# Brownlow Group Practice

## Quality Report

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

## Ratings

| | |
|---|---|
| Overall rating for this service | Outstanding ☆ |
| Are services safe? | Good ● |
| Are services effective? | Outstanding ☆ |
| Are services caring? | Good ● |
| Are services responsive to people's needs? | Outstanding ☆ |
| Are services well-led? | Outstanding ☆ |

# 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 Brownlow Group Practice on 14 & 15 December 2016. Overall the practice is rated as outstanding.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, the support given to homeless patients and the support given by student services.
- Feedback from patients about their care was consistently positive.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs.
- Regular meetings and discussions were held with staff and multi-disciplinary teams to ensure patients received the best care and treatment in a coordinated way.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice actively reviewed complaints and how they were managed and responded to, and made improvements as a result.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.

# Summary of findings

We saw several areas of outstanding practice including:

- The practice had a contract to support a number of local intermediate care homes and in 2015 this number increased from 45 to 100 inpatient beds. Key changes were made to the practice team to ensure continuity of care and targeted treatments could be achieved. As the roles developed and services were put in place the practice audited their performance to monitor patient experience and outcomes. A review across April to October 2015 showed improvements in the number of patients having letters sent on to their GPs, improved number of pharmacy led medication reviews (37% to 96%) and low numbers of patients being admitted to hospital (only 4% in the audit period) amongst other positive outcomes.
- The practice had a cancer support service. This was a nurse led service providing prompt and targeted cancer support and advice to patients and this was achieved within one week of their cancer diagnosis. The nurse acted as a central point of contact for cancer patients and their families across the practice. Communications improved as the nurse developed close links with local hospitals and cancer and Macmillan support agencies and for this development the practice was nominated as a finalist in the Nurse of the Year award in Innovations in Practice 2014.
- The practice had commissioned a diabetes nurse for two sessions each week to support diabetic students, in particular Type 1 patients. As part of this the nurse had contacted the patients' previous GPs across the country to ensure that all required treatments and screening had been completed. If not, this would be undertaken at the Student Health location. We found the nurse also provided personalised support via email and mobile number access. These examples had a very positive impact on ensuring continuity of care but also on improving patient outcomes so that a transfer of care could be coordinated safely and effectively.
- The practice had a significant homeless and hostel dwelling population with drug and alcohol dependent needs and access to services for these patients was good. The practice ran a combination of open same day access clinics, along with booked appointments, as this flexible approach best suited the needs of people who often found it difficult to keep to rigid timetabling and appointments. The practice had experienced clinicians including two dedicated homeless nurses, an alcohol nurse, shared drugs workers, two specialist GPs and close links with the local homeless organisations. During the inspection we observed a flexible, sensitive, confidential and responsive approach when dealing with patients with complex health and mental health needs. We found the practice had good links with a local homeless hostel and daily support was given by a support worker who acted as a waiting room mentor to support patients when they first and subsequently attended the homeless clinic.
- The learning needs of staff were kept under constant review. The management team and all staff was supported to undertake training and development appropriate to their roles. For example, to support the patients attending the homeless clinic run each week staff had completed training for undertaking ultrasonic liver function tests. This enabled these patients to have a fuller assessment within the practice rather than having to attend hospital which might cause them anxiety.

However there were areas of practice where the provider should make improvements. They should:

- Review the systems in place for reporting and analysing the risks, adverse incidents and near misses.
- Review the monitoring of all areas of the building to ensure cleanliness standards are maintained in all areas including store cupboards.
- Review the medicines procedures to ensure robust arrangements are in place for doctors taking prescriptions pads to home visits when required

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The practice is rated as good for providing safe services. Our findings at inspection showed that:

- There was an effective system in place for reporting and recording significant events. Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. Risks to patients were assessed and well managed.

**Are services effective?**

Outstanding

The practice is rated as outstanding for providing effective services. Our findings at inspection showed that:

- Systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. A number of management meetings took place to monitor this and ensure compliance. Evidence to confirm that the practice used these guidelines to positively influence and improve practice and outcomes for patients was shown.
- The practice had a contract to support a number of local intermediate care homes and in 2015 this number increased from 45 to 100 inpatient beds. To support this development a lead GP was identified for intermediate care, there was an increase in sessions undertaken at the care homes, this was carried out across the week at set times and by the same GPs to ensure continuity. Also a team of prescribing clerks worked with the practice pharmacist to review discharged patients and the medicines they had been and were now taking.
- The information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. We saw two very good examples of this. One included how staff that treated homeless patients were having regular contact with hospitals when patients were admitted to ensure their care could be continued after discharge when they had no home address. The other included outstanding care and support

# Summary of findings

given to young diabetic student patients who had started at the university and registered with the practice. These examples had a very positive impact on ensuring continuity of care, but also on improving patient outcomes so that a transfer of care could be coordinated safely and effectively.

**Are services caring?**

Good

The practice is rated as good for providing caring services. Our findings at inspection showed that:

- Data from the national GP patient survey showed patients rated the practice comparable to other practices for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible. We observed a strong patient-centred culture.
- Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We saw this at the homeless access clinic when Christmas presents had been collected and were given out to all homeless people attending.
- We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

**Are services responsive to people's needs?**

Outstanding

The practice is rated as outstanding for providing responsive services. Our findings at inspection showed that:

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs. For example, the practice had monitored and developed a psychology service working alongside Liverpool University. As the service expanded, this included the practice commissioning the support of a clinical psychologist one day each week.
- There were innovative approaches to providing integrated patient-centred care. For example, the practice had a cancer support service which was a nurse led service providing prompt

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and targeted cancer support and advice to patients within one week of their canner diagnosis. The nurse provided a central point of contact for cancer patients and their families across the practice. Close links were developed with local hospitals.

