clear systems and procedures to protect and maintain patient safety were in place at the practice.
- Safeguarding protocols were adhered to. Practice staff researched and checked information for accuracy. Updated information was accessible to all clinicians, including GPs on training placement with the practice. All patients connected to the safeguarded child or vulnerable adult were identified and this was mapped and recorded in a chart. This was reviewed and updated regularly. This mapping gave information 'at a glance' to other clinicians that shared the building, for example district nurses and health visitors.
- Prescribing followed best practice guidance and was 4.5% under budget in 2013-14.
- The practice worked innovatively with other organisations in the community to secure the very best outcomes for patients
- Our intelligent monitoring data was mirrored by patients we spoke with who told us the service was very caring.
- The practice was well-led. All staff were engaged with the vision and values of the practice.

We saw one area of outstanding practice.

- The practice worked with other community agencies to secure quality outcomes for patients. One example we saw included patients given a prescription for advice from benefits advisers and debt counsellors, which addressed reasons for their anxiety around financial problems. We could see that these advice sessions identified that some patients had not been receiving their full benefit entitlement, and work was done quickly to address this, which represented a further positive outcome for the patient.

The provider should:

- Review best practice in relation to responding to a medical emergency, in particular the availability of oxygen.

Summary of findings

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. Patients' treatment followed recognised best practice. Trainee GPs were well supported by the lead GP and other clinicians at the practice. Safeguarding procedures were in place; information in relation to any safeguarded child or vulnerable adult was regularly reviewed, updated and accessible to all clinicians at the practice.

Are services effective?

Good

The practice is rated as good for effective. It was using innovative and proactive methods to improve patient outcomes. It worked with other local providers to share best practice. Multi-disciplinary team meetings were held by the practice on a weekly basis, when shared care of patients was discussed. Where possible, clinicians supported patients to address root causes of clinical problems, for example anxiety and depression. We saw examples of how this worked in practice.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. Patients reported good access to the practice and a named GP or GP of choice, with continuity of care and urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. The practice worked hard to ensure patients preferences were met, for example, to see a female GP.

Are services well-led?

Good

The practice is rated as good for well-led. There was visible leadership of staff and clear lines of accountability. The practice was a training practice which displayed a strong vision and set of values which all staff identified with. High standards were promoted and owned by all practice staff with evidence of team working across all roles. The lead GP spoke of how he encouraged a sense of pride in

Summary of findings

all staff, and of how each staff member was valued for their contribution to the success of the practice. The provider worked with community based services to address social issues which contributed to people's health problems, for example referral to debt advice services and welfare benefit review officers.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Historically the practice had a low figure for the identification of older patients with dementia. To address this, the practice conducted a fresh audit on patients who had presented with any related symptoms to ensure any diagnosis of dementia had not been overlooked. Once patients had received a diagnosis of dementia the practice worked with other community health professionals to deliver a holistic package of care and support to those patients. Patients over the age of 75 had a named GP.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. Two practice nurses supported patients, offering regular appointments to monitor their condition and effects of medications. Repeat prescribing was in place to ensure patients did not run out of medicines, but this was subject to regular review. Blood tests could be conducted on site, rather than patients having to visit the hospital for this service.

Families, children and young people

Good

The practice is rated as good for the care of children and young people. Any new patients registering with the practice received a comprehensive health check and assessment of their needs from the practice nurse. Any clinical problems identified were referred to a GP who would generally see the patient on the same day if required. The health check offered by the nurse was also used to identify whether children and young people had received all required vaccinations and immunisations.

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 these patients had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering a full range of health promotion and screening which reflected the needs of this age group. The practice offered extended hours of surgery on Thursday evening, when the practice was open until 7.30pm.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice served a number of patients living in vulnerable circumstances including homeless people and those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities and offered longer appointments with the GP to ensure enough time was available for discussion of their health needs.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice kept up to date registers of patients experiencing poor mental health. These patients had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had advance care planning for patients with dementia, which included the involvement of care navigators, who supported carers to access the support they required when caring for a person with mental health needs.

