Marybone Health Centre

Inspection report

2 Vauxhall Road
Liverpool
Merseyside
L3 2BG
Tel: 0151 330 8200
www.marybone.brownlowhealth.co.uk

Date of inspection visit: 17 October 2018
Date of publication: 01/02/2019

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 location	Good
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Overall summary

This practice is rated as Good overall.

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at Marybone Health Centre on 17 October 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- Staff worked well together as a team, knew their patients well and all felt supported to carry out their roles.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
- The practice had an active Patient Participation Group (PPG) who worked closely with staff to monitor and develop services.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw areas of outstanding practice:

- The practice had the support of a Diabetic Specialist Nurse Consultant who was employed to coordinate and streamline care for students and complex diabetic patients. The nurse worked across a number of the Brownlow Health practices. At Marybone Health Centre the nurse provided added support to newly arrived students, who had type one diabetes. Patients were contacted and invited to register at the practice. For patients with complex needs the nurse would contact their previous GP to ensure all required treatments were in place. 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 and on improving patient outcomes so that a transfer of care could be coordinated safely and effectively.
- The practice had a senior GP who worked closely with YPAS (Young Person's Advisory Service) attending monthly meetings with a multi-disciplinary team working for children and young people. Some of this work involved developing and supporting patients with transgender needs. The practice had a Transgender Management Protocol to support GPs when prescribing. Staff had completed specialist training to ensure they understood and could respond sensitively to the needs of this population group. Staff we spoke with were aware of the risks for this population group and were responsive in the way their care was approached. We were told that patient referral to specialist support services and gender clinics were made direct to avoid delays. This resulted in improved waiting times for patients. The practice completed an assessment of risk for each patient and this was maintained at each stage of transition. Robust systems were in place to monitor the prescribing of medicines and patient care plans, evidence was provided after the inspection of the audits that were completed to achieve this.

The areas where the provider **should** make improvements are:

- Develop an inventory of equipment in use.

Overall summary

- Improve the action planning process following completion of risk assessments, audits, incident and complaints reporting.
- Should review and monitor the outcomes of the action plans to improve the practice children's immunisations and cervical screening rates for patients.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

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

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector**.** The team included a GP specialist adviser and a practice manager adviser.

Our inspection team was led by a Care Quality Commission (CQC) lead inspector**.** The team included a GP specialist adviser and a practice manager adviser.

Background to Marybone Health Centre

Marybone Health Centre is situated in the centre of Liverpool at 2 Vauxhall Road

Liverpool, L3 2BG. The practice website address is www.marybone.brownlowhealth. The practice is part of NHS Liverpool Clinical Commissioning Group (CCG) and has an Alternative Medical Services (APMS) contract, which has been in place since April 2017.

The provider is Brownlow Health who also has a number of other GP practices across Liverpool.

At this practice there are five GPs, two advance nurse practitioners, practice nurse and clinical support worker and a mix of administration and reception staff. The practice had a full-time practice manager.

Marybone Health Centre is registered with the Care Quality Commission to carry out the following regulated activities: Diagnostic and screening procedures, Surgical procedures and Treatment of disease, disorder or injury.

Marybone Health Centre is situated in a socially deprived area of Liverpool with high unemployment rates. There were 6058 patients on the practice register at the time of our inspection.

Patient information states that the practice is open 8am to 6.30pm every weekday. Patients requiring a GP outside of normal working hours are advised to contact NHS 111 for the GP out of hours service.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Learning from safeguarding incidents was available to staff. Staff who acted as chaperones were trained for their 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.)
- We noted that safeguarding children's policies were out of date during inspection and updated versions were sent following inspection.
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice carried out
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order. However, there was no inventory of equipment in use.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- New systems had recently been put into place to ensure patient records were managed and stored safely.
- The care records we saw showed that information needed to deliver safe care and treatment was available to staff.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety.

Good

Are services safe?

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed safety using information from a range of sources.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and acted to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the evidence tables for further information.

Good

Are services effective?