- Patients could access appointments and services in a way and at a time that suited them. The practice had four GP locations, once registered, all patients used any site, with the exception of one which was for University of Liverpool students and staff only. We saw that weekly access meetings and regular systems information reports took place to with the senior management team to closely review patient demand and how flexible this could be met by the practice.
- The practice had a significant homeless and hostel dwelling population with drug and alcohol dependent needs and they were commissioned to provide an enhanced service to these patients. This included a specialist drop in service called the Homeless Access Clinic (HAC) which ran every Thursday. The practice ran a combination of open access (walk-in) clinics, along with booked appointments, as this flexible approach best suited the needs of people who often find it difficult to keep to rigid timetabling and appointments.
- The needs of the student population had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, we observed outstanding care and support given to young diabetic student patients who had started at the university and registered with the practice.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

**Are services well-led?**

**Outstanding** ☆

The practice is rated as outstanding for being well-led. Our findings at inspection showed that:

- The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. A comprehensive understanding of the performance of the practice was maintained.

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- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. For example, the development and investments made in the delivery of care and treatments for the intermediate care services have been closely monitored to ensure the right skill mix, training for staff and resources were put in to support the practice.
- The practice was aware of and complied with the requirements of the duty of candour. A culture of openness and honesty was encouraged. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction. Staff described a clear leadership structure and they felt supported by management. Staff said they felt respected, valued and supported, particularly by the partners in the practice.
- A good staff newsletter was published monthly and this covered feedback from patients, welcome comments to new staff, service and staff developments, top tips for staff amongst others.

# Summary of findings

## The six population groups and what we found

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

### Older people

Good

The practice is rated as good for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs. They had a contract to support a number of local intermediate care homes and in 2015 this number increased from 45 to 100 inpatient beds. We saw a report that identified the challenges the practice faced and the development of staff to meet the increasing needs of their services. A lead GP was identified for intermediate care, there was an increase in sessions undertaken at the care homes, and this was carried out across the week at set times and by the same GPs to ensure continuity. Administration roles were developed and a team of prescribing clerks worked with the practice pharmacist to review discharged patients and the medicines they had been and were now taking.
- All the older patients had a named GP who coordinated their care and contacted patients over 75 following discharge from an unplanned hospital admission.
- Nationally reported data showed that outcomes for patients were good for conditions commonly found in older patients.
- The practice provided care for patients at three local nursing homes. GPs visited weekly and also responded to urgent heath care needs when required.
- The practice had signed up to the admissions avoidance service, which identified patients who were at risk of inappropriate hospital admission.

### People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- All patients diagnosed with a long term condition had a named GP and a structured annual review to check that their health and medicine needs were being met.

# Summary of findings

- Data from the 2015/2016 QOF performance showed the practice achieved % of the total points available for all performance indicators. This was above the CCG and national average.
- Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check their health and medicines needs were being met.
- For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

**Families, children and young people**

Good

The practice is rated as good 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 at risk, for example, children and young people who had a high number of A&E attendances.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice had recently developed the receptionist role to provide added support to new mums and their babies. These staff named 'Care Navigators' had been trained to develop closer links with mums in an effort to improve the practice uptake of children's vaccination programmes.
- Appointments were available outside of school hours and the premises were suitable for children and babies. We saw positive examples of joint working with midwives, health visitors and school nurses.
- The practice had worked hard in recent months to develop their communications with students and young people via a social media platform. At the time of inspection the practice website was receiving a very high number of visits per day (300) and they had achieved 2,715 followers on social media Twitter, which is more than any other practice in the country.

**Working age people (including those recently retired and students)**

Outstanding

The practice is rated outstanding for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible

and offered continuity of care. For example, we observed outstanding care and support given to young diabetic student patients who had started at the university and registered with the practice. The practice had commissioned the support of a diabetes nurse who had contacted the patients previous GPs across the country to ensure that all required treatments and screening had been completed. If not this would be undertaken at the Student Health location. We found the nurse also provided personalised support via email and mobile number access.

- The practice monitored and developed a service effectively which included the establishment of a psychology service with Liverpool University. As the service expanded, this included the practice commissioning the support of a clinical psychologist 2.5 days per week.
- The practice also worked closely with psychiatry services in Liverpool to secure the support of a community psychiatric nurse and they liaised with university services, including university welfare and counselling services to provide mental health services to students across the city. The practice identified a designated GP partner to liaise with Liverpool University when new students arrived and at the time of inspection approximately 16,000 students had registered with the practice.
- We saw that health promotional days had been set up for students (e.g. a student mental health and well-being day) with support from the practice GP and health trainer to raise awareness of mental health issues and services available at the practice.