Staff had received training on how to care for people with mental health needs and dementia. This included a visit from the mental health lead clinician for the area, to deliver training on dementia and its effect on patients. All practice staff had received this training, including front-line reception staff.

Summary of findings

What people who use the service say

We spoke with seven patients who were attending appointments at the practice on the day of our inspection. They told us they were happy with the care and treatment provided. Two patients commented particularly on how important it was to them that they received continuity of care.

Patients told us that if they needed to see a male or female GP, they could ask for this when booking an appointment. All patients we spoke with told us they were able to get a GP appointment quickly, for example, the day following their request. We were able to confirm that if a patient needed to be seen on the same day, this could be accommodated.

The practice had an active patient participant group who were supportive and involved with initiatives started by the practice. We were told how the practice worked with other neighbourhood partners to engage with patients, for example, by working with the local housing trust to advertise practice initiatives, such as flu vaccination clinics, or the services of care navigators, who offered support to carers of people with dementia.

We received six Care Quality Commission comment cards, which were made available to patients before our inspection, so they could share their views anonymously if they wished to. All comments were favourable; patients particularly commented on the good availability of appointments and the continuity of care they received.

Areas for improvement

Action the service SHOULD take to improve

- The provider should review best practice in relation to responding to a medical emergency, in particular the availability of oxygen. If the provider does not have oxygen available in an emergency, this should be a decision based on risk assessment.

Outstanding practice

The practice worked with other community agencies to secure quality outcomes for patients. One example we saw included patients given a prescription for advice from benefits advisers and debt counsellors, which addressed reasons for their anxiety around financial problems. We could see that these advice sessions identified that some patients had not been receiving their full benefit entitlement, and work was done quickly to address this, which represented a further positive outcome for the patient.

Dr Andreas Tobias Keyser

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr Andreas Tobias Keyser

Albion Surgery is led by Dr Andreas Tobias Keyser. The practice is registered to deliver the regulated activities:

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder or injury.

The practice is located in the Everton Valley area of Liverpool which is recognised as one of the most economically deprived areas of the city. The practice serves just over 3,000 patients and is able to offer approximately 348 routine appointments a week. Appointment times are typically 15 minutes long and the practice is open until 7.30pm on Thursday each week. Requests for home visits are assessed by the GPs with house calls made between 12.00pm and 3.00pm.

Albion Surgery is a training practice, offering experience to foundation year one doctors and speciality training doctors. The practice nurses run disease management clinics where patients with long-term chronic conditions have their progress monitored and receive support to manage their conditions effectively.

All clinical services are delivered under PMS contract.

From data we reviewed as part of our inspection we saw that the practice outcomes are in line with, or better than those of neighbouring practices within the area. Childhood immunisations and vaccines are delivered to children by Liverpool Community Health. However, if the practice comes into contact with a child patient that may have missed a vaccination appointment, the practice will take action to address this. Prescribing by the practice is within expected budget and last year delivered a 4.5% saving. Management of chronic health conditions is consistent over time. The practice keeps up to date registers of those patients with learning disabilities, mental health conditions and palliative care patients. We could see on inspection that multi-disciplinary team meetings were in place to support these patient groups.

The practice does not deliver out-of-hours services. These are delivered by Urgent Care 24. (UC24).

Why we carried out this inspection

We inspected this service as part of our new inspection programme. This provider had not been inspected before and that was why we included them in our quarter three inspection programme for 2014.

How 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

Detailed findings

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.

Before our inspection we reviewed data from our intelligent monitoring system. We considered the results of the last NHS England patient survey, asked patients who use the service for their views, and left comment cards for patients to complete before we visited the practice on 29 October 2014.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

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

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

During our visit we spoke with a range of staff including the two salaried GPs, the lead GP and practice nurse. We were also able to speak with one of the medical students on placement with the practice to gain experience of working as a GP. We spoke with reception and administrative staff and with patients who used the service. We talked with carers and/or family members. We reviewed the anonymised personal care or treatment records of patients to check treatments offered followed recognised guidance and best clinical practice. We also met the practice's Patient Participant Group chairman, who spoke to us about services offered by the practice.

