

# Parkgate Surgery

## Quality Report

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

## Ratings

### Overall rating for this service

Outstanding 

Are services safe?

Good 

Are services effective?

Outstanding 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Outstanding 

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Parkgate Surgery on 11 February 2016. Overall the practice is rated as outstanding.

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

- The practice delivered services to a higher than average proportion of older patients and had good working relationships with the 15 care homes contained within the practice boundary.
- The practice demonstrated a thorough awareness of the needs of its patient population and had put measures in place to improve outcomes for patients identified as being at risk. This was particularly evident in the work undertaken around provision for older patients and those at risk of hospital admission. The practice closely monitored its quality improvement work to ensure a comprehensive understanding of the impact it had on patient outcomes.
- The practice had implemented additional nursing time specifically to facilitate home visits to over 75 year olds, housebound and frail patients. The practice also employed a care coordinator who oversaw administration tasks relating to those patients at risk of hospital admission.
- The practice had produced a branded folder in which patients could store their hand held personalised care plan. This made it easily identifiable and so facilitated information sharing with other professionals and gave patients an increased sense of ownership of their care.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised. The practice logged and categorised incidents in order to monitor trends and allow them to better predict where problems may arise.
- The practice used innovative and proactive methods to improve patient outcomes, working with other

# Summary of findings

local providers to share best practice. For example they carried out opportunistic screening for atrial fibrillation during a weekend flu vaccination clinic which resulted in three new diagnosis.

- Feedback from patients about their care was consistently and strongly positive. Patients told us that they felt valued and were always made to feel like a priority by staff.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. Multidisciplinary team meetings were held in the practice on a weekly basis, and care plans for complex patients drawn up jointly with other professionals to ensure the best care was provided.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example the telephone system had been updated following patient feedback that it could be difficult to get through to the practice by phone.
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.

We saw several areas of outstanding practice including:

- The practice was engaged in a comprehensive programme of clinical audit which allowed them to clearly demonstrate quality improvement and how this improvement had been achieved. This allowed the practice to have a robust understanding of its performance. Key areas of improvement included a significant reduction in emergency admissions, an increased prevalence of atrial fibrillation and reduction in prescribing of hypnotics. For example the practice could demonstrate how emergency admissions into hospital had been reduced by 95% over an 18 month period, and attendance at other secondary care services reduced by 50%.
- The practice was proactive in identifying clinical risks, and then taking rapid action to address and mitigate these risks. Once identified they were discussed at the next weekly clinical meeting, assigned to a nominated GP lead as well as having administration time identified to support the resulting work undertaken to make improvements.
- Staff had received carer awareness training to give them the skills to screen and identify those patients with caring responsibility.

**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.

Good



- There was an effective system in place for reporting and recording significant events.
- Lessons were shared effectively to make sure action was taken to improve safety in the practice. These changes were then reviewed and revisited to ensure they had been successful in mitigating against a repeat of the event.
- When there were unintended or unexpected safety incidents, patients received support, truthful information, a verbal and written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice categorised incidents into themes and monitored trends in an attempt to become more proactive at predicting risks to patients. Risks to patients were assessed and well managed.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- The practice nurse was identified as infection prevention and control lead, and had completed training to allow her to fulfil this role. The premises were clean and tidy and cleaning was monitored appropriately. Annual infection prevention and control audits were carried out.

### Are services effective?

The practice is rated as outstanding for providing effective services.

Outstanding



- 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 saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients.
- Data showed that the practice was performing highly when compared to practices nationally and within the local Clinical Commissioning Group. Medicines audits demonstrated the practice had made the highest savings in the CCG area over the previous year.

# Summary of findings

- The practice used innovative and proactive methods to improve patient outcomes and working with other local providers to share best practice.
- The practice was engaged in a comprehensive programme of audit activity to monitor performance and ensure improvements to patient outcomes. For example the practice could demonstrate how emergency admissions into hospital had been reduced by 95% over an 18 month period, and attendance at other secondary care services reduced by 50%.
- Following under-diagnosis of atrial fibrillation being identified as a clinical risk, the practice implemented measures to address this. The practice prevalence of this condition was increased from 137 to 193 patients over a 16 month period, and the number of these patients having their condition appropriately managed by anticoagulants rose from 60 to 109.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.