**People whose circumstances may make them vulnerable**

Outstanding ☆

The practice is rated outstanding for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

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- 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 normal working hours and out of hours.
- The practice had a significant homeless and hostel dwelling population with drug and alcohol dependent needs and they were commissioned to provide an enhanced service to these patients. This included a specialist drop in service called the Homeless Access Clinic (HAC) which ran every Thursday. The practice ran a combination of open access (walk-in) clinics, along with booked appointments, as this flexible approach best suited the needs of people who often found it difficult to keep to rigid timetabling and appointments. The practice had experienced clinicians including two dedicated homeless nurses, an alcohol nurse, shared drugs workers two specialist GPs and close links with the local homeless organisations. These staff members attend multi-disciplinary meetings across the city for this population group. During the inspection we observed a flexible, sensitive, confidential and responsive approach when dealing with patients with complex health and mental health needs.

**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 regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health. The Homeless Access Clinic (HAC) provided all of the full range of medical and health care in a standard GP practice but in addition they provided specialised mental health and alcohol and drug treatment services, therapeutic interventions, welfare rights support and housing advice. The service worked closely with a social work team to provide integrated care plans for users and a waiting room manager ensured access was straight forward during the open access clinic. Workers provided outreach clinics in a number of partner agencies, but also worked with clients from local hostels and voluntary services providing support to the homeless across the centre of Liverpool. We spoke with staff and found a tenacious attitude to making sure the access to treatments was kept going for patients before, during and after they had been admitted to hospital

# Summary of findings

- The practice carried out advanced care planning for patients with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

# Summary of findings

## What people who use the service say

The National GP Patient Survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. Three hundred and seventy one survey forms were distributed and 45 were returned. This represented a 12% completion rate but the provider informed us that this was only 0.012% of the practice's patient list which was 37,000 patients. The results showed that;

- 89% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 87% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 85%.
- 83% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 86% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 81%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 48 comment cards which were all positive about the standard of care received. Some of the comments made related to the support they had been given to patients and family members, how caring staff had been and how they had been treated with dignity respect and compassion.

We spoke with one member of the patient participation group (PPG) and seven patients. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. They told us of occasions when the GPs had 'gone the extra mile' to ensure their relative's needs were met and how compassionate they had been during times of bereavement.

## Areas for improvement

**Action the service SHOULD take to improve**

- Review the systems in place for reporting and analysing the risks, adverse incidents and near misses.
- Review the monitoring of all areas of the building to ensure cleanliness standards are maintained in all areas including store cupboards.
- Review the medicines procedures to ensure robust arrangements are in place for doctors taking prescriptions pads to home visits when required.

## Outstanding practice

- The practice had a contract to support a number of local intermediate care homes and in 2015 this number increased from 45 to 100 inpatient beds. Key changes were made to the practice team to ensure continuity of care and targeted treatments could be achieved. As the roles developed and services were put in place the practice audited their performance to monitor patient experience and outcomes. A review across April to October 2015 showed improvements in the number of patients having letters sent on to their GPs, improved number of pharmacy led medication reviews (37% to 96%) and low numbers of patients being admitted to hospital (only 4% in the audit period) amongst other positive outcomes.
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Communications improved as the nurse developed close links with local hospitals and cancer and Macmillan support agencies and for this development the practice was nominated as a finalist in the Nurse of the Year award in Innovations in Practice 2014.

- The practice had commissioned a diabetes nurse for two days each week to support diabetic students, in particular Type 1 patients. As part of this the nurse had contacted the patients' previous GPs across the country to ensure that all required treatments and screening had been completed. If not, this would be undertaken at the student services location. We found the nurse also provided personalised support via email and mobile number access. These examples had a very positive impact on ensuring continuity of care but also on improving patient outcomes so that a transfer of care could be coordinated safely and effectively.
- The practice had a significant homeless and hostel dwelling population with drug and alcohol dependent needs and access to services for these patients was good. The practice ran a combination of open access (walk-in) clinics, along with booked appointments, as this flexible approach best suited the needs of people who often found it difficult to keep to rigid timetabling and appointments. The practice had experienced clinicians including two dedicated homeless nurses, an alcohol nurse, shared drugs workers and close links with the local homeless organisations. During the inspection we observed a flexible, sensitive, confidential and responsive approach when dealing with patients with complex health and mental health needs. We found the practice had excellent links with a local homeless hostel and daily support was given by a support worker who acted as a waiting room mentor to support patients when they first and subsequently attended the homeless clinic.
- The learning needs of staff were kept under constant review. The management team and all staff was supported to undertake training and development appropriate to their roles. For example, to support the patients attending the homeless clinic run each week staff had completed training for undertaking ultrasonic liver function tests. This enabled these patients to have a fuller assessment within the practice rather than having to attend hospital which might cause them anxiety.

# Brownlow Group Practice

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

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

## Background to Brownlow Group Practice

Brownlow Group Practice is registered with the Care Quality Commission to provide primary care services. The practice provides GP services for approximately 38,000 patients residing in Liverpool city centre. The practice is sited in four premises across the city providing general medicine, student health and homeless services in and around the city centre. The practice has eight GP partners, one nurse and one business partner. They employ 19 associate GPs, 18 nurses, two pharmacists, two health care assistants, administration and reception staff and a large number of supervisory and management staff. The practice is an approved training practice for GP registrar training and student nurses and other professionals. Brownlow Group Practice holds a General Medical Services (GMS) contract with NHS England.

The practice is open Monday to Friday 8am to 6.30pm, plus extended hours 4 times per week**.** Student Health locations are usually closed during university holidays. A Saturday surgery is held weekly between 9am and 1pm with prior arrangements with the practice. Patients can book appointments in person, via the telephone or online. The practice provides telephone consultations, pre-bookable consultations, urgent consultations, home visits and drop in clinics. The practice treats patients of all ages and provides a range of primary medical services.

The practice is part of Liverpool Clinical Commissioning Group (CCG) and is situated in the centre of Liverpool. The practice population has a much younger population than the rest of the city. Almost half of the population are aged between 19 and 25 years (48.6% of the population) reflecting the large student population in the city centre. There are 1,922 people aged 65+ (4% of the population) and 144 people aged 85+ (0.3% of the population), the lowest levels in the city. Levels of unemployment and long term unemployment are the lowest in the city.

The practice does not provide out of hours services. When the surgery is closed, patients are directed to the local GP out of hour's service and NHS 111. Information regarding out of hours services was displayed on the website, on the practice answering machine and in the practice information leaflet.

## 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. The 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.

# Detailed findings

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 14 and 15 December 2016 and we visited three of the practice locations.

During our visit we:

- Reviewed policies, procedures and other information the practice provided before the inspection. We also supplied the practice with comment cards for patients to share their views and experiences of the practice.
- Spoke with a range of staff and spoke with patients who used the service.
- Looked at procedures and systems used by the practice.
- Spoke with eight patients, including one member of the Patient Participation Group (PPG). A PPG is a group of patients registered with the practice who worked with the practice team to improve services and the quality of care.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed 48 comment cards where patients and members of the public shared their views and experiences of the service.'

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 were provided for specific groups of people and what good care looked 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).

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

Good

# Are services safe?

## Our findings

**Safe track record and learning**

There was a system in place for reporting and recording significant events. This included the reporting of significant events such as a patient's death and also there was a second reporting system named PAIRS (preventable, avoidable, incident reporting system). We were told that all clinical events would be reported via the significant event process but on the day of inspection we found that some were included only in the PAIRS information system.

All staff were engaged and proactively reported such incidents and we saw that after each event a reflective tool was used to look closely at what happened, to prevent it occurring again. This reflective tool was used each time a patient died to provide the assurance to the practice that everything that could have been done had been or action would be taken. There was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour, (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again. The practice carried out a thorough analysis of all events at weekly meetings but an annual review of all incidents did not take place to identify any trends. We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. As well as discussing significant events with staff, they were discussed with people outside the practice so that ideas for improvement could be shared.

**Overview of safety systems and processes**

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. Staff we spoke with had a good understanding of safeguarding matters arising. There were lead members of staff for safeguarding, both for adults and children. The GPs attended safeguarding meetings when possible and provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. All clinicians were trained to child protection or child safeguarding level 3.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Some staff members did not undertake chaperoning duties and a risk assessment was in place to support this.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed each of the locations to be clean and tidy. The nurse manager was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. We undertook a tour of each of the locations and found that whilst the areas were clean and tidy the cleaning cupboard in the Brownlow location was not part of a cleaning schedule and this required deeper cleaning.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice had a medicines management team which included a lead pharmacist and prescribing clerks. This team had a lead role in managing the

development of new policies. For example, the methadone policy, the regular review of patients on high risk medicines and the review of patients when changes were made to prescriptions, such as when they were discharged from hospital.

- We saw that the development of the role of the lead pharmacist had a positive outcome for patients and the systems and processes supported safer practice and management of medicines across each of the practice locations. For example, the medicines management team carried out regular medicines audits, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. However, the procedures for doctors taking prescriptions pads to home visits required improvement to make the logging in and out of the prescriptions more secure.
- A number of the nurses had qualified as Independent Prescribers and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

**Monitoring risks to patients**

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health (COSHH) and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment at all times.

**Arrangements to deal with emergencies and major incidents**

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. We noted during the inspection that paediatric pads were not available for use with the defibrillator, however, the practice immediately remedied this matter by purchasing some paediatric pads on the day of inspection. A first aid kit and accident book was available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Outstanding ☆

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

Systems were in place to ensure all clinical staff stayed up to date. This included relevant and current evidence based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment were delivered. The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. A number of management meetings took place to monitor this and ensure compliance. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

**Management, monitoring and improving outcomes for people**

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results in October 2016 (for the period April 2015 – March 2016) showed the practice had achieved 95.9% of the total number of points available. Exception reporting was 6.9% for the clinical domain (exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Data from 2015-2016 showed that outcomes were comparable to other practices locally and nationally:

- The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months was 76% compared to the CCG average of 80%.
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) was 5 moll/l or less was 79% compared to the CCG average of 83% and the national average of 80%.
- The percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 90% compared to the CCG average of 90% and the national average of 88%.
- The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less was 87% compared to the CCG average of 85% and the national average of 82%.

Weekly meetings took place with the management team to monitor and act on the results of QOF and other reporting systems. This included the progress made with the development of care plans for patients at risk of hospital admission and friends and family comments.

There was evidence the practice regularly reviewed the effectiveness of care and treatment through local audit and national audit. For example, there had been an audit carried out for reviewing the condition Coeliac disease in line with NICE guidance. The aim of the audit was to determine how well Coeliac disease was managed at the Brownlow Group Practice as compared to the NICE guidelines. Results showed that only 50% had achieved an annual review as recommended and actions were taken to make improvements to this result. Based on the results the practice made a number of improvements. A protocol was developed, patients were monitored more closely to ensure that received an annual review. During the review the nurse would measure weight and height, review symptoms, considers the need for assessment of diet, consider the need for specialist dietetic and nutritional advice. If concerns were identified the nurse would refer to the patients GP.

The practice participated in local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services. The GPs and nurses had key roles in monitoring and improving outcomes for patients. These roles included the management of long term conditions, mental health, safeguarding, minor surgery, clinical governance and medication management. The clinical staff we spoke with told us they kept their training up to date in their specialist areas. This meant that they were able to focus on specific conditions and provide patients with regular support based on up to date information.

Outstanding ☆

# Are services effective?

## (for example, treatment is effective)

Staff worked with other health and social care services to meet patients' needs. The practice had multi-disciplinary meetings to discuss the needs of patients with complex and palliative care needs. A meeting was also held with the health visiting service to review the needs of children where concerns had been identified.

There were numerous other examples of how health, social services and the voluntary sector worked together to improve patient outcomes. For example, the practice had a contract to support a number of local intermediate care homes and in 2015 this number increased from 45 to 100 inpatient beds. We saw a report that identified the challenges the practice faced and the development of staff to meet the increasing needs of their services. To support this development a lead GP was identified for intermediate care and there was an increase in sessions undertaken at the care homes. This was carried out across the week at set times and by the same GPs to ensure continuity. Administration roles were developed and a team of prescribing clerks worked with the practice pharmacist to review discharged patients and the medicines they had been and were now taking. Though patients did not register at the practice because they were temporary patients at the home, the practice continued to liaise with the hospital, their GPs and the home to ensure continuity of care and support for patients.

As the roles developed and services were put in place for the intermediate care places, the practice audited their performance to monitor patient experience and outcomes. A review across April to October 2015 showed improvements in the number of patients having letters sent on to their GPs, improved number of pharmacy led medication reviews (37% to 96%) and low numbers of patients being admitted to hospital (only 4% in the audit period) amongst other positive outcomes. A letter from a consultant geriatrician was shown to us as evidence confirming the practice had worked in an integrated way to provide clinical leadership to a multidisciplinary team with members of the local acute trust, community trust, local authority and the mental health trust to meet the care needs of patients.

Another example for how the practice had monitored and developed a service effectively was the support given to the psychology services at the Student health centre attached to the university. The services offered a range of interventions such as psychoeducation and evidenced based step 3 therapies such as Cognitive Behavioural Therapy (CBT), Acceptance and Commitment Therapy (ACT) and Cognitive Analytic Therapy (CAT). Referral data from a 17-month period (October 2014 to March 2016 inclusive) were evaluated to ascertain changes in referral numbers, identify service needs and identify the potential benefits to developing new service provision with regard to waiting times. As the service expanded, the practice commissioned the support of a clinical psychologist working jointly with the university 2.5 days per week. Working as a multi-disciplinary team, students with a range of psychological problems (approximately 84 each year) received services which included rapid access and prompt referral to mental health services if required.

The practice also worked closely with psychiatry services in Liverpool to secure the support of a community psychiatric nurse and they liaised with university services, including university welfare and counselling services to provide mental health services to students across the city. The practice identified a designated GP partner to liaise with Liverpool University when new students arrived and at the time of inspection approximately 16,000 students had registered with the practice. We saw that health promotional days had been set up for students (e.g. a student mental health and well-being day) with support from the practice GP and health trainer to raise awareness of mental health issues and services available at the practice.

### Effective staffing

We found that a number of meetings took place weekly to continuously improve how the practice delivered services to patients. Many of these meetings included external professionals and invited patients as appropriate. We spoke with staff and reviewed their training files, which verified they had the skills, knowledge and experience to deliver effective care and treatment. This included when they started their employment, when they took on a new role or new responsibilities and on a continual basis. The learning needs of staff were kept under constant review by the management team and all staff were supported to undertake training and development appropriate to their roles. For example, to support the patients attending the homeless clinic run each week, staff had completed

training for undertaking ultrasonic liver function tests (liver fibro scans), this enabled these patients to have a fuller assessment within the practice rather than having to attend hospital which might cause them anxiety.

The practice had a good induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. In addition to this, staff who worked at the weekly homeless clinic also worked at a nearby homeless hostel as part of their induction, to enable them to have a greater understanding of the challenges faced by this vulnerable group and how best to support them. The practice demonstrated how they ensured role-specific training and updating for relevant staff, for example, those reviewing patients with long-term conditions. Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings. We found that administration staff had been developed to undertake the new role of Care Navigators, this role was developed to try and improve relationships with mothers and their children to improve the uptake of children's vaccines.

We found very good arrangements for supporting and managing staff, this included annual appraisals, meetings and reviews of practice to identify development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. We heard that after a complex and stressful significant event, staff were supported with de-briefing meetings and some were enabled to obtain clinical supervision from a supervisor outside of the organisation for as long as they felt they needed this. This showed how important the practice valued the promotion of good reflective practice to improve patient's outcomes and experiences. We found that all staff had received an appraisal within the last 12 months or dates were in place.

Staff received training that included: safeguarding, fire safety awareness, and basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. We saw a training matrix and supporting information for all members of staff across each location.

