

# Drs Kinloch and Moran

## 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

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

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

This is the report from our inspection of Drs Kinloch and Moran's practice. Drs Kinloch and Moran's practice is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on the 24 February 2015 at the practice. We reviewed information we held about the service and spoke with patients, GPs, and staff.

The practice was rated as Good overall.

Our key findings were as follows:

- There were systems in place to mitigate safety risks. The premises were clean and tidy. Systems were in place to ensure medication including vaccines were appropriately stored and in date.
- Patients had their needs assessed in line with current guidance and the practice had a holistic approach to patient care. The practice promoted health education to empower patients to live healthier lives.

- Feedback from patients and observations throughout our inspection highlighted the staff were kind, caring and helpful.
- The practice was responsive and acted on patient complaints and feedback.
- The practice was well led. The staff worked well together as a team and had regular staff meetings and training. There was an open culture that supported reflective learning and promoted effective change.

We saw an area of outstanding practice:

The lead GP was an active member of the Halewood Partnership Board which included school councillors, police, social services and public health. This group supported the development of local responsive strategies to promote health and wellbeing through health initiatives, housing and social needs initiatives.

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

Importantly the provider should:

# Summary of findings

Ensure that all staff receive Mental Capacity Act 2005 training appropriate to their roles.

**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. The practice had systems in place for monitoring safety and learning from incidents and safety alerts to prevent reoccurrences. For example the practice had a system in place to ensure learning from incidents was shared across all staff groups through practice meetings, clinical meetings and protected learning time. There was evidence that the clinical staff were engaged with reflective practice and learned from each other to promote patient safety and well-being.

The staff team had received safeguarding training appropriate to their roles.

There were systems in place to ensure medication including vaccines, were safely stored and in date.

The practice was clean and tidy. All equipment was regularly maintained to ensure it was safe to use.

The practice had emergency medication available and had access to a defibrillator and oxygen.

Good



### Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and considered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs was being identified and planned from their appraisals. Staff worked with multidisciplinary teams such as community cardiac clinicians, community matrons, community diabetic services, health visitors and district nurses to provide continuity of care.

Good



### Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer

Good



# Summary of findings

kind and compassionate care and worked to overcome obstacles to achieving this. There was accessible information to ensure patients understood the services available. We observed that patients were treated with kindness and respect.

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

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and learning points from complaints were discussed in practice meetings.

**Good**



## **Are services well-led?**

The practice is rated as good for being well-led. Staff were clear about the values of the practice being patient centred. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

**Good**



# 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

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. The practice kept a register of those patients 75 and over which was regularly updated and the practice offered a named GP for these patients in line with the new GP regulations. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The practice held Gold Standard Framework meetings to discuss patients who required palliative care with other health care professionals to ensure patients received 'joined up' care appropriate to their needs.

Immunisations such as the flu and shingles vaccinations were offered to older patients and the Quality and Outcomes Framework (QOF) information indicated the percentage of patients aged 65 and older who had received these vaccinations was higher than the national average.

Good



### People with long term conditions

There were registers of patients with long term conditions which enabled the practice to monitor and arrange appropriate medication reviews. The practice nurse looked after patients with long term conditions such as diabetes and liaised with the GPs to ensure where necessary appropriate reviews of care and risk were carried out.

The practice used the Quality and Outcomes Framework to monitor patient outcomes and worked on local initiatives such as the locally managed CCG area referral pilot scheme to determine the effectiveness of referrals for vulnerable patients.

The practice sent the out of hours service a weekly report of priority patients, for example, those that had a serious long term condition or terminal illness that may need to contact the out of hours service.

Good



### Families, children and young people

The practice is rated as outstanding 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

Outstanding



# Summary of findings

number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. 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. Appointments were available outside of school hours and the premises were suitable for children and babies. The lead GP provided pre and post natal care and we saw good examples of joint working with midwives, health visitors and school nurses.

The lead GP was an active member of the Halewood Partnership Board which included school councillors, police, social services and public health. This group supported the development of local responsive strategies to promote health and wellbeing through health initiatives, housing and social needs initiatives.

The practice was part of the local community and felt a sense of responsibility to be part of health and social initiatives in the area.

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

Good



The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of 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. The practice was proactive in offering online services such as a repeat prescription service, an on line appointment booking service and the choose and book service. The practice also offered a full range of health promotion and screening that reflects the needs for this age group.