Good

Are services safe?

Our findings

Safe track record

Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. Patients' treatment followed recognised best practice. Trainee GPs were well supported by the lead GP and other clinicians at the practice.

The practice had systems in place to respond to any Medicines and Health Care Products Regulatory Alerts (MHRA). These were distributed and shared with all clinicians. There were clear lines of accountability in place, for example, in relation to acting on medicines alerts, GPs were given the time needed to contact patients to assess any changes required in medication and treatment. We saw on inspection, mechanisms were in place to support trainees at the practice. Sufficient time was given to doctors between consultations, to discuss their assessment and diagnosis of a patient's needs, with the lead GP. There was clear clinical oversight in place, which protected patient health and welfare.

Learning and improvement from safety incidents

Mechanisms to report and record safety incidents, concerns and near misses were in place. The practice held weekly meetings where any significant events were reviewed and discussed with staff. The practice had a 'no blame' culture, where staff were encouraged to report any matters of concern. Learning from any incident was shared with all staff at the practice. We reviewed two examples of incident reporting and investigation which showed analysis of any root cause and how aspects of service delivery were reviewed in light of the findings. Staff confirmed they felt confident they would be supported when reporting any concerns.

The practice used recognised best practice guidance to support trainee doctors, which promoted patient safety, for example following National Institute for Health and Care Excellence guidance.

Reliable safety systems and processes including safeguarding

The practice had a safeguarding policy in place. All staff we spoke with were clear that the subject of safeguarding was 'everybody's business'. All staff demonstrated their understanding of safeguarding and how to raise a concern. We saw from training records that all staff had received training in safeguarding and that this had been refreshed on a regular basis.

Information was available to clinicians and staff about each patient that was subject to a safeguarding plan. Names of people that the safeguarded child or vulnerable adult had contact with were mapped and recorded in a place that all involved clinicians and staff could access – for example, health visitors, district nurses, midwives and practice nurses. This is a feature of outstanding practice in this area. GPs had received safeguarding training to Level III, as is required. We were able to confirm that the practice had met its commitments in respect of reports for safeguarding boards and attendance at safeguarding review boards when required.

We noted and discussed with the practice, the fact that the safe haven fax, used to receive any safeguarding alerts or messages on, was placed alongside other fax machines. This could result in information being lost, or being accessed by the wrong person. We were told that this was due to all the telephone ports (for receipt of faxed communications through a telephone line) being cited in one place when the facility was built. The provider accepted that this was not ideal but underlined that it was clearly labelled as the safe haven fax, that staff were aware it was for safeguarding messages and that it could only be accessed by authorised staff.

The practice operated a chaperone service. The staff that acted as chaperones were clinical staff and they had received training to support them in this role. Patients we spoke to on the day of our inspection told us they were aware of the chaperone service and would request this if they needed to.

We saw how the senior GP at the practice reviewed all incoming correspondence. All letters, reports, discharge summaries and test results were 'date received' stamped and recorded. The lead GP then worked with the patient's named GP to discuss and determine follow-up action. The practice was able to demonstrate that any delay in follow-up could be identified, and reasons for this checked and addressed. This system used by the practice helped reduce the risk of errors.

Good

Are services safe?

Medicines management

We checked how the practice managed, stored and used vaccines. These were held in a dedicated medicines fridge in the treatment room. We noted that vaccinations with similar colour packaging were stored as far apart as possible within the fridge, to reduce the risk of error when selecting the vaccine to be administered. Records of temperature checks were maintained and we saw that the fridge was alarmed, meaning it would emit a bleep if temperatures rose beyond those recommended for the safe storage of vaccines.