**Coordinating patient care and information sharing**

All the information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. This included care and risk assessments, care plans, case notes and test results. We found very good systems in place for when patients moved between teams and services, including at referral, discharge, transfer and transition. They had particular pathways for staff to follow to manage electronic discharge letters, faxes and out of hour's reports. We reviewed a number of patient care plans (87% of careplans had ben completed for patients on the avoiding hospital admissions register) and found good multi agency working to meet the needs of all of the patient population groups. We observed how staff that treated homeless patients were having regular contact with hospitals when patients were admitted to ensure their care could be continued after discharge if they had no home address. This example had a very positive impact on not only ensuring continuity of care but also on improving patient outcomes so that a transfer of care could be coordinated safely and effectively.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan on going care and treatment. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. In particular, we saw how closely the practice worked with the social care and the voluntary sector professionals when proving treatments and support to the homeless community.

**Consent to care and treatment**

We spoke with staff about patient consent and found they understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. All staff had received training for this and we heard of examples of how patients had been supported to make difficult decisions. Some of these included how patients

Outstanding ☆

# Are services effective?

## (for example, treatment is effective)

who were homeless and who lacked the mental capacity to make a decision had been supported to attend the practice so that treatments could be provided in a safe environment.

Staff we spoke with were clear about how to seek authorisation for a deprivation of liberty if this was applicable to patients they were treating. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

**Supporting patients to live healthier lives**

The practice identified patients who may be in need of extra support. For example, patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

The practice's uptake for the cervical screening programme was 64%, which was slightly below the CCG average of 71% and the national average of 76%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by setting up a weekly Saturday morning clinic to target working aged women who had not attended for this test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

For example, childhood immunisation rates for the vaccinations given to under two year olds. The practice average for those in the 2 year age group was 73.0%, compared with the CCG average of 76%. The practice average for those under 2 was 80.1% and the CCG average for was 83.5%. The practice was aware of these results and had taken steps to try to improve these figures.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

# Are services caring?

## Our findings

**Kindness, dignity, respect and compassion**

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

We attended the Homeless Access Clinic (HAC) during our inspection and could see that there was recognition for staff that dealing with and responding to the needs of homeless people required kindness, respect and compassion. We saw that staff had been trained and supported to care for this vulnerable population group. They were non-judgemental and sensitive in the manner and approach and all patients we spoke with told us how welcoming staff had been. We found the staff covering the clinic were stable and had extensive experience and knowledge about the needs of homeless people. We found the practice had excellent links with a local homeless hostel and daily support was given by a support worker who acted as a waiting room mentor to support patients when they first and subsequently attended the homeless clinic. On the day of our visit to the clinic Christmas parcels were being given to homeless patients, some of the content of this had been given by staff members.

All of the 48 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We looked at some of the comments made by patients for the Family and Friends Test and found their views aligned with the comments we received.

We spoke with one member of the patient participation group (PPG) and seven patients. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the National GP Patient Survey showed patients felt they were treated with compassion, dignity and respect. However, the practice was below average for the following results:

- 88% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 85% of patients said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 90% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 74% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 80% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 79% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.

The practice worked with the local Health Watch to complete 'patient stories'. Results published in April 2016 showed that patients feltl access and the availability of doctors was good and staff overall were caring and gave good advice.

**Care planning and involvement in decisions about care and treatment**

Patients told us 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 available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the National GP Patient Survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

Good

# Are services caring?

- 81% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and the national average of 86%.
- 70% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 73% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care. 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 of the different sites informing patients this service was available. Information leaflets were available in easy read format.

**Patient and carer support to cope emotionally with care and treatment**

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website for all of the practice population groups including students and homeless patients.

The practice's computer system alerted GPs if a patient was also a carer. The practice identified patients as carers and had a carers leaflet, 0.26% (100) patients were coded as being a carer. We spoke with a number of patients as part of the inspection. We were told that as a carer they received extra support themselves both in terms of access to appointments and how staff at the clinic treated them with compassion. Written information and posters were available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. We spoke with a family member who told us the GPs had provided excellent end of life care for their relative, including giving their telephone numbers at weekends.

Outstanding ☆

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

The practice 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. We saw many examples of this and amongst others the practice had:

- Recently developed the receptionist role to provide added support to new mums and their babies. These staff named 'Care Navigators' had been trained to develop closer links with mums in an effort to improve the practice uptake of children's vaccination programmes
- Set up a psychology service for students with Liverpool University and this included the practice commissioning the support of a clinical psychologist 2.5 days per week.
- Developed their communications with students and young people via a social media platform. At the time of inspection the practice website was receiving a very high number of visits per day (300) and they had achieved 2,715 followers on social media Twitter, which is more than any other practice in England at the time of inspection.
- Had a contract to support a number of local intermediate care homes and in 2015 this number increased from 45 to 100 inpatient beds. We saw a report that identified the challenges the practice faced and the development of staff to meet the increasing needs of their services. A lead GP was identified for intermediate care, there was an increase in sessions undertaken at the care homes, and this was carried out across the week at set times and by the same GPs to ensure continuity. Administration roles were developed and a team of prescribing clerks worked with the practice pharmacist to review discharged patients and the medicines they had been and were now taking.
- Developed a cancer support service which was a nurse led service providing prompt and targeted cancer support and advice to patients within one week of their canner diagnosis. The nurse provides a central point of contact for cancer patients and their families across the practice. Close links had been developed with local hospitals and cancer and Macmillan support agencies and for this development the practice was nominated as a finalist in the Nurse of the Year award in Innovations in Practice 2014.
- Excellent links with a local homeless hostel and daily support was given by a support worker who acted as a waiting room mentor to support patients when they first and subsequently attended the homeless clinic.
- Commissioned the support of a Diabetes Nurse would contracted newly registered student patients previous GPs across the country to ensure all the treatments and screening they should have had was now completed. If not this would be undertaken at the student services location. We found the nurse also provided personalised support via email and mobile number access.
- The practice was part of three year national project commissioned by the Department of Health under its 'Innovations' scheme, run by two national charities – the Association for Young People's Health and Youth Access, along with the Royal College of GPs' Adolescent Health Group. The practice worked with the Young Persons Advisory Service (YPAS) to scope the local health needs and concerns of young people. The findings of the consultation resulted in the development of the practice setting up a GP clinical surgery and health drop-in, accommodated in a non-clinical/non-stigmatized environment at YPAS.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.