## **People whose circumstances may make them vulnerable**

Good



The practice held a register of patients living in vulnerable circumstances including people with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability to enable more time to discuss treatment options.

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

# Summary of findings

## **People experiencing poor mental health (including people with dementia)**

The practice maintained a register of patients who experienced mental health problems. The register was used by clinical staff to offer patients an annual health check and medication review.

The practice kept a separate registers for long term conditions including patients with dementia and depression. The practice liaised with other health and social care services to ensure patients received appropriate care and support. The practice supported patients to access local support services to enable patients to manage their mental health.

The practice supported patients with mental health needs who lived in supported living environments. The GPs demonstrated an understanding of their roles and responsibilities with regard to the Mental Capacity Act 2005.

Good



# Summary of findings

## What people who use the service say

What people who use the service say

As part of our inspection process, we provided CQC comment cards for patients to complete prior to our inspection.

We received 19 comment cards and spoke with six patients. All comments received indicated that patients found the reception staff helpful, caring and polite and many described their care as excellent.

For the practice, results received from the national GP patient survey showed that in July 2014 97.53% of patients described their overall experience of this practice

as fairly good or very good which is significantly higher than the national average. Just over sixty seven percent of patients responded that they always or almost always see or speak to the GP they prefer this is significantly higher than the national average.

Results from the national GP patient survey also showed that 96.06% of patients said the last nurse they saw or spoke to was good at treating them with care and concern and 92.98% said the last nurse they saw or spoke to was good or very good at involving them in decisions about their care. Both these results were significantly higher than the national average.

## Areas for improvement

### Action the service SHOULD take to improve

The provider should ensure that all staff receive Mental Capacity Act 2005 training appropriate to their roles.

## Outstanding practice

The lead GP was an active member of the Halewood Partnership Board which included school councillors,

police, social services and public health. This group supported the development of local responsive strategies to promote health and wellbeing through health initiatives, housing and social needs initiatives.

# Drs Kinloch and Moran

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) inspector and the team included a GP specialist advisor.

### Background to Drs Kinloch and Moran

The Dr Kinloch and Dr Moran practice was located in the Halewood area of Liverpool. There were approximately 5135 patients registered at the practice at the time of our inspection, the practice provided primary medical services to all age groups.

The practice has two GP partners (both male) and employed a salaried GP (Female) a practice nurse, a practice manager and reception and administration staff. The practice is open 8.00am to 6.00pm Monday to Friday. The practice runs a triage system for emergency appointments every morning whereby a GP calls patients back first to ascertain whether clinical advice can be offered or that an appointment is needed. Patients requiring a GP outside of normal working hours are advised to contact an external out of hours service provider, Urgent Care 24(UC24). The practice has a GMS contract and also offers enhanced services for example; various immunisation and health check schemes.

One of the GP partners is a supervisor for medical students who visit the practice on a weekly basis. The lead GP is the chair of the Local Medical Committee

The CQC intelligent monitoring placed the practice in band six. The intelligent monitoring tool draws on existing

national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

### 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:

# Detailed findings

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

Before visiting the practice we reviewed information we held and asked other organisations and key stakeholders

to share what they knew about the practice. We also reviewed policies, procedures and other information the practice provided before the inspection day. There were no areas of risk identified across the five key question areas. We carried out an announced visit on 24 February 2015.

We spoke with a range of staff including three GPs, the practice nurse the practice manager, reception and administration staff on the day. We sought views from patients and looked at comment cards and reviewed survey information.

# Are services safe?

## Our findings

### Safe track record

The Practice had a system in place for reporting, recording and monitoring significant events and information from complaints. The practice had a significant event monitoring policy and a significant event recording form which was accessible to all staff via the practice's computers. The practice carried out an analysis of these significant events and this also formed part of GPs' individual revalidation process. There was evidence that GPs used significant events analysis as part of their appraisal and reflective practice. Information we received from NHS England and the Clinical Commissioning group, prior to inspection, indicated that this practice had a safe track record.

### Learning and improvement from safety incidents

We viewed written reports of the events, details of the investigations (significant event analysis) and learning outcomes. Minutes from weekly and monthly staff meetings clearly demonstrated that discussions about any incidents took place. We looked at three incidents that had occurred and found appropriate actions had been taken and new procedures had been implemented to reduce the risk of incidents happening again. For example a prescribing audit was undertaken that resulted in changes to prescribing practices. To ensure the changes made had been embedded within the practice a further audit was undertaken and confirmed the changes prescribing practices had been maintained. Records showed the analysis of the audits were detailed and involved all parties and supported reflective learning that resulted in a safer prescribing environment for patients.