## Are services caring?

The practice is rated as good for providing caring services.

- Data from the National GP Patient Survey showed patients rated the practice higher than others for many aspects of care.
- Feedback from patients about their care and treatment was consistently and strongly positive.
- We observed a strong patient-centred culture and patients told us they felt treated as individuals and made to feel that they were a priority.
- Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this.
- We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. For example patients who had recently been diagnosed with a long term condition told us how treatment options were explained in detail by the clinician and that they as patients were involved in the decisions made. Where referrals to hospital were required, patients told us they were offered a choice of where they would prefer to attend.
- Views of external stakeholders were very positive and aligned with our findings.

**Good**



# Summary of findings

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. Training had been arranged for reception staff in how to register asylum seekers appropriately with the practice in anticipation of an influx of this vulnerable population group into the area in the near future.
- There were innovative approaches to providing integrated person-centred care. The practice had proactively taken the decision to utilise additional nursing time to facilitate home visits for its elderly, frail and housebound patients. The practice could demonstrate that as a direct result, emergency admissions from the nursing home population had reduced by 33%.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example, following feedback from the PPG around difficulties with telephone access, the practice had updated the telephone system in the practice to improve this and minimise patient waiting times on the telephones.
- Following the identification of clinical risk, or themes in complaints or incidents, the practice was responsive to addressing them through the facilitation of staff training and changes to practice. For example, ensuring reception staff received customer care training and clinicians received update training around atrial fibrillation.
- Patients could access appointments and services in a way and at a time that suited them. The practice offered a range of online services such as ordering repeat prescriptions. Telephone appointments and home visits were also available. The practice also offered in house electrocardiograms (ECGs) and 24 hour blood pressure monitoring services, reducing the need for patients to access secondary care within hospitals.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

## Are services well-led?

The practice is rated as outstanding for being well-led.

Outstanding



# Summary of findings

- The practice had a clear vision with quality improvement and safety as its top priorities. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. Staff were clear about the vision and their responsibilities in relation to this.
- High standards were promoted and owned by all practice staff and teams worked together across all roles.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The quality of care delivered was constantly reviewed with changes to practice implemented and monitored with measurable results to demonstrate improvement.
- Clinical risks were assigned to nominated GPs to manage, and audit activity undertaken to monitor the improvements made.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction.
- The practice actively gathered feedback from patients using surveys and it had an active patient participation group which influenced practice development. We saw that the practice acted on patient feedback.
- There was a strong focus on continuous learning and improvement at all levels. The practice had recently been invited to be a pilot site for new initiatives such as electronic pathology tests and previously had piloted electronic prescribing services.

# 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 as outstanding for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice delivered services to a higher than average proportion of older patients and had good working relationships with the 15 care homes contained within the practice boundary.
- The practice had implemented additional nursing time specifically to facilitate home visits to over 75 year olds, housebound and frail patients. In the year 2014/15 the practice completed a total of 453 health checks for patients over the age of 75 (this was compared to just three the previous year before the additional nursing time had been sourced).
- The nurse had a ringfenced session each week to carry out home visits for this population group.
- The practice regularly audited the services it provided for older people, and could demonstrate that emergency admissions from patients residing in care homes had reduced by 33% as a direct result of improvements to care pathways.

Outstanding



### People with long term conditions

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

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The practice employed a care coordinator who oversaw administration tasks relating to those patients at risk of hospital admission.
- Patients on the admissions avoidance register were provided with a hand held personalised care plan which was easily identifiable as it was in a branded practice folder. This facilitated information sharing with other professionals and gave patients an increased sense of ownership of their care.

Outstanding





# Summary of findings

- The practice demonstrated that improvements to services had resulted in a reduction of emergency admissions to hospital of 95%, and a reduction of 50% in patients presenting to other secondary care services.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Multidisciplinary meetings were held on a weekly basis.
- Of all patients on four or more medications, 92% had attended a medication review appointment in the last year, while 83% of patients on repeat medication had had their medicines reviewed.
- The practice offered an ECG telehealth service, where results were analysed instantly and feedback offered by a consultant cardiologist.
- The practice had recognised an underdiagnosis of atrial fibrillation, and had taken action resulting in an increased prevalence from 137 to 193 patients.

## Families, children and young people

The practice is rated as good for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- The percentage of patients with asthma, on the register, who had an asthma review in the preceding 12 months that included an assessment of asthma control using the three RCP questions was 79.44%, compared to the national average of 75.35%.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 82.53%, which was in line with the national average of 81.83%. The practice had carried out audit activity to address repeated

Good



# Summary of findings

failures to attend for cervical smear appointments. Following targeted intervention the practice was able to demonstrate a 12% increased uptake in smear appointments amongst this patient cohort.

- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

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

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 as well as a full range of health promotion and screening that reflects the needs for this age group.
- Telephone consultations were offered for those patients requiring medical advice who were unable to make it into the surgery.

Good



## People whose circumstances may make them vulnerable

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

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people.
- The practice informed vulnerable patients about how 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.
- Staff had received carer awareness training to give them the skills to screen and identify those patients with caring responsibility.

Outstanding



# Summary of findings

- Reception staff had attended training around how to appropriately register migrants in anticipation of an influx of this population group to the area in the near future.

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

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 89.04% compared to the national average of 84.01%.
- Performance for mental health related indicators was consistently higher than the national average. For example the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record in the preceding 12 months was 90.32% compared to the national average of 88.47%. The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 89.04% compared to the national average of 84.01% and the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months was 94.12% compared to the national average of 89.55%.
- The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia. Reception staff had received training to raise their awareness of issues around dementia.

Good



# Summary of findings

## What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing above local and national averages. A total of 253 survey forms were distributed and 129 were returned. This was a response rate of 51% and represented 2% of the practice's patient list.

- 85.3% found it easy to get through to this surgery by phone compared to a CCG average of 69% and a national average of 73.2%.
- 82.9% were able to get an appointment to see or speak to someone the last time they tried (CCG average 71%, national average 76%).
- 89.6% described the overall experience of their GP surgery as fairly good or very good (CCG and national averages both 85%).
- 79.7% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 76%, national average 79.3%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 34 comment cards which were all positive about the standard of care received. Many comments praised staff members and GPs by name for the caring service delivered and thanked them for the support they gave. As well as making positive comments about the practice, three cards did express some concern regarding the amount of time it could take to get an appointment with the GP of their choosing.

We spoke with four patients during the inspection, one of whom was also a member of the Patient Participation Group (PPG). All four patients said they were very happy with the care they received and thought staff were extremely approachable, committed and caring. They told us that clinical staff listened to patients concerns and thoroughly explained treatment options, offering patients a choice in their care. All the patients we spoke to on the day of inspection told us that appointments could be accessed in a timely manner.

## Outstanding practice

We saw several areas of outstanding practice including:

- The practice was engaged in a comprehensive programme of clinical audit which allowed them to clearly demonstrate quality improvement and how this improvement had been achieved. This allowed the practice to have a robust understanding of its performance. Key areas of improvement included a significant reduction in emergency admissions, an increased prevalence of atrial fibrillation and reduction in prescribing of hypnotics. For example the practice could demonstrate how emergency admissions into hospital had been reduced by 95% over an 18 month period, and attendance at other secondary care services reduced by 50%.
- The practice was proactive in identifying clinical risks, and then taking rapid action to address and mitigate these risks. Once identified they were discussed at the next weekly clinical meeting, assigned to a nominated GP lead as well as having administration time identified to support the resulting work undertaken to make improvements.
- Staff had received carer awareness training to give them the skills to screen and identify those patients with caring responsibility.

# Parkgate Surgery

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

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

## Background to Parkgate Surgery

Parkgate Surgery is situated on a main road close to the town centre of the semirural town of Ormskirk. The practice occupies a converted Victorian building and has a patient list size of 6313. The practice is part of the NHS West Lancashire Clinical Commissioning Group (CCG) and services are delivered to patients under a General Medical Services (GMS) contract with NHS England.

The average life expectancy of the practice population is above local averages for both males and females, with males on average living to 80 years and females to 83 years (CCG average being 79 and 82 respectively, national averages being 79 and 83 years). The practice's patient population consists of a higher proportion of older people, with 27% being over the age of 65 (CCG average 20.4%, national average 17.1%), 12.9% being over the age of 75 (CCG average 8.9%, national average 7.8%) and 3.7% being over the age of 85 (CCG and national averages both 2.3%). The practice also caters for a higher proportion of patients with a long-standing health condition at 64%, compared to the CCG average of 55.5% and national average of 54%.

Information published by Public Health England rates the level of deprivation within the practice population group as nine on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice is staffed by three GP partners (two female and one male). The GPs are supported by two practice nurses (both female). The clinical staff are supported by a practice manager, assistant practice manager and nine administration and reception staff.

The practice is open Monday to Friday between the hours of 8am and 6:30pm. Appointments are offered from 8:30am until 11:30am in the morning, and between 2pm and 6pm in the afternoon (with some slight variation in these times depending on the day of the week). Outside normal surgery hours, patients are advised to contact the out of hours service, offered locally by the provider OWLS CIC Ltd.

## Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 11 February 2016. During our visit we:

# Detailed findings

- Spoke with a range of staff including the GPs, practice nurse, practice manager, reception and administration staff and spoke with patients who used the service.
- Observed how staff interacted with patients and talked with carers and family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

# Are services safe?

## Our findings

### Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system.
- The practice carried out a thorough analysis of the significant events. Events were discussed and analysed immediately at the next weekly practice meeting attended by the GP partners and practice manager meeting. Learning and changes to practice were implemented and fed back to all staff at the quarterly staff meetings. Significant events and resulting changes to systems and processes were revisited and reviewed annually at the significant event analysis meeting in order to ensure that changes put in place were effective at preventing a repeat of the incident.

We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. We saw that significant events were a standing agenda item at practice staff meetings, and staff were able to discuss in detail with us the outcomes of recent incidents that had been investigated. For example, the practice had quickly identified a prescribing error that occurred on a home visit; it had not been safe due to the patient's previous medical history. We saw how the practice responded swiftly to rectify the situation, and put in place a change in practice processes whereby GPs would no longer issue hand written prescriptions during home visits, but instead would issue the prescription electronically to the pharmacy upon returning to the practice. This ensured GPs had full access to the patient's records, and any 'flags' highlighting issues the GP needed to be aware of prior to the prescription being completed.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

The GPs told us that they were not content that significant event analysis alone was sensitive enough as a process for maximising patient safety. The practice had begun to shift towards implementing the NHS's National Reporting and Learning System for patient safety and serious incident classifications. Incidents and near misses of varying seriousness were logged and categorised into themes. Through monitoring these themes the practice hoped to become more proactive in predicting potential risks and therefore be able to implement changes to practice to prevent significant events from occurring, without the need for an incident to have taken place to trigger the change initially.

### Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse 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 member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs were trained to Safeguarding level 3. Staff were able to discuss with us in detail examples where concerns about patient's welfare and safety had been appropriately referred on to relevant agencies, and how the practice had hosted a number of multidisciplinary meetings to discuss the cases and ensure appropriate care and support was put in place for the patients.
- Notices in the waiting room and consultation rooms advised patients that chaperones were available if required. The practice's chaperone policy stipulated that only other GPs or nursing staff would be asked to act as chaperones. This was confirmed through discussion with staff during the inspection.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. One of the practice nurses was the infection control clinical lead and was aware of how to liaise with the local infection prevention teams to keep



## Are services safe?

up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and although staff were able to discuss with us the action that was taken to address any improvements identified as a result, we did not see that these action plans were documented.

- The arrangements for managing medicines, including emergency drugs and vaccinations, kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation, and we saw that there was a system in place to monitor their use and ensure they were in date.
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (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).
- There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

### Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were thorough procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The practice had up to date fire risk assessments and carried out regular fire drills and alarm tests. All electrical equipment was checked to ensure the equipment was

safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, use of display screen equipment (computer monitors) and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for the different staffing groups and staff annual leave was planned to ensure that enough staff were on duty. Staff reported a good skill mix and a willingness to work flexibly should the need arise to cover unexpected staff absence, for example through illness.

### Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the old dispensary room on the ground floor.
- The practice had a defibrillator available on the premises as well as oxygen. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.
- 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 and local suppliers and contractors, as well as detailing appropriate temporary accommodation that had been identified for use should the practice premises become inaccessible.





# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs. New guidelines were discussed and disseminated as part of the weekly practice meeting attended by all GPs and the practice nurses. The GPs talked us through a specific example where updated practice protocols had been produced around menopause management following the publication of new NICE guidance. A nominated GP took responsibility for producing a summary of the updated guidance and identified areas where changes to practice procedures were required. This was then disseminated not only to the other clinical staff but also the admin team in order to ensure required changes were implemented effectively.
- The practice monitored that these guidelines were followed through risk assessments, comprehensive audits and case discussions.

### Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results saw the practice achieve 97.9% of the total number of points available, with an average of 7.7% exception reporting across clinical domains (exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This practice was not an outlier for any QOF clinical targets, although it was an outlier for one prescribing indicator. Data from 2014/15 showed;

- Performance for diabetes related indicators was either in line with or above the national average. For example, the percentage of patients with diabetes on the register in whom the last IFCC-HbA1c was 64mmol/mol or less in the preceding 12 months was 79.86%, compared to the national average of 77.54%. The percentage of patients on the diabetes register with a record of foot examination and risk classification within the preceding 12 months was 94.66%, compared to the national average of 88.3%. The percentage of patients with diabetes on the register who had an influenza immunisation in the preceding 1 September to 31 March was 96% compared to the national average of 94.45%.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding nine months was 150/90mmHg or less was 82.65% compared to the national average of 83.65%.
- Performance for mental health related indicators was consistently higher than the national average. For example the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record in the preceding 12 months was 90.32% compared to the national average of 88.47%. The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 89.04% compared to the national average of 84.01% and the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months was 94.12% compared to the national average of 89.55%.
- The percentage of patients with asthma, on the register, who had an asthma review in the preceding 12 months that included an assessment of asthma control using the three RCP questions was 79.44%, compared to the national average of 75.35%.
- The practice had been identified as an outlier for its average daily quantity of hypnotics prescribed per specific therapeutic age – sex related prescribing unit (STAR PU; hypnotic medicines prescribed to help patients sleep) between 1/7/2014 and 30/6/2015 (with a value of 0.65 compared to the national average of 0.26). The practice were aware of this, and had already put measures in place to bring their performance in line with the national average; for example ensuring that



# Are services effective?

## (for example, treatment is effective)

patients were prescribed hypnotics for a maximum of 30 days at a time in line with current department of health guidance. Through a process of completed audits around the prescribing trends for hypnotics the practice could demonstrate that the STAR PU value had reduced to 0.59. Work was ongoing to reduce this further.

Clinical audits were fully embedded into practice processes and were consistently used to clearly demonstrate quality improvement.

- There had been 30 clinical audits completed over the previous year. We reviewed seven of these audits in detail that were all completed audit cycles where changes were implemented and improvements monitored via at least one reaudit.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, recent action taken as a result of the six full cycle medicine audits completed by the practice resulted in changes to prescribing patterns which meant the practice achieved the largest underspend in the CCG footprint during the previous year, with a £60,000 underspend compared to its prescribing budget.
- The practice carried out proactive work around admissions avoidance, and had developed a practice specific folder in which to give patients on the admissions avoidance register their hand held care plans which included summaries of health problems, medication and allergies as well as advanced care planning relating to chronic disease management and emergency care decisions. The practice employed an administrative care coordinator who liaised with the lead GP for admissions avoidance and ensured contact was made with patients within three days of receipt of hospital in patient discharge notification to ensure that all care required was put into place. The lead GP for admissions avoidance had a dedicated session each week to allow time for care plans to be reviewed with patients on the register. The practice had collated figures through an audit that demonstrated as a result of this work, admissions to hospital had been reduced by 95% in the period January to March 2015, when compared to the same months the previous year. The

figures also demonstrated that when the two time periods were compared, presentations to other secondary care services by this group of patients had also reduced by 50%.

Information about patients' outcomes was used to make improvements such as an increase in diagnosis rate of patients with atrial fibrillation (AF) (a heart condition that causes irregular and often abnormally fast heart rate). The practice recognised that the West Lancashire CCG area had historically been identified as having low rates of atrial fibrillation rates. The GPs told us that once an area of clinical risk such as this was identified by the practice, the risk area was assigned a clinician who took management lead for that area and audit activity was undertaken in order to address the risk. Audit activity was undertaken around atrial fibrillation diagnosis and use of anticoagulants (medicines that help prevent blood clots) as part of the management of this condition over 18 months between September 2014 and January 2016. Changes to practice included the GRASP AF Toolkit (an audit tool that allows patient data to be captured and summarised) being run quarterly in order to identify those patients exhibiting risk factors for AF. The clinical records of these patients were then reviewed and patients called in to see the GP in order to identify cases. In addition, the practice undertook opportunistic screening for AF as part of their flu vaccination weekend sessions. In recognition of this clinical risk area, the practice had ensured that all clinical staff had received atrial fibrillation update training in order to improve knowledge and awareness of anticoagulation options. This work resulted in the practice's prevalence of AF increasing from 137 patients in September 2014 to 193 in January 2016. Over the same time period the number of patients on anticoagulants increased from 60 to 109.

### Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. It covered such topics as infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff for example, for those reviewing patients with long-term conditions. Staff administering vaccinations and taking samples for the cervical screening programme had



# Are services effective?

## (for example, treatment is effective)

received specific training which had included an assessment of competence. Staff who administered vaccinations could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.

- The learning needs of staff were identified through a system of appraisals, meetings and comprehensive reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had had an appraisal within the last 12 months with appropriate areas for training and development identified.
- Staff received training that included: safeguarding, fire procedures, basic life support, equality and diversity awareness and information governance awareness. Reception staff had also received customer care training. Staff had access to and made use of e-learning training modules and in-house training.

### Coordinating patient care and information sharing

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 investigation and test results. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team (MDT) meetings took place on a weekly basis, with further scheduled palliative care MDT meetings each month, and that care plans were routinely reviewed and updated. We were given specific examples of

how the multi-disciplinary team worked together to support patients who were placing high demand on services through repeated visits to accident and emergency and repeated home visit requests. The MDT worked together to formulate personalised care plans which resulted in patients contacting the community matron and community nursing team rather than visiting hospital.

### Consent to care and treatment

Staff sought patients' consent to care and treatment 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. We saw that the practice had a mental capacity act policy in place.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment. The GPs were able to discuss specific examples where patient's capacity had been assessed appropriately and treatment delivered accordingly.
- The practice maintained a register of patients where deprivation of liberty safeguards (DoLS) were in place.

### Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those at risk of admission to hospital. Patients were then signposted to the relevant service. Smoking cessation and dietary advice were offered by the practice nurses, and a dietician ran a monthly clinic at the practice. Patients were also referred on to the exercise on prescription service offered at both the local university gym and local swimming pool.

The practice's uptake for the cervical screening programme was 82.53%, which was in line with the national average of 81.83%. The practice had carried out audit activity to address repeated failures to attend for cervical smear appointments. Following targeted interventions such as follow up phone calls the practice was able to demonstrate



## Are services effective? (for example, treatment is effective)

a 12% increased uptake in smear appointments amongst this patient cohort. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Data from the National Cancer Intelligence Network published in march 2015 placed the practice above CCG averages. For example 78.4% of females aged between 50 and 70 had been screened for breast cancer in the previous three months, compared to the CCG average of 69.6%. The percentage of patients aged between 60 and 69 who had been screened for bowel cancer in the last 30 months was 64.1%, compared to the CCG average of 57.1%.

Childhood immunