

Aintree Park Group Practice

Quality Report

The Orrell Park Surgery
46 Moss Lane
Liverpool
Merseyside
L9 8AL

Tel: 0151 2958350

Website: www.aintreeparkgrouppractice.nhs.uk

Date of inspection visit: 15 October 2015

Date of publication: 26/11/2015

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	8

Detailed findings from this inspection

Our inspection team	9
Background to Aintree Park Group Practice	9
Why we carried out this inspection	9
How we carried out this inspection	9
Detailed findings	11

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Aintree Park Group Practice on 15 October 2015. Aintree Park Group Practice has a branch surgery at the address: Oriel Drive Liverpool Merseyside L10 6NJ, which was also inspected. Where information refers to the practice, this refers to both sites unless otherwise specified.

Overall the practice is rated good and outstanding for providing well led services and for providing services for more vulnerable patients and patients experiencing poor mental health.

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

- The practice was clean and had good facilities including disabled access and parking, hearing loops, and translation facilities.
- There was an ethos that safety was everyone's responsibility. There was an effective system in place for reporting and recording significant events.

- Information about services and how to complain was available. The practice sought patient views about improvements that could be made to the service, including having a patient participation group (PPG) and acted on feedback.
- The practice used surveys to gain feedback from all affiliated services such as community teams, pharmacies and nursing homes and acted on any improvements required.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- There was a strong leadership with a desire to use innovative approaches to deliver patient care. Staff morale was high and staff were encouraged at every level to be part of the forward planning of the practice.

There were elements of outstanding practice including:

- There was a strong leadership with a desire to use innovative approaches to deliver patient care. For example, the practice employed a full time pharmacist and was part of a pilot scheme with the local ambulance service and worked with a paramedic.
- The practice monitored patients in care homes on a monthly basis to establish which patients were subject

Summary of findings

to a deprivation of liberty safeguards (DoLS) and in addition those that could potentially be subject to DoLS in the future. Records were updated including updating the out of hours service.

However there were improvements the provider should consider:-

- Ensure there is a system in place to monitor the ongoing professional registration status of nursing staff.
- Have more information about support services available for carers.

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?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff.

Good



Are services effective?

The practice is rated as good 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. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. The practice used innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

Good



Are services caring?

The practice is rated good for providing caring services. Patients' views gathered at inspection demonstrated they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We also saw that staff treated patients with kindness and respect. Staff helped people and those close to them to cope emotionally with their care and treatment.

Good



Are services responsive to people's needs?

The practice is rated good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements from feedback from the patient participation group (PPG), staff and services affiliated with the practice. The practice reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Information about how to complain was available. Learning from complaints was shared with staff.

Good



Summary of findings

Are services well-led?

The practice is rated outstanding for being well-led. It had a clear vision and strategy. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and had an active PPG. Staff had received inductions and attended staff meetings and events. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice implemented innovative ways of working and recognised future challenges.

Outstanding



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

The practice is rated good for older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and offered home visits and nursing home visits. The practice participated in meetings with other healthcare professionals and social services to discuss any concerns. There was a named GP for the over 75s. In addition the practice worked with a paramedic for care planning and a pharmacist to ensure optimisation of medications for patients in care homes.

Good



People with long term conditions

The practice is rated good for people with long term conditions. The practice had registers in place for several long term conditions including diabetes and asthma. The practice pharmacist assisted with medication reviews for patients and carried out telephone consultations.

Good



Families, children and young people

The practice is rated good for 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 or those that failed appointments. The practice regularly liaised with health visitors. Immunisation rates were high for all standard childhood immunisations. The main surgery had a children's toy area and both sites had baby changing facilities.

Good



Working age people (including those recently retired and students)

The practice is rated good for working age people. The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible. For example, the practice offered online appointment bookings and prescription ordering. The practice had extended hours opening and the branch surgery offered appointments on Saturday mornings and the main site on Tuesday evenings. Saturday morning appointments for a variety of clinics with both the GP and practice nurse were available including cervical screening and flu vaccinations.

Good



People whose circumstances may make them vulnerable

The practice is rated outstanding for people whose circumstances make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning

Outstanding



Summary of findings

disability. It had carried out annual health checks and longer appointments were available for people with a learning disability which were either scheduled at the beginning or end of a clinical session. Staff had received safeguarding training. The practice worked with local support services including Addaction teams who attended the surgery. The practice gave us several examples of care whereby vulnerable patients had been additionally supported to access tests and treatment.