We spoke with one GP who told us after any medical emergency, there was a discussion held between staff to ascertain if the emergency was handled appropriately and if there were any identified learning points for the practice.

Any information from national patient safety alerts or from the Medicines and Healthcare products Regulatory Agency (MHRA) was cascaded to appropriate staff members. For example we could see the alert regarding the Ebola outbreak in Africa had been actioned.

### Reliable safety systems and processes including safeguarding

The practice had safeguarding vulnerable adults and children policies in place which were accessible to all staff.

The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. In addition there were flow charts for guidance and contact numbers displayed within the reception area and treatment areas. There was a GP lead for safeguarding who demonstrated a clear understanding of his and the practices roles and responsibilities with regard to safeguarding children and vulnerable adults.

All staff had received safeguarding children training at a level suitable to their role, for example all clinicians had level three training. Staff had also received safeguarding vulnerable adults training and understood their role in reporting any safeguarding incidents. GPs attended safeguarding meetings when possible and provided reports where necessary for other agencies.

The practice had a computer system for patients' notes and there were alerts on a patient's record if they were at risk or subject to protection. The lead GP held regular meetings with health visitors to discuss children who may be at risk.

A chaperone policy was available on the practice's computer system. The practice nurses and reception staff acted as chaperones if required and a notice was in the waiting room to advise patients the service was available should they need it. Staff had received training to carry out this role and risk assessments were in place detailing why disclosure and barring checks had not been sought for non-clinical staff.

### Medicines management

There were systems in place for medicine management. Patients' medication reviews were carried out opportunistically when patients visited the practice. There was a system in place to recall patients if they had not visited the surgery in a twelve month period. There was a system in place to ensure certain drug types such as anti-depressants were coded as acute, this was to ensure patients requesting a repeat prescription were assessed by the last GP who prescribed the medication. The GPs re-authorised repeat medication on a six monthly basis or more frequently if necessary. A system was in place to ensure that any changes made to medication by the out of hours service or following hospital discharge were actioned without a delay.

## Are services safe?

The practice used a software system that supported them with their prescribing decisions and provides information about national guidelines, local initiatives and formulary choices.

GPs worked with pharmacy support from the Clinical Commissioning Group (CCG) to review prescribing trends and medication audits. GPs reviewed their prescribing practices as and when medication alerts were received and in accordance with good practice guidelines.

Prescription pads and forms were securely stored. We discussed with the practice manager the need to maintain audits of the ordering and use of prescription pads and forms. Following the inspection the practice manager confirmed an audit system had been put in place.

We looked at how the practice stored and monitored emergency drugs and vaccines, to ensure patients received medicines that were in date and ready to use. Vaccines were securely stored and were in date and organised with stock rotation evident. We saw the fridge was checked daily to ensure the temperature was within the required range for the safe use of the vaccines. A cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was in place for the safe management of vaccines.

Emergency drugs were listed and checked to ensure they were in date and ready to use. The emergency drugs were stored in a secure area which gave easy but secure access to staff.

### Cleanliness and infection control

There was a current infection control policy with supporting policies and guidance. We found that clinical staff had completed training in infection control relevant to their role. Staff we spoke with were able to describe their own roles and responsibilities in relation to infection control. The practice nurse was the lead for infection control and had undertaken training to support her in this role.

The six patients we spoke with commented that the practice was clean and appeared hygienic. We looked around the premises and found and observed that all areas looked clean and tidy. The consultation rooms and treatment rooms, waiting areas and toilets were well maintained. Surfaces were easy to clean and uncluttered. Staff had access to gloves and aprons and there were

appropriate segregated waste disposal systems for clinical and non-clinical waste. We observed good hand washing facilities to promote good standards of hygiene. Instructions about hand hygiene were available throughout the practice with hand gels available in clinical rooms.

We discussed with the practice manager the need to record the visual infection control/ cleaning checks at the practice to ensure any issues could be shared with the building manager. The building manager had direct line management responsibilities for the cleaning staff. Following the inspection the practice manager confirmed a formal audit system had been put in place.

We were told the practice did not use any instruments which required decontamination between patients and that all instruments were single use only. Checks were carried out to ensure items such as instruments, gloves and hand gel were available and in date. Procedures for the safe storage and disposal of needles and clinical waste products were evident.

Legionella testing was carried out by the building manager and the results were shared with practice.

### Equipment

All electrical equipment was checked to ensure the equipment was safe to use.

Clinical equipment in use was checked to ensure it was working properly. For example blood pressure monitoring equipment was annually calibrated. Staff we spoke with told us there was enough equipment to help them carry out their role and that equipment was in good working order.

### Staffing and recruitment

Staff told us there were enough staff to meet the needs of patients and they covered for each other in the event of unplanned absences.

The practice had a procedure for the safe recruitment of staff. This included guidelines about seeking references, checking qualifications/clinical registration, checking an applicant's physical and mental fitness and obtaining where necessary Disclosure and Barring service (DBS), (these checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post).

The practice did not routinely use locums and when this service was required used a GP known to the practice. Duty

## Are services safe?

rotas took into account planned absence such as holidays. Staff we spoke with felt staffing levels and the skill mix of staff were appropriate and met the needs of the service and patients. GPs and the reception manager told us that patient demand was monitored through the appointment system and staff and patient feedback to ensure that sufficient staffing levels were always in place.

We looked at a sample of recruitment files for one GP, and three reception and administrative staff. We found that the recruitment procedure had been followed and the required checks had been undertaken to show that the applicants were suitable for the posts they had applied for.

The professional registration of clinical staff was checked prior to appointment and there was a system in place to record checks of on going professional registration with the General Medical Council (GMC) and Nursing Midwifery Council (NMC).

### **Monitoring safety and responding to risk**

Staffing levels were reviewed to ensure patients were kept safe and their needs were met. In the event of unplanned absences staff covered from within the service. The practice website had a portal allowing patients to raise concerns which in turn was monitored by the lead GP.

The practice had other systems, processes and policies in place to manage and monitor risks to patients, staff and

visitors to the practice. These included checks of the fire fighting equipment, medicines management, dealing with emergencies and monitoring the safety of equipment. Health and safety information was displayed for staff and patients to see around the premises. A health and safety policy and procedure was available. The practice manager was the lead for health and safety and these issues were discussed at staff meetings.

### **Arrangements to deal with 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 access to oxygen and a defibrillator available on the premises. There was a first aid kit and accident book available. There was no formal medical emergency protocol in place but when we discussed medical emergencies with staff, they were aware of what to do.

The practice had a comprehensive disaster handling and business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and we found staff were aware of the practicalities of what they should do in the event of a major incident.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

When patients registered with the practice, the practice nurse carried out a full health check which included information about the patient's individual lifestyle as well as their medical conditions. Patients were booked in for an extended appointment to discuss their needs and to be introduced to the services available in order for patients to make best use of the practice. The practice nurse referred the patient to the GP when necessary.

The practice carried out assessments and treatment in line with best practice guidelines and had systems in place to ensure all clinical staff were kept up to date.

The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to For example, patients on the 'at risk' register, learning disabilities and palliative care register.

There were a number of effective assessment systems in place. For example, complex patients with diabetes were seen by the practice nurse and the specialist community diabetic nurse. This enabled the practice to provide specialist services to minimise the need to refer patients to secondary health services.

The practice took part in the avoiding unplanned admissions scheme. The clinicians discussed patient's needs at meetings and ensured care plans were in place and regularly reviewed.

### Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system for the performance management of GPs intended to improve the quality of general practice and reward good practice.

All GPs and nursing staff were involved in clinical audits. Examples of audits included Chaperone use audit, prescribing antipsychotics in dementia, cephalosporin audit, lansoprazole prescribing audit. Audits were discussed in practice meetings and e-mailed to the whole team. Some audits such as cephalosporin medication audit had resulted in a change in prescribing patterns. The practice had monitored the increase in patients and their needs and had adjusted the service provision accordingly.

The practice also met with the local (CCG) to discuss performance. The lead GP was the chair of the Local Medical Committee and used this role to drive improvement in the practice and in other practices within the CCG area.

### Effective staffing

The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and confidentiality.

Staff received training that included: - safeguarding vulnerable children, basic life support and information governance awareness. There was no training schedule in place to demonstrate what training staff had previously received or were due to receive.

The practice nurse attended local practice nurse forums and attended a variety of external training events. She told us the practice fully supported her in her role and encouraged further training.

All GPs were up to date with their yearly continuing professional development requirements and they had been revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). There were annual appraisal systems in place for all other members of staff.

### Working with colleagues and other services

Incoming referral letters were scanned onto patient notes and then all three GPs were given the letters to ensure no issue that required action was missed and any action required was taken in a timely manner.

Patients were referred to hospital using the 'Patient Choose and Book' system and used the two week rule for urgent referrals such as cancer. The practice had monitoring systems in place to check on the progress of any referral. For example a medical secretary monitored and when necessary contacted local hospitals for test results and appointments.

The practice liaised with other healthcare professionals such as the community diabetic specialist service, the community cardiac care clinic, Community Matron and the community mental health team.

# Are services effective?

(for example, treatment is effective)

The practice used Urgent Care 24's (UC24) visiting service to carry out acute visits to patients in the afternoons while GPs were in surgery. The practice had put a system in place to triage each home visit request to ensure it was appropriate for UC24 to carry out the visit. If the assessment identified it was not appropriate a GP would carry out the visit after surgery had ended.

## Information sharing

Systems were in place to ensure information regarding patients was shared with the appropriate members of staff. Individual clinical cases were reviewed at team meetings as necessary. For example, the practice in conjunction with community nurses and matrons held regular Gold Standard Framework (GSF) meetings for patients who were receiving palliative care.

The practice used summary care records to ensure that important information about patients could be shared between healthcare settings. The practice planned and liaised with the out of hours provider regarding any special needs for a patient; for example faxes were sent regarding end of life care arrangements for patients who may require assistance during the weekend.

The practice operated a system of alerts on patients' records to ensure staff were aware of any issues for example alerts were in place if a patient was a carer.

## Consent to care and treatment

The practice had a Mental Capacity Act policy in place to help GPs with determining mental capacity of patients. We spoke with the GPs about their understanding of the Mental Capacity Act 2005 and Gillick guidelines, their understanding was varied. Some staff did not feel confident in their knowledge of the Mental Capacity Act 2005 and the accompanying code of practice.

The lead GP was aware of Gillick guidelines for children. Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

The practice carried out injections for joint conditions and we found appropriate information and consent forms for patients were in place.

## Health promotion and prevention

The practice had a variety of patient information available to help patients manage and improve their health. There were health promotion and prevention advice leaflets available in the waiting rooms for the practice including information on dementia.

The practice staff sign posted patients to additional services such as lifestyle management and smoking cessation clinics.

# Are services caring?

## Our findings

### **Respect, Dignity, Compassion & Empathy**

We observed throughout the inspection that members of staff were courteous and very helpful to patients at the reception desk and on the telephone.

CQC comment cards we received and patients we spoke with all indicated that they found staff to be helpful, respectful, caring, friendly and polite and that they were treated with dignity. Results from the national GP patient survey showed that 89.96 of patients said the last GP they saw or spoke to was good at treating them with care and concern which was higher than the national average. The patient survey also showed that 97.53% of patients described the overall experience of their GP surgery as fairly good or very good.

Curtains were provided in consulting rooms and treatment 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 practice had a confidentiality policy in place and all staff were required to sign this annually at their appraisals.

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

Results from the national GP patient survey showed that 88.64 of patients stated that the last time they saw or spoke to a GP, the GP was good or very good at involving them in decisions about their care this is in line with the national average.

Comments received from patients highlighted that they felt listened to by GPs, they felt GPs were concerned about their welfare and that they were referred appropriately. and were supported in terms of managing either long term or acute illnesses.

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

Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed that they would offer them a private room to discuss their needs. The lead GP told us that patients who had suffered bereavement or had mental health needs were contacted, offered support and signposted to various counsellors and support organisations to ensure their needs were being met.

There was a variety of supporting information to help patients who were carers which was available on the noticeboards in the waiting room. The practice also kept a list of patients who were carers and alerts were on these patients' records to help identify patients who may require extra support.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain a consistent level of service. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The lead GP was a member of the Halewood Partnership Board which included school councillors, police, social services and public health. This group supported the development of local responsive strategies to promote health and wellbeing through housing and social need initiatives.

Records viewed showed the practice engaged well with the NHS England Area Team and Clinical Commissioning Group (CCG). Records showed the practice met regularly with other practices to discuss local needs and service improvements that needed to be prioritised. We saw evidence that where issues had been discussed actions were implemented to ensure service improvements were made to manage delivery challenges to its population. For example developing clear referral systems to the locally based cardiac care service.

### Tackling inequity and promoting equality

The surgery had access to interpreter services (language line) but staff told us they had rarely had to use this facility. The practice had alerts on patients' records who may require extra assistance such as the visually impaired. All staff received training about Equality and Diversity.

The building had disabled facilities including access and a ramp. All consulting rooms were on the ground floor.

### Access to the service

The practice was open 8.00am to 6.00pm Monday, Tuesday, Wednesday, Friday and until 3:30pm on Thursday. Patients

requiring a GP outside of normal working hours are advised to contact an external out of hours provider (UC24). GPs triaged calls to ascertain whether the patient needed to attend the practice.

There were notices in the waiting room and information on the practice website to advise patients that if they had more than one medical problem that needed attention, they should book a longer appointment. The practice carried out telephone consultations and home visits when necessary.

Pre-bookable appointments for those patients who found it difficult to attend the practice during working hours were also available for early morning with the GP or practice nurse. Patients attending these appointments were either telephoned or sent text messages to remind them and this system had reduced the non-attendance rate of the practice.

### Listening and learning from concerns & complaints

The practice had a complaints policy in place and information about how to make a complaint was available in the practice leaflet, on the website and on the noticeboard in the waiting room. The complaints policy clearly outlined a time framework for when the complaint would be acknowledged and responded to. In addition, the complaints policy outlined who the patient should contact if they were unhappy with the outcome of their complaint.

We looked at a review of an annual summary of formal complaints received by the practice for 2014. Complaints were broken down into different categories such as clinical issues, work flow systems or about staff attitude. This supported the practice to identify trends. Learning points from complaints were discussed at staff meetings.

# Are services well-led?

Good 

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

## Our findings

### Vision and Strategy

Staff we spoke with were aware of the culture and values of the practice and told us patients were at the centre of everything they did. They felt that patients should be involved in all decisions about their care and that patient safety was paramount. Comments we received were very complimentary about the standard of care received at the practice and confirmed that patients were consulted and given choices as to how they wanted to receive their care.

The practice engaged with the local Clinical Commissioning Group (CCG) to ensure services met the needs of the local population.

### Governance arrangements

The practice had policies and procedures in place to support governance arrangements. These policies were available to all staff on the practice's computer system. The policies included a 'Health and Safety' policy, safeguarding policy and procedure and 'Infection Control' policy. All policies were in date and regularly reviewed.

Policies and procedures were discussed regularly through staff training events and the regular staff meetings that took place. Personal development was encouraged and supported by training days and appraisals for all staff.

The GP partners had a clear structure to support the safe delivery of the service. They had defined areas of responsibility including designated areas for the oversight of the performance and monitoring of the practice. For example one of the GPs was responsible for the engagement with the CCG and both partners monitored the QOF data to monitor the quality and safety of the service offered to patients.

Both GPs had specific clinical lead roles such as pre and post natal care, palliative care and minor surgery. Staff we spoke with told us they were well supported and knew who to go to in the practice with any concerns.

### Leadership, openness and transparency

The practice had monthly staff meetings to ensure all staff had an opportunity to be involved in the running of the practice. Minutes for all meetings were kept on the practice's computer systems which all staff could access.

Members of staff were supported at the practice for example there was a 'zero tolerance policy' to prevent and

cope with any untoward behaviour from patients against the practice staff. Staff we spoke with thought they were well supported and the culture within the practice was open and honest.

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

Results of surveys, comments received through the practice website and comments box and complaints were discussed at staff meetings.

We also saw evidence that the practice also listened to staff feedback and acted accordingly. For example members of the staff team told us the lead GP regularly discussed with them how the practice could improve IT support to improve services to patients.

The practice had an active Patient Participation Group (PPG). Members we spoke with told us they felt listened to and valued by the practice. They told us through their work with the practice the telephone appointments system had been changed. This resulted in a queue waiting system being introduced.

### Management lead through learning and improvement

GPs were all involved in revalidation, appraisal schemes and continuing professional development and supported the training of medical students. All staff received annual appraisals.

The practice had a comprehensive meeting schedule with set agendas. Minutes were available for all meetings and cascaded to staff. The practice held weekly clinicians' meetings. Where gaps or improvements could be identified meetings were held with other stakeholders, for example social services and community based health services. Records showed the practice enabled reflective practice and supported all staff with their professional development. Monthly non-clinical meetings took place to ensure best practice development and the clear dissemination of information and feedback.

The practice held regular training sessions for both clinical and non-clinical staff which included a mix of training both in house and by external trainers/facilitators.

The practice was also involved in meetings with the local CCG, multidisciplinary meetings for the Gold Standard Framework and Neighbourhood meetings.