We looked at emergency medicines kept at the practice. These were kept in a locked cabinet in the treatment room of the practice. The key was accessible to staff qualified to administer emergency medicines. Medicines kept for emergencies were in date and included adrenalin, GTN spray, dispersible aspirin and penicillin suitable for use in emergency, for example, for a suspected case of childhood meningitis.

The practice nurse prepared emergency drugs boxes for GPs. Regular checks were in place to ensure all medicines used were replaced, and that medicines in the box were in date and suitable for use.

The practice did not carry a supply of oxygen. We discussed guidelines on best practice. Oxygen is considered essential in dealing with certain medical emergencies (such as acute exacerbation of asthma and other causes of hypoxemia). If the practice does not have oxygen they may not be able to quickly and effectively deal with emergencies.

Cleanliness and infection control

We reviewed the infection control procedures in place. We found the treatment room was well ordered, clean, tidy and held sufficient stocks of single use disposable items for use by nurses and doctors at the practice. We saw audits were in place to ensure that high standards of hygiene were maintained by all staff using the treatment room. Bins operated by foot pedal opening were available for disposal of waste, and were clearly labelled for clinical and general waste. Contracts were in place for the removal of clinical waste and sharps bins. The building was a purpose built facility and had the recommended hand washing facilities with lever taps. The storage cupboards and work surfaces were of the recommended design as was the flooring, which was sealed and free from cracks or wear and tear. We saw that hand sanitizer was available in all areas, including patient waiting and reception areas.

We were able to review the last infection control audit conducted by Liverpool Community Health team in October 2013, which showed that standards had been maintained.

We saw monthly audits of cleaning schedules. These showed that all areas within the practice were being cleaned to the required standards. We were also able to review the Control of Substances Hazardous to Health (COSHH) register for cleaning materials used at the practice. This ensured that cleaning products used on surfaces in treatment areas were appropriate and safe for use in a clinical environment.

The practice had Legionella risk assessments in place which were updated annually. Water temperature checks were carried out monthly and recorded.

Equipment

We reviewed checks on equipment at the practice. We saw that all measurement equipment, such as blood pressure cuffs and weighing scales had been serviced and calibrated to ensure accurate measurement. Small portable electrical appliances had recently been PAT (portable appliance testing) tested.

All treatment rooms were well stocked with single use items. When making checks we saw that stock of these items was rotated correctly to ensure all items were sterile at the time of use. Personal protective equipment (PPE), such as masks, gloves and aprons were available in treatment rooms, and store rooms.

Staffing and recruitment

The practice was led by the lead GP Dr Keyser and supported by two further salaried GPs. We checked the staff records of one GP, one nurse, an administrator and receptionist. 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 via the Disclosure and Barring Service.

The practice also held up to date copies of medical insurance certificates for GPs and also car insurance details, as GPs would be expected to make house calls and attend clinical meetings outside of the practice premises. Although the practice could confirm that all nurses registrations were up to date, copies of annual renewal of

professional registration were not held in staff records. The provider confirmed they would print off details of renewal of nurses' registrations and add to staff records immediately, which represents best practice.

We looked at how the practice organised staffing to ensure medical students were supported at all times, and to ensure that the skill mix of each shift was sufficient to deliver all services of the practice. The practice manager was also a nurse who delivered some nursing duties. When we checked staffing, we could see that the deputy practice manager, full time nurse, and the two salaried GPs were sufficiently skilled to deal with all aspects of service delivery. We could also confirm that trainee GPs at the practice were also supported in the absence of the lead GP.

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.

Training was delivered to all staff on suicide awareness. The practice also had accelerated referral systems in place for patients who had been in the armed forces, particularly in terms of mental health problems.

Arrangements to deal with emergencies and major incidents

The practice had a comprehensive business continuity plan in place. We were shown how this was reviewed on an annual basis, or more often when required. The practice were able to show us how the plan had been reviewed recently when a major event was held in the city. Local parks and thoroughfares in the immediate vicinity of the practice would be filled with hundreds of thousands of people, and the practice had worked with other providers to ensure that planning for a major incident was sufficiently robust to deal with any major clinical incident.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice used innovative and proactive methods to improve patient outcomes. It linked with other local providers to share best practice. Multi-disciplinary team meetings were held by the practice on a weekly basis, when shared care of patients was discussed. Where possible, clinicians supported patients to address root causes of clinical problems, for example anxiety and depression. We saw examples of how this had worked in practice.

We checked a sample of anonymised patient records to review treatment of patients and check that a full assessment of needs had been carried out. We found in all cases that the practice followed current guidance on best practice and referral pathways for treatment. Trainee GPs on placement with the practice were supported by the lead GP in clinical assessment of patients. The appointment time for patients in these cases were sufficiently long enough to explore patient symptoms and make a diagnosis. The appointment was followed by discussion and review of the consultation with the lead GP, who confirmed the prescribed course of treatment.

The practice tapped into other community services to enhance outcomes for patients by addressing some of the root causes of their problem. One example was that of patients who were being treated for anxiety and depression. The practice showed us how they had worked with debt advisers and counselling services to help patients address financial anxieties. We saw how this had a positive impact, especially in cases where some patients were found to be entitled to financial support but were not aware of this, or were not receiving their correct benefit entitlement.

The practice ran disease management clinics where nurses supported patients to manage their chronic illnesses effectively. We saw how medicines were reviewed and how patients were referred back to the GP for further consultations if patient outcomes were not in line with those expected. The practice conducted blood testing using finger prick testing; this allowed nurses to monitor many conditions closely. Venous blood sampling was available for those patients who required more in-depth blood testing.

Management, monitoring and improving outcomes for people

The practice used data to target initiatives to improve patient outcomes. One example we looked at was that of breast screening for patients. The practice had committed to achieving and improving on targets for breast screening of patients. In the first instance they looked at when the window for appointments for breast screening was. They had found this was between the middle of December 2013 and January of 2014. The practice identified that this was likely to result in poor uptake of screening appointments, due to the other pressures that this window in time presented. For example, Christmas school holidays (childcare responsibilities), and those in temporary Christmas work who would be unable or unlikely to attend an appointment at that time. As a result of this, the practice asked for an extension of this window of time, allowing more patients to take up appointments offered.

The practice had a system in place for completing clinical audit cycles. We reviewed a recent example of clinical audit on oral contraception. Patients' medication was reviewed for any side effects and for any risks posed by long term use of some oral contraceptives. Other examples of clinical audits included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance. The practice was also due to commence a planned audit on the use of Warfarin, which demonstrated its commitment to the management and monitoring of patient outcomes.

Effective staffing

All staff and clinicians had the required qualifications, knowledge and skills required to do their job. The practice was committed to the ongoing development of all staff. The practice manager conducted a training needs analysis on the practice nurse and all support staff at the practice. This was reviewed annually. The practice manager was coached, developed and performance reviewed by the GPs at the practice. The practice manager was undertaking a front line leadership course through NHS England, and shared plans for the deputy practice manager to complete the course if they wished to. All staff took an active part in performance review and appraisal; we were able to confirm that clinical staff had the benefit of peer review of their work and regular feedback on their performance.

Good

Are services effective?

(for example, treatment is effective)

The lead GP supported the trainees at the practice, with support from the salaried GPs. One of the salaried GPs had recently completed training in acupuncture and this service was made available to patients at the practice.

The practice had recently recruited an apprentice administrator, who would be trained to NVQII in business administration. We saw that this staff member had received an induction, an assessment of needs in relation to practice specific training and was supported by regular one-to-one meetings with the practice manager.

Working with colleagues and other services

We reviewed patient records of referral to other services, such as hospital consultations. We saw that referrals contained all necessary information relating to the patient's condition, relevant medical history and results of any recent blood tests. This confirmed that there was no unnecessary delay in a patient being referred for treatment.

The lead GP at the practice dealt with incoming correspondence, including details of patients who had been discharged from hospital. The practice held multi-disciplinary team meetings on a regular week day, when all clinical staff attended along with district nurses and community matrons. These meetings were used to manage the care of patients with complex needs, those discharged from hospital who required follow-up visits, and to update on the care of patients receiving palliative care delivered by district nurses.

From our intelligent monitoring data, we found that 96.3% of patients had a care plan documented in their records, which was agreed between clinicians, patient and family member or carer. This is above the average for GP practice in England, where the percentage of patients with an agreed care plan in place is only 87.4%.

Reception staff we spoke with showed us how communications from the out of hours' service provider (Urgent Care 24) were received and managed. We were able to confirm that updates on patients visited by out of hours services were received by 8.00am each day and passed to the lead GP who checked and updated patient records and organised any follow up appointment needed.

Information sharing

The practice kept a list of those patients receiving palliative care and shared details of those patients that may pass away overnight with the out- of-hours services. Care plans were in place for people with complex needs and community clinicians and out-of-hours services had access to these.

The facility to receive new patients' medical records electronically was not available at the practice. When paper records were received, they were summarised and added to the computer record of the patient, created by the practice. This presented the possibility that a patient subject to a safeguarding plan would not be known immediately to the practice. The provider spoke with us about how they contacted the previous practice that the patient was registered with, to check on this detail.

Staff we spoke with had all received training on patient confidentiality and were aware of Caldecott principles.

Consent to care and treatment

GPs, nurses and trainee GPs at the practice could demonstrate their understanding of consent, the Mental Capacity Act 2005 and the Children Act 1989. Consultations where mental capacity was explored were recorded in detail. Where a consultation took place with a patient with a learning disability, appointment times were longer and carers were invited to attend with the permission of the patient.

Nursing staff demonstrated their understanding of informed consent and knowledge of Gillick competency. This is the principle that determines whether a child has the maturity of understanding to make a decision about their care and treatment.

When we reviewed a sample of anonymised records for evidence of informed consent to surgical procedures, we saw that evidence of consent was held on patient records.

Health promotion and prevention

All new patients registering with the practice received an initial health check appointment with the practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. The practice used this opportunity to check if all immunisations for children were up to date and to add patients to particular care registers, for example, for patients with asthma. Patients were also made aware of any health promotion initiatives, for example, support with giving up smoking.

The practice offered details of referral to community based services for those with drug or alcohol problems. The

Good

Are services effective?

(for example, treatment is effective)

practice was pro-active in trying to meet the complex needs of patients from vulnerable circumstances, for example, those patients who were homeless. The practice served patients who were allocated a place in a homeless hostel that was close by, and found ways to accommodate those with no fixed address when they left the hostel. This could be by leaving messages with the hostel, which the patient would return to periodically to collect.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with seven patients on the day of our inspection. All expressed that they were very happy with the care and treatment provided. Six CQC comment cards had been completed by patients before the inspection day. Some of these gave detailed descriptions of the high standard of care patients had experienced at all times at the practice. Patients had used words such as 'fantastic' and 'amazing' and commented on the continuity of care and the level of respect they were shown by GPs and support staff. Figures from the last national patient survey supported these comments. The proportion of patients who responded to the survey, who stated that their GP was good or very good at involving them in decisions about their care was 93.9%. This is higher than the England average of 81.8%. The same question was put to patients about nursing care at the practice. The patients who responded in the last national patient survey, who said the nurse they last saw at the practice was good or very good at involving them in decisions about their treatment or care was 91.4%. This compares with the England average of 85.1%.