People experiencing poor mental health (including people with dementia)

The practice is rated outstanding for people experiencing poor mental health. Patients experiencing poor mental health received an invitation for an annual physical health check. Those that did not attend had alerts placed on their records so they could be reviewed opportunistically. All clinical staff were aware of the Mental Capacity Act and had received training in dementia awareness. The practice monitored patients in nursing homes on a monthly basis to establish which patients were subject to a deprivation of liberty safeguards (DoLS). One of the GPs at the practice was a youth mental health champion and another GP was working on research around mental health and alternatives to medication.

Outstanding



Summary of findings

What people who use the service say

Results from the National GP Patient Survey July 2015 (from 104 responses which is equivalent to 0.7% of the patient list) demonstrated that the practice was performing mainly above local and national averages. For example:

- 97% of respondents described their overall experience of this surgery as good compared with a CCG average of 87% **and** national average of 85%.
- 96% of respondents would recommend this surgery to someone new to the area compared with a CCG average of 79% and national average of 78%.
- 89% of patients described their experience of making an appointment as good which was higher than the local CCG average of 75% and national average of 73%.

However; results indicated the practice could perform marginally better in certain aspects of care, for example:

- 57% of respondents with a preferred GP usually get to see or speak to that GP compared with a local CCG average of 59% and a national average of 60%.

As part of our inspection process, we asked for CQC comment cards to be completed by patients prior to our inspection. We received 29 comment cards (which is 0.2% of the practice patient list size) which were positive overall about the standard of care received. GPs and nurses all received praise for their professional care and patients said they felt listened to and involved in decisions about their treatment. Patients informed us that they were treated with dignity and respect.

Aintree Park Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector and included two CQC inspectors, a GP specialist advisor and practice manager specialist advisor.

Background to Aintree Park Group Practice

Aintree Park Group Practice is located across two sites in a deprived area of Liverpool. There were 14,700 patients on the practice list at the time of our inspection that was predominantly of a white British background.

The practice is a training practice managed by seven GP partners. There are also six salaried GPs and GP locums and one GP registrar. There are two nurse practitioners, two practice nurses and two healthcare assistants. Members of clinical staff are supported by the practice manager and an assistant manager, reception and administration staff. The practice also employs a full time pharmacist.

The practice at Moss Lane is open 8am to 6.30pm Monday, Thursday and Fridays; 8am-8pm on Tuesdays and 8am-4.30pm on Wednesdays. The branch surgery (Old Roan Surgery) is open 8am-6.30pm on Mondays, Tuesday, Wednesday and Friday and 8am-4.30pm on Thursdays. In addition, Saturday morning appointments are available from 8.30am-11.45am at the branch surgery. Patients requiring a GP outside of normal working hours are advised to contact the GP out of hours service by calling 111.

The practice has a General Medical Services (GMS) contract and had enhanced services contracts for example, childhood vaccinations.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

How we carried out this inspection

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

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

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

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

Detailed findings

- People experiencing poor mental health (including people with dementia)

The inspector :-

- Reviewed information available to us from other organisations e.g. NHS England.
- Reviewed information from CQC intelligent monitoring systems.
- Carried out an announced inspection visit on 15 October 2015.
- Spoke to staff and representatives of the PPG.
- Reviewed patient survey information.
- Reviewed the practice's policies and procedures.

Are services safe?

Our findings

Safe track record and learning

Safety was a top priority for the practice and the ethos of the practice was that safety was everyone's responsibility. The practice was able to provide evidence of a good track record for monitoring safety issues. The practice took the opportunity to learn from internal and external incidents, to support improvement. The practice carried out root cause analysis of events and demonstrated they followed the Duty of Candour by involving patients in the investigation process.

Meetings were held to discuss significant events as a team, to identify any trends and any lessons that could be learnt. We reviewed examples of significant events. The practice demonstrated that following an incident, external protocols involving other health care services had been improved for the benefit of patients in the area. Another significant event had resulted in all old written records being reviewed to check that the correct details were added to summary care records on the computer system.

All staff were involved in incident reporting and those we interviewed told us they could do this confidently and felt supported to do so without any fear of blame. There was a significant event policy and recording systems in place which all staff used. Complaints were routinely analysed to see if information related to a significant event.

There was a protocol in place for handling medicine and safety alerts and information was cascaded to relevant staff to act on the information.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to support staff to deliver safe care, which included:

- Arrangements in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and 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. There was a lead GP for safeguarding for the practice who was also the safeguarding lead for the local CCG. The practice had regular safeguarding meetings which all GPs attended. In addition, the GPs attended external safeguarding

meetings when possible and always provided reports where necessary for other agencies. Clinical staff demonstrated they understood their responsibilities and all had received training relevant to their role. The practice met with health visitors weekly and also every two months on a formal basis with health visitors and other healthcare professionals to discuss any safeguarding issues involving children and vulnerable adults. 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 or those that failed appointments.

- A notice was displayed in the waiting room and in treatment and consultation rooms, advising patients that chaperones were available, if required. All staff who acted as chaperones had received a disclosure and barring services check (DBS). These 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.
- Recruitment checks were carried out and seven files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and DBS checks. There was a record of historical professional registration checks for nursing staff, although there was no system in place to monitor on going registration.
- Standards of cleanliness and hygiene were followed. All areas of the practice were clean and monitoring systems were in place. One of the nurse practitioners was the designated lead. There was an infection control protocol in place and staff had received up to date training. The practice had previously carried out infection control audits and one was due to be undertaken later this year. The practice had carried out Legionella risk assessments and regular monitoring.
- Arrangements for managing medicines, including emergency medicines and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). One of the nurse practitioners ensured there was sufficient medication in GP bags and that it was in date.

Are services safe?

Prescription pads were securely stored and there were systems in place to monitor their use. The practice employed a full time pharmacist to reduce prescribing errors to improve safety. In addition the pharmacist monitored all changes of medication for patients discharged from hospital, liaised with nursing homes to ensure correct medication was given to patients and was involved in medication reviews for patients. The pharmacist had designed a set of decision aids for GPs to facilitate safer prescribing.

Monitoring risks to patients

There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy and poster on display. The practice had up to date fire risk assessments carried out fire drills twice a year. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked and calibrated to ensure it was working properly.

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 that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

- The practice was part of a pilot scheme with the local ambulance service and worked with a paramedic who dealt with urgent cases for patients who had contacted the surgery directly and for the practices' patients who had dialled 999.
- All staff received annual basic life support training and there were emergency medicines available in the treatment rooms. The practice had a defibrillator available in both premises and oxygen with adult and children's masks. The practice staff gave us examples of their responses to medical emergencies and in addition how the practice had improved systems in place after reflective learning.
- 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.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with the National Institute of Health and Care Excellence (NICE) best practice guidelines and had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. For example, NICE guidance for patients with atrial fibrillation. The practice also had access to the "Map of Medicine" program which was available to all the clinicians on their computers which explained national and local guidance on referral and treatment pathways.

Consent to care and treatment

Patients' consent to care and treatment was sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Summary notes explaining the principles of the Mental Capacity Act were available in all consultation rooms. The practice monitored patients in nursing homes on a monthly basis to establish which patients were subject to a deprivation of liberty safeguards (DoLS) and in addition those that could potentially be subject to DoLS in the future.

When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Consent forms were used including for surgical procedures and these were scanned on to the computerised medical records.

Protecting and improving patient health

Patients who may be in need of extra support were identified by the practice. This included patients who required advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service. The practice also had a visiting health trainer at both sites who gave advice on lifestyle management. Blood pressure monitoring equipment was available in the waiting room and a form to complete which gave

instructions to the patient about how to respond to their reading. The practice used the text messaging system to contact patients about smoking status and alcohol intake, and responded by signposting to appropriate agencies.

Childhood immunisation rates (2014) for the vaccinations given to two year olds and under ranged from 90% to 100% and were higher than CCG averages of 83% to 97%. Vaccination rates for five year olds were also higher and ranged from 90% to 99% compared with local CCG averages of 88% to 97%.

The practice had many adverts in the waiting room for seasonal flu vaccinations and had open Saturday morning clinics available throughout October. The percentage of patients aged 65 and older who had received a seasonal flu vaccination was 81% compared to a national average of 73%.

Screening for various cancers was actively encouraged. Saturday morning appointments for screening were available for patients who worked and letters were sent out to invite patients to attend. The percentage of women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding 5 years was 83% compared to a national average of 82%.

On the suggestion from one of the receptionists, the practice had organised a 'health festival'. The event included community services and stalls had various support information available. The event had been very successful and one of the GPs had won a local community award.

Coordinating patient care and information sharing

All the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. Three letters were sent to patients for reminders for appointments for example, for medication reviews and if the patient failed their GP was advised.

There was an information governance policy in place to ensure patient's details were kept safe and staff received training in handling confidential data and used smart cards to access computer systems. There was a confidentiality policy available.

Are services effective?

(for example, treatment is effective)

Incoming mail such as hospital letters and test results were scanned onto patient notes by administration staff within 24 hours and were then assigned to the relevant GP and the pharmacist. One of the nurse practitioners monitored information from the out of hours services. Arrangements were in place to share information for patients who needed support from out of hours.

The practice worked with a variety of other health care professionals including community matrons, health visitors, midwives, district nurses and Macmillan nurses. One of the GPs was the Macmillan lead for Liverpool. We reviewed feedback from other services affiliated to the practice such as nursing homes, pharmacies, community teams including health visitors who were all very positive about interactions with staff and accessing the GPs for advice.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. There was a designated GP to look at QOF performance and another GP monitored local guidelines and local quality performance and action plans were in place to meet targets. Patients who had long term conditions were continuously followed up throughout the year to ensure they all attended health reviews. Current results for QOF were 99% of the total number of points available with an exception reporting rate of 9%. Patients were not exception reported unless a GP had reviewed the patient's record. Data from 2014-2015 showed:

- Performance for diabetes assessment and care was comparable with the national averages for some aspects of care.
- Performance for mental health assessment and care was comparable with the national averages.

The practice could evidence quality improvement with full cycle clinical audits and all relevant staff were involved. Audits included minor surgery, medication and referrals.

The practice had reviewed CQC's intelligent monitoring report and was already aware they were an outlier for certain types of antibiotic prescribing. In response to this

the practice had carried out further training to highlight the issue and updated staff on the new local guidelines which were available to every prescriber. An alert was added to the computer system to highlight any risks when prescribing. The practice audited the use of antibiotics and we saw that there had been a reduction in use of this particular medication over the previous year.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. Evidence reviewed showed that:

- There were enough staff to provide services and this was monitored. The practice had recently recruited three salaried GPs. The practice did use locums but these were regular locums who received induction, locum information pack and continuous support. They attended staff meetings including significant events meetings. Trainee GPs and locums were monitored for clinical competence.
- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as fire safety, health and safety, and confidentiality.
- Staff received training that included: safeguarding, fire procedures, basic life support, equality and diversity and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training. Practice nurses attended local nursing forums for additional training and clinical staff attended protected learning events organised by the CCG.
- All GPs were up to date with their continuing professional development. GPs read each other's consultation notes to improve standards. There were annual appraisal systems in place for all other members of staff. Training needs were identified through appraisals and quality monitoring systems.
- The practice carried out exit interviews for all staff to ascertain any improvements that could be made to their induction, training and support and used this feedback to improve. We reviewed the interview notes and all were positive about the support given.

Are services effective?

(for example, treatment is effective)

The practice was a training practice and had a registrar and also mentored medical students. The practice had a system of protected mentoring time for GP registrars and newly qualified salaried GPs. All staff interviewed told us they felt supported in their role.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The reception area had separate room away from the front desk for staff to deal with incoming calls. This ensured the receptionist was not interrupted when talking to patients which allowed them to fully focus on the patient's needs.

All of the CQC patient comment cards we received were positive about the service patients experienced. Patients said they felt the practice offered an excellent service and clinicians were helpful, caring and treated them with dignity and respect. We also spoke with five members of the PPG. They also 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 patients needed help and provided support when required.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks and longer appointments were available for people with a learning disability which were either scheduled at the beginning or end of a clinical session. The practice worked with local support services including Addaction teams who attended the surgery. The practice gave us several examples of care whereby vulnerable patients had been additionally supported to access tests and treatment.

Data from the National GP Patient Survey July 2015 showed from 104 responses that performance was better than local and national averages for example,

- 96% said the GP was good at listening to them compared to the CCG average of 90% and national average of 89%.
- 91% said the GP gave them enough time compared to the CCG average of 89% and national average of 87%.

- 97% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%.

Care planning and involvement in decisions about care and treatment

Patients from the PPG we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Data from the National GP Patient Survey July 2015 information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were in line with local and national averages. For example:

- 89% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 86%.
- 92% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 91% and national average of 90%.
- 91% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 81%.

Patient and carer support to cope emotionally with care and treatment

Carers were asked if they were happy to be identified as a carer, so they could be included on a practice register to help the practice consider their needs. Flu vaccinations and health checks were offered to carers. However, there was no information available in the waiting room for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them and would visit them at home to discuss any of their needs. Alerts were placed on relevant patient's records so all staff were aware.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice recognised the impact of changes within the local area for example, the two surgeries crossed boundaries between Sefton and Liverpool which sometimes caused confusion around the external services provided for patients. The practice had identified issues with referral systems and had brought this to the attention of other services and new systems to work around the problems had been adopted as a result.

Some of the GPs were part of the local Clinical Commissioning Group (CCG). For example, one GP was the urgent care lead and the practice was part of a pilot study for the use of paramedics at GP surgeries. The paramedic dealt with urgent cases for patients who had contacted the surgery directly and for the practices' patients who had dialled 999. In addition the paramedic was involved in care planning for nursing home patients to reduce the number of hospital admissions.

The practice attended Neighbourhood meetings with other local GP practices. One GP from the practice was the lead for these meetings. The practice also gained feedback from services affiliated with the practice such as nursing homes, pharmacies and community teams.

In order to understand the needs of their population, the practice carried out a demographic survey. Results from the survey were then used to formulate specific questions for patient feedback in order to improve services.

The practice conducted in depth surveys to gain information about patient satisfaction and identified where they could improve by carrying out a gap analysis. Action taken from the 2014 survey had resulted in a new phone system being installed. The practice could monitor the number of calls received hourly and hence allocate appropriate staff numbers accordingly.

There was an established and very active patient participation group (PPG) which met on a regular basis and submitted proposals for improvements to the practice management team.

The practice had recognised that the reception area at the Moss Lane surgery could be improved to provide patients

with more privacy at the reception desk. The reception was being renovated the day after our inspection to incorporate an additional room within reception to enable patients to discuss matters privately should they so wish.

Services were planned and delivered to take into account the needs of different patient groups. For example;

- There were longer appointments available for people with a learning disability.
- Home visits were available for elderly patients and palliative care patients.
- Urgent access appointments were available.
- There were good disabled facilities, hearing loop (at the branch surgery), and translation services available.
- The practice held regular meetings with other healthcare professionals to support patients with more complex needs.
- There were open Saturday morning flu clinics available throughout October.
- Saturday morning appointments for a variety of clinics with both the GP and practice nurse were available including cervical screening and flu vaccinations.

Access to the service

The practice monitored its appointments on a formal weekly basis and daily if necessary to ensure the systems could cope with demand and that there was adequate staffing available. Appointments were 10 minutes for urgent on the day and 15 minutes for booked appointments. Staff worked across both sites. The practice at Moss Lane is open 8am to 6.30pm Monday, Thursday and Fridays. 8am-8pm on Tuesdays and 8am-4.30pm on Wednesdays. The branch surgery – (Old Roan Surgery) is open 8am-6.30pm on Mondays, Tuesday, Wednesday and Friday and 8am-4.30pm on Thursdays. In addition, Saturday morning appointments are available from 8.30am until 11.45am at the branch surgery. Patients requiring a GP outside of normal working hours are advised to contact the GP out of hours service by calling 111.

Results from the national GP patient survey indicated patients were satisfied with the appointment systems in place. For example,

- 89% of patients described their experience of making an appointment as good which was higher than the local CCG average of 75% and national average of 73%.

Are services responsive to people's needs?

(for example, to feedback?)

- 85% of patients found it easy to get through to this surgery by phone which was higher than the local CCG average of 75% and national average of 73%.
- 86% usually waited 15 minutes or less after their appointment time to be seen which was higher than the local CCG average of 62% and national average of 65%.
- 84% felt they don't normally have to wait too long to be seen which was higher than the local CCG average of 59% and the national average of 58%.
- 87% were satisfied with the surgery's opening hours which was higher than the local CCG average of 79% and national average of 75%.

However, data for patient satisfaction around making appointments with the same GP was lower with 57% of respondents with a preferred GP said they usually got to see or speak to that GP compared with a local CCG average of 59% and a national average of 60%.

Listening and learning from concerns and complaints

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

who handled all complaints in the practice. Information about how to make a complaint was available in the waiting room and in a practice leaflet. The complaints policy clearly outlined a time framework for when the complaint would be acknowledged and responded to. If verbal complaints were not resolved on the day they were automatically treated as a formal complaint. In addition, the complaints policy outlined who the patient should contact if they were unhappy with the outcome of their complaint.

We reviewed complaints and found that both written and verbal complaints were recorded and written responses for both types of complaints which included apologies given to the patient, an explanation of events and sometimes an invite to discuss issues further. A full complaints analysis was conducted with complaints being categorised into whether the complaint was about GPs, nurses, reception or administration errors, premises or management issues to help identify any trends. For example, we saw there had been complaints from local residents regarding the congregation of youths around the practice at night. The practice had responded by altering the layout of the external premises to minimise disruption.

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

The practice had a clear mission statement to 'work with patients to achieve excellence in local healthcare'. The whole practice team had been involved in producing the mission statement and values for the practice and their mission statement underpinned their policies and procedures. The practice had adopted its ethos from a patient comment 'big enough to cope, small enough to care'. All staff we interviewed were passionate about providing the best possible care for patients and were proud to work for the practice.

Management were aware of their strengths and weaknesses, opportunities and external challenges facing the practice. They held regular strategy meetings and had a business plan in place. The strategic plan covered quality, services, resources and leadership. The practice held annual away days to discuss strategy, their achievements and to encourage team building. The last away day held in February 2015, was about Liverpool Clinical Commissioning Group's (CCG) Healthy Liverpool Programme to encourage well-being through physical activity.

Governance arrangements

The practice had an overarching clinical governance policy. The practice had policies and embedded procedures in place to cover key areas of governance: clinical effectiveness, risk management, information governance, patient experience and involvement, resource effectiveness, strategic effectiveness and learning effectiveness. Evidence reviewed demonstrated that the practice had:-

- A clear organisational structure and a staff awareness of their own and other's roles and responsibilities. The practice employed over 50 staff. To ensure team coordination there was a nursing team manager, reception team leader, administration team leader, information facilitator, operations manager and the general (practice) manager.
- Practice specific policies that were implemented and that all staff could access. Some policies had been simplified for easy quick use by staff. This included many medication protocols and flow charts for what to do in cases when children did not attend appointments.

- A system of reporting incidents without fear of recrimination and whereby learning from outcomes of analysis of incidents actively took place. Incidents were categorised to identify trends including those events whereby good teamwork had a positive impact on outcomes for patients. Significant event analysis at the practice had led to improved communications with secondary care in the area.
- A system of continuous quality improvement including the use of audits which demonstrated an improvement on patients' welfare. For example, referral audits to prevent unnecessary hospital admissions.
- Encouraged and supported staff via informal and formal methods including structured appraisals to meet their educational and developmental needs. The practice is a training practice and also worked with the local university fourth year medical students. Students were encouraged to participate in audit work. Career progression was positively encouraged. For example, one member of staff who was receptionist had received further training to become a healthcare assistant.

Leadership, openness and transparency

There was a clear leadership structure in place and staff felt supported by management and could raise any concerns.

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.

The practice had clear methods of communication that involved the whole staff team and other healthcare professionals to disseminate best practice guidelines and other information. A wide range of meetings were planned and regularly held to support communication including: weekly partner's meetings, monthly board meetings (that had a fixed agenda to discuss significant events, complaints, safeguarding, quality, clinical commissioning, education and research, facilities, medication management and staffing). Once a week, there was a 'meet and eat' session held over a lunch time which covered topics such as safeguarding and palliative care reviews and sometimes involved a training session given by a guest speaker. Other meetings were held to discuss palliative care, safeguarding and significant events. Meeting minutes were circulated and available for all staff.

Are services well-led?

Outstanding



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

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

The practice proactively gained patients' feedback and engaged patients in the delivery of the service and responded to any concerns raised by both patients and staff. For example, the practice was redesigning the reception area to improve the patient experience.

Staff told us they felt involved and engaged to improve how the practice was run. The practice also sought feedback from affiliated services such as local pharmacies and nursing homes.

There was a strong focus on continuous learning and improvement at all levels within the practice. For example, GPs read each other's consultation notes to improve standards.

The practice team was forward thinking and had previously implemented practice changes prior to other practices in the area. For example, employing nurse practitioners and pharmacists and piloting gold standards framework meetings for palliative care. The practice was currently working on an initial pilot for urgent care and worked with a paramedic.

Continuous improvement