**Access to the service**

The practice had four clinical locations at Brownlow General Practice, Student Health centre, Ropewalks Surgery and Student Health Advice Centre (SHAC). Once registered, all patients used any site, with the exception of SHAC, which was for University of Liverpool students only. Phone lines for patient appointments opened at 8am and close at 6.30pm (calls were automatically put through to the out of hour's service after this time). There was a mix of appointments in different locations starting from 7am to

Outstanding ☆

# Are services responsive to people's needs?

## (for example, to feedback?)

8pm with same day access at each site for urgent patient requests. Some Saturday morning clinics were available by prior appointment. We were told that Student Health was usually closed during university holidays.

Weekly access meetings took place with the senior management team to closely review patient demand and how flexible this could be met by the practice. One such project and report looked at a telephone consultation project that was undertaken from June to December 2016. The aim of this review was to ascertain clinician experience of covering telephone consultations sessions, review practice systems relevant to the telephone consultations, audit outcome data for each GP undertaking telephone consultations and reflecting on clinical management of patients with acute conditions by phone. The outcomes of this extensive audit gave the practice the opportunity to understand the impact of offering patient telephone consultations on patients, staff and practice systems and processes were put in place to support this.

The practice had a significant homeless and hostel dwelling population with drug and alcohol dependent needs and access to services for homeless patients with drug and alcohol dependent needs was good. This included a specialist drop in service (HAC) which ran every Thursday. The practice ran a combination of same day open access clinics, along with booked appointments, as this flexible approach best suited the needs of people who often find it difficult to keep to rigid timetabling and appointments. We attended the clinic during our inspection visit. The practice had experienced clinicians including two dedicated homeless nurses, an alcohol nurse, shared drugs workers and close links with the local homeless organisations. During the inspection we observed a flexible, sensitive, confidential and responsive approach when dealing with patients with complex health and mental health needs. An outstanding feature of the care given was the success in earning the trust of patients through effective engagement, good training for staff and expert patient care.

We found the HAC clinic provided all of the full range of medical and health care in a standard GP practice but in addition they provide specialised mental health and alcohol and drug treatment services, therapeutic interventions, welfare rights support and housing advice.

The service worked closely with a social work team to provide integrated care plans for users and a waiting room manager ensured access was straight forward during the open access clinic.

Staff provided outreach clinics in a number of partner agencies, but also worked with clients from local hostels and voluntary services providing support to the homeless across the center of Liverpool. We spoke with staff and found a tenacious attitude to making sure the access to treatments was kept going for patients before, during and after they had been discharged from hospital. Close contact would be maintained with the local hospitals if patients were admitted to ensure continuity of care and safe practice was achieved if the patient was to suddenly discharge themselves from hospital. Staff told us that the patients who attended the HAC clinic had often experienced extensive barriers before they attended the drop in clinic and for this reason extended roles for staff had been developed. For example, the practice had set up a unique primary care based hepatitis C treatment service which linked in with secondary care with a specialist nurse for stable patients who otherwise struggled to access hospital services

Results from the National GP Patient Survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 82% of patients were satisfied with the practice's opening hours compared to the national average of 76%.
- 89% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

People told us in each of the sites across the two days we inspected that they were able to get appointments when they needed them. A patient attending the HAC clinic told us they had experienced considerable barriers to accessing GP service but that their experience at this practice was excellent.

The practice had a system in place to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. In cases where the urgency of need was so great that it would be inappropriate for the

Outstanding ☆

# Are services responsive to people's needs?

## (for example, to feedback?)

patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

**Listening and learning from concerns and complaints**

The practice had an effective system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. 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 in poster form and in patient information leaflets. We looked at three complaints received in the last 12 months and found these were dealt with in a timely way, and in an open and transparent manner. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken as a result to improve the quality of care.

# Are services well-led?

Outstanding ☆

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

## Our findings

**Vision and strategy**

We found the leadership, governance and culture of the practice were used to drive and improve the delivery of high quality person centred care. The practice had a clear vision to promote good outcomes for patients. We heard that they 'aspire to excellence in the healthcare of a socially diverse population by developing our team and our systems of clinical and corporate governance' and we saw good evidence of this throughout our inspection.

The practice had a robust, realistic strategy for achieving their priorities and delivering good quality care. This had been developed by staff with involvement of patients and the commissioners. Staff we spoke with knew and understood what the vision and values were and we saw examples of how this had been incorporated in their daily work, for example in the support given to the homeless population group. We saw a systematic approach to working with a wide range of public, private and charity based organisations to achieve this and to tackle health inequalities in a socially diverse area. The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

**Governance arrangements**

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. For example, structures, processes and systems of accountability were clearly set out, understood and effective. These included the governance and management of partnerships, joint working arrangements and shared services. These systems ensured that:

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. A number of these included extended roles for nurses and they were supported by the practice to maintain their continuous professional development learning.
- Practice specific policies were implemented and were available to all staff. All policies viewed were in date and had been developed with the support of the team, for example the medicines management policies which had been developed by the lead pharmacist. We saw that the development of the role of the lead pharmacist had a positive outcome for patients and the policies and processes supported safer practice and management of medicines across each of the practice locations.
- A comprehensive understanding of the performance of the practice was maintained. For example, the information used in reporting, performance management and delivering quality care was accurate, valid, reliable, timely and relevant. There were numerous examples of this including information gathered for unexpected deaths, significant events, patient feedback and complaints, prescribing performance, QOF and Enhanced Service performance data, clinical and non-clinical audit findings, risk assessments, policy reviews and business plan. We saw that weekly management meetings took place during which time information was used in reporting, performance management and planning to delivery of quality and timely patient care. Actions were taken when performance and quality was put at risk.
- A broad programme of continuous clinical and internal audit was ongoing within the practice. These audits demonstrated improvements even where outcomes showed high quality care. For example, the development and investments made in the delivery of care and treatments for the intermediate care services have been closely monitored to ensure the right skill mix, training for staff and resources were put in to support the practice. Other quality improvement activities were undertaken. These included a number of activities such as regular reviews of outcomes data, small scale data searches, significant event analysis, large scale national audit participation, reflective case reviews and reflection on formal patient and colleague feedback. Across all of the evidence we viewed the practice was able to demonstrate they reviewed the care provided in relation to current best practice guidance, made changes where necessary or appropriate in order to improve and they revisited their new ways of working to see whether the changes made have resulted in an improvement.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. The practice held regular meetings to discuss all significant events and untoward incidents and they encouraged the whole healthcare team

# Are services well-led?

Outstanding ☆

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

involved in a case or incident to have a supportive discussion. At times this included external review and support for clinicians. The aim was to use this as a process to allow reflection and learning from the incident and so improve care. For example, discussion and analysis took place for all patient deaths, new cancer diagnosis, complaints received by the practice, a sudden or unexpected death or admission to hospital for the practice homeless population and any errors or near misses that had taken place. We saw good evidence of learning from incidents and improving quality which had a positive impact on improving patient care. This resulted in a culture of openness and reflective learning, not individual blame or self-criticism. Staff used the tools for team development as well as their individual continuing professional development.

**Leadership and culture**

The partners and senior management team had the shared aim to drive the practice forward and motivate their staff to succeed. They demonstrated the right skills, knowledge, experience and integrity to provide strong leadership in an inner city practice providing services to vulnerable patient groups. The partners understood the challenges to performance such as the low uptake of cervical smears, the low performance prevalence figures, low uptake of childrens immunisations and they knew what actions were needed to address these. The leaders were visible and approachable and were appreciative of the supportive relationships among staff across all of the practice sites.

Leaders provided evidence to show us they prioritised safe, high quality and compassionate care. For example, when things went wrong and patient care was compromised. Staff told us the partners were approachable and they promoted a culture that allowed staff to contribute and give constructive feedback on individual and team performance. We saw good systems in place to support this including a confidential way for staff to raise concerns about risks to patients, poor practice and adverse events. Staff we spoke with understood the reporting system and told us they would be confident to use it.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.
- All staff completed a reflective tool to identify the root course of the incident and what might be done differently to avoid the same incident occurring again.

There was a clear leadership structure in place and staff felt supported by management.

- There were high levels of staff satisfaction. Staff we spoke with demonstrated pride in their practice and the work they undertook and they spoke highly of the culture in which they worked. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff told us the practice held regular team meetings and they were supported to attend these. This included the closure of the practice for one afternoon each month to provide training and development.
- Staff said they felt respected, valued and supported. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- We found a strong emphasis on promoting the safety and well-being of staff when we spoke with the partners and senior management team. For example, allowing staff members to access clinical supervision outside the organisation when things went wrong or there had been a difficult significant event or adverse incident.

**Seeking and acting on feedback from patients, the public and staff**

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

# Are services well-led?

Outstanding ☆

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

- The practice had gathered feedback from patients through the active patient participation group (PPG), through the national GP patient survey, friends and family test results and complaints received. The PPG were valued and worked well with the practice. They met regularly with the practice management team.
- Action plans were in place following the review of survey results.
- The practice provided evidence they had worked with the local Health watch team to use patient stories and experiences to gain patient opinions to improve practice.
- A good patient newsletter was published on a regular basis, keeping patients up to date with patient feedback, health promotion advice and changes to practice staff and access changes.
- The practice gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. A good staff newsletter was published monthly and this covered feedback from patients, welcome comments to new staff, service and staff developments, top tips for staff amongst other items.

**Continuous improvement**

There was a focus on continuous learning and improvement at all levels within the practice. There were numerous of examples of this described through this report for example, they had recently developed the receptionist role to provide added support to new mums and their babies. These staff named 'Care Navigators' had been trained to develop closer links with mums in an effort to improve the practice uptake of children's vaccination programmes. The practice was a training practice and valued the addition of trainee GPs (GP registrars). The practice supported staff in their professional development and revalidation.