Care planning and involvement in decisions about care and treatment

Figures from Quality and Outcomes Framework (QOF) data showed that the percentage of patients on the practice register, who had a comprehensive care plan documented in their records, that was agreed with the patient and their family or carers were appropriate, was 96.3%. This is higher than the England average of 87.4%. Some patients we spoke with were able to confirm that their medicines were reviewed regularly, and that either the nurse or GP they had seen at that appointment had explained the benefits of particular medications, the time of day they should be taken to give maximum effect, and how any other medicines, over the counter remedies or particular foods could interfere with absorption of medication.

Patient/carer support to cope emotionally with care and treatment

The practice manager described to us the strong familial support available to many patients on their practice register. The practice provided details to patients and carers of organisations locally who could offer carer support. This included the help of a community resource called Care Navigators. This service worked with family members who were carers of patients diagnosed with dementia. The practice historically had a low dementia patient register. A planned audit was carried out on patients that had showed some related symptoms of the disease. When those patients were referred to the memory clinic, some were diagnosed as having dementia. The practice had proactively involved support services, such as care navigators, to help family members who were carers to access the help they needed to look after their relative at home.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. People we spoke with on the day of our inspection told us that continuity of care was important to them.

The practice staff talked about development of services constantly to ensure they met the needs of patients. One of the GP's at the practice was the neighbourhood lead on redesign of community nursing services. The practice manager and other clinicians attended regular meetings with other practices in the locality to share ideas on how to deliver services that met the particular needs of patients of an inner city practice

The practice had an active Patient Participant Group (PPG). A member of the group we were able to spend time with, was realistic in what could be achieved by the group. For example, we were told it was difficult to engage with some younger adult patients on subjects such as obesity and healthy eating. However, the group member discussed with us, ideas for reaching out to child patients, through primary and junior schools in the area, and was keen to help in any way possible. The group had worked with the local housing association by inserting flyers in the housing association magazine about the availability of flu vaccinations for people in the area. The practice welcomed the enthusiasm of the PPG and valued the support it provided in communicating with all patients.

Tackling inequity and promoting equality

The practice and its staff were aware of access issues for some patients trying to register with the practice, and for those patients who did not speak English as their first language. The practice staff had access to Language Line, an over the phone interpreter service for patients for whom English was not their first language. We were told that interpreters were booked to accompany patients at the practice on their first appointment, to aid understanding of how services were delivered. Patients who required a longer appointment time, for example, those who needed the service of interpreters, those with a learning difficulty or for those with more complex needs, would be booked in with a GP for 30 minutes.

The practice was close to a hostel for homeless people. Patients from the hostel registered with the practice, and the practice worked hard to overcome barriers to healthcare that some vulnerable groups such as homeless people face. For example, when patients left the hostel and moved out of the area, they were still of no fixed abode. GPs worked with those patients to ensure they had access to the healthcare services at the surgery, by leaving messages for the patient at the hostel which could be collected, for example messages about repeat medication and any follow up appointments.

Access to the service

The practice is a purpose built facility and access to reception areas, waiting areas and treatment rooms was wheelchair friendly. A lift to the upper floors was available which was big enough for parents with children in double pushchairs (for two children or twins) and prams. There was a hearing loop facility in the reception area, for use by people with hearing difficulties.

The practice was open each day from 8.00am to 6.30pm, and open late on Thursday evening until 7.30pm. The appointment system was capable of providing 348 appointments each week. This was slightly above the number of appointments expected from a practice with a patient list of 3150. Patients were able to book appointments by phone, or by using the practice website. Repeat prescriptions could also be ordered on-line.

Those patients who required a visit to their home by the GP could request this, with GPs doing house calls between 12.00pm and 3.00pm each day. Practice nurses were available to give advice on managing chronic conditions and would refer a patient on to a GP if needed. Patients we spoke with told us that they never experienced a problem getting an appointment to see a GP. When a patient had required an emergency appointment, GPs would see those patients following their planned morning or afternoon clinics.

The practice regularly reviewed the numbers of patients from their register that visited the nearby accident and emergency unit. The result of analysis showed that these patients were generally from the adult population and had

Good

Are services responsive to people's needs?

(for example, to feedback?)

presented for primary care rather than as an emergency case. This is a trend, mirrored in other cities, which the practice worked hard to address by ensuring that sufficient appointments were always available to patients, and by offering extended hours surgeries on Thursday evenings.

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 designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand how the complaints system worked, and that if they were not happy with the outcome of an investigation into their complaint, they could ask the Health Care Ombudsman to review their complaint. The practice had received two complaints within the last 12 months. When we reviewed these we could see that the complaints policy and procedure had been followed and a detailed response had been sent to the complainant. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

The practice manager held a regular slot on complaints within the practice meetings each Thursday. Any complaint received was discussed, and findings from any investigation shared with all staff.

The practice had a patient charter which was displayed in the waiting area. This was written in plain English and free from jargon. It stated that the practice had listened to what was important to patients, for example access to appointments, being seen on time, being told if there would be an extended wait to see their preferred GP. The charter set out what it would do to meet patients' expectations. The charter told patients they would be seen on time, or, were there was a delay, they would be seen within 20 minutes of their appointment time. If a delay beyond 20 minutes was likely, patients would be informed, offered an alternative appointment, or be seen by another doctor. Patients we spoke to told us that they very rarely experienced a delay when attending for GP or nurse appointments.

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

There was a clear vision and strategy for the practice which staff shared and engaged fully with. The GPs described their vision of a caring practice which put patients at the centre of all they did. A range of healthcare professionals met regularly to share knowledge and information for the benefit of patients' health and welfare. The lead GP told us how he valued the contribution of all staff, telling them they should be extremely proud of their contribution to the health and welfare of the community they served.

Support staff we spoke with told us they felt valued as an employee and that the work they did was appreciated by the clinicians at the practice. Staff told us they cared about the patients they served and knew that the service they provided was appreciated and valued by patients. We saw that staff meetings were held regularly and that staff were encouraged to share their thoughts and ideas on how any improvements to the patient experience at the practice could be achieved.

Governance arrangements

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing above the England average in many areas. We saw that QOF data was regularly discussed at practice meetings and plans were produced to maintain or improve outcomes. Recent examples of targeted areas for improvement were in bowel cancer screening and breast screening of patients.

The practice had a range of policies and procedures in place to assist with the smooth running of the practice. These were indexed and were reviewed and updated annually to reflect any changes required, for example, in relation to changes in employment law or health and safety in the work place. The practice relied on an external provider for advice on HR related matters.

The practice manager held a regular governance update within the weekly practice meeting. We reviewed minutes from recent meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

The practice benefited from clear leadership, which was visible and accessible to all staff. The lead GP at the practice spoke of the 'no blame culture' in place, but understood and explained the limitations of this to staff. The two salaried GPs said they were well supported and were encouraged to further develop their skills and knowledge. The practice manager led the administrative support staff. Staff we spoke with told us they felt they could raise any concerns they had and told us they had confidence in leadership at the practice.

The practice shared a building with clinicians from Liverpool Community Health, who were invited to and attended practice meetings. The vision of the practice, of sharing knowledge for the benefit of patients was evident from records of these meetings.

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

The practice had a Patient Participant Group (PPG). When we met with the Chair of the group, we were told the practice valued ideas and input from the group. The Chair of the group understood the challenges that came with an inner city practice, but said the practice was happy to work with other community groups to reach patients. For example, the PPG told us about working with the local housing association to deliver leaflets advertising flu immunisation clinics. The practice had an action plan around developing the PPG and the contribution it could make to patient feedback on the design of service delivery for patients. The PPG was also involved in the development of questions for an annual patient survey. The results of this survey will be posted on the practice website.

Management lead through learning and improvement

Staff we spoke with confirmed they had personal, agreed objectives set in their annual performance and development review. Staff told us they understood the vision and aims of the practice and that their ongoing development was part of that vision. The practice manager reviewed staff objectives with support staff to ensure that learning highlighted was achievable and that staff had the time and resources available to them to undertake this.