We rated the practice and all of the population groups as good for providing effective services overall.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Patients were able to access improved patient access services on line. For example, they could book online appointments, repeat prescriptions and have access to their patient health care records.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- All older patients were given a named GP for contact and support.
- Registers were kept of older people and those who had dementia care needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- The practice had robust call and recall systems, to avoid duplication when multiple long-term conditions existed.
- Core teams had been developed with lead clinicians designated to each area across the Brownlow Health services. Monthly clinical meetings took place and staff from Marybone Health Centre attended to review their performance and to benchmark practice.
- The practice had newly developed templates to ensure accurate data gathering.
- Brownlow Health had a new diabetes model of care, this was in place across each site including this practice.
- When Brownlow Health took over the practice each of the long terms conditions registers required review and revalidation and this was completed by the time of inspection. New document pathway systems and staff training was established to ensure errors with coding did not occur.
- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice could demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension)
- The practice's performance on quality indicators for long term conditions had improved since the new provider Brownlow Health had taken over the service. Many of the indicators for long term conditions were now in line or above local and national averages.

Families, children and young people:

Good

Are services effective?

- Childhood immunisation uptake rates were below the target percentage of 90% or above. The practice was aware of this and an action plan was put in place to make improvements. This included the development of a lead co-ordinator to review and recall children who did not attend for appointments. These figures were monitored centrally.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- Monthly health visitor meetings took place.
- The practice had Royal College General Practitioners young person's poster/information in consultation rooms to encourage and facilitate young people to be confident in accessing medical care confidentially.

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

- The practice's uptake for cervical screening was below the 80% coverage target for the national screening programme. The practice was aware of this and an action plan was put in place to improve this.
- The practice's uptake for breast and bowel cancer screening was above national and local levels.
- The practice had a process map for responding to patients with a new diagnosis of cancer. This showed that the named GP would be informed and if needed a referral would be sent to a cancer support nurse working across the Brownlow Health locations. Contact was made with patients by the nurse within the first week of diagnosis and followed up after this depending on the needs of the patient.
- The practice had systems to inform eligible patients to have the meningitis vaccine. For example, before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The practices performance on quality indicators for working age people was in line with local and national averages.
- The practice had developed the nurse practitioner role and worked to ensure permanent GPs for the practice to try and improve access for patients.
- The practice provided a service to local universities. Registration events were set up and staff acted quickly to establish those students who might have complex medical conditions or mental health issues, for example, at risk to suicide or depression.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those 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 had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice had a vulnerable patient list, each of these patients had a named GP and monthly meetings took place to review their needs.
- Patients who were at high risk of admission to hospital were referred to a community care multi-disciplinary team (MDT).
- The practice monitored the needs of patients living in hostel accommodation and those who were homeless. They practice had good links with the homeless team at another of the practices in the Brownlow Heath group.
- A transgender record review, template and care plan was introduced by the lead GP working alongside a voluntary sector organisation named Young Person Advisory Service (YPAS).
- Learning events for staff took place and this included care of patients with alcohol and drug misuse, homeless people and conflict resolution.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity,

obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.

- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.
- The practices performance on quality indicators for mental health was in line with local and national averages.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

- The practice used information about care and treatment to make improvements. The most recent published (2016/2017) Quality Outcome Framework (QOF) results were 98% of the total number of points available and in line with national and CCG averages.
- Published scores also showed the practice had higher than average exception reporting rates. However, information provided after the inspection that showed improvements for this had been achieved.
- Data produced by the practice demonstrated an increase in achievement in QOF for this year (2017/2018). This data and other data provided by the practice had not yet been verified or published.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.

Good

Are services effective?

- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to decide.
- The practice monitored the process for seeking consent appropriately.

Please refer to the evidence tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practices GP patient survey results were in line with local and national averages for questions relating to kindness, respect and compassion.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given).

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.
- The practices GP patient survey results were in line with local and national averages for questions relating to patients feeling involved in decision making.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues, or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the evidence tables for further information.

Good

Are services responsive to people's needs?

We rated the practice and all of the population groups as good for providing responsive services overall.

Responding to and meeting people's needs

- The practice organised and delivered services to meet patients' needs. It took account of the practice understood the needs of its population and tailored services in response to those needs. For example, the large population of student patients.
- Telephone and web GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- Provider information showed that 3% of the practice population (770 patients) was aged 75yrs or over. All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. A dementia care strategy was in place across each of the Brownlow Heath practices including Marybone Health Centre.
- The GP and practice nurse accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- The practice had developed the role of the health care assistant and this now included added responsibility to supporting patients and families with complex needs such as those for older people. This person followed up on patients who had been admitted to hospital, those who needed reminders for GP appointments also liaising with district nurses and health visitors about the patient and their on-going management needs.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- Protected time for home visits to housebound LTC patients.
- The practice had the support of a Diabetic Specialist Nurse Consultant who was employed to coordinate and streamline care for students and complex diabetic patients. The nurse worked across a number of the Brownlow Health practices. At Marybone Health Centre the nurse provided added support to newly arrived students, who had type one diabetes. Patients were contacted and invited to register at the practice. for patients with complex needs the nurse would contact their previous GP to ensure all required treatments were in place. 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 and on improving patient outcomes so that a transfer of care could be coordinated safely and effectively.

Families, children and young people:

- We found there were systems 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 accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The practice had a senior GP who worked closely with YPAS (Young Person's Advisory Service) attending monthly meetings with a multi-disciplinary team working for children and young people. Some of this work involved developing and supporting patients with transgender needs. The practice had a Transgender Management Protocol to support GPs when prescribing. Staff had completed specialist training to ensure they understood and could respond sensitively to the needs of this population group. Staff we spoke with were

aware of the risks for this population group and were responsive in the way their care was approached. We were told that patient referral to specialist support services and gender clinics were made direct to avoid delays. This resulted in improved waiting times for patients. The practice completed an assessment of risk for each patient and this was maintained at each stage of transition. Robust systems were in place to monitor the prescribing of medicines and patient care plans, evidence was provided after the inspection of the audits that were completed to achieve this.
- Targeted interventions were in place for certain groups for example, a Score project for young adults with asthma was in place.
- The practice participated in a central social media campaign to encourage young people to gain access.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice provided services to local community colleges and universities so services were specifically targeted to meet this population.
- A targeted actions plan was in place to improve practice performance for cytology. This showed a responsive, flexible approach to improve access to this test for those patients not responding to appointment requests.
- Clinicians were on site from 8am-6pm each day. All appointments were 15 minutes appointments -bookable in advance and same day access.
- Telephone consultations took place to improve access for working families.
- Registration -packs were available for patients and this included on-line registration to encourage students to register.
- The practice had a full range of specialist sexual health services which included sexually transmitted infections.
- Travel pre-assessment and personalised plans with facilitated appointment were available.
- A Diabetic Specialist Nurse Consultant was employed to coordinate and streamline care for students and complex diabetic patients.
- Targeted vaccination sessions were carried out for meningitis for students and at-risk flu population.
- There were good opportunities set up for liaison with local colleges and universities. This included such issues as suicide, infectious disease and complex risk management

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice held GP led dedicated monthly mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP.
- The practice had a GP lead for mental health.
- The practice worked closely with a Primary Care Mental Health Team Practitioner.
- MDT meetings took place monthly and this included discussion of patients experiencing poor mental health.
- The practice had a depression review process which included codes being added to patients records to flag up follow up arrangements.
- A suicide prevention protocol was in place and some clinicians were suicide prevention trainers. All staff had received this training.
- Training events took place for staff. This included, mental health risk, self-harm, personality disorder, psychology, eating disorders, alcohol and drugs.
- Review systems were in place for all patients on high risk mental health medicines.
- The practice had a GP representative on local Student Mental Health Group.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.

Good

Are services responsive to people's needs?

- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- The practices GP patient survey results were in line with local and national averages for questions relating to access to care and treatment.
- The practice monitored closely the appointment systems in place and the consultations recorded. Regular audits were taking place to assess the consultations recorded on the clinical system, to highlight any areas for development and training and to ensure data was recorded to a high standard using appropriate and consistent read codes.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care.

Please refer to the evidence tables for further information.

Good

Are services well-led?

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. As part of the new governance arrangements key staff had lead roles in areas such as safeguarding, significant events and complaints management. Nurses had key roles in developing recall systems and supporting patients with long term conditions.
- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. These included policies that belonged to the wider provider system and local policies for the practice.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

Good

Are services well-led?

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. However, we found that the action planning process following risk assessment, audits, incident and complaints reporting was not robust.
- The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients.
- The practice had plans in place and had trained staff for major incidents.
- The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was an active patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was a focus on continuous learning and improvement at all levels within the practice. Brownlow Health was a new provider for this practice and staff and patients had experienced a number of recent changes to systems and processes at the time of our inspection. There were numerous examples of how the practice had worked to improve patient care.

- There was evidence of systems and processes for learning, continuous improvement and innovation.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the evidence tables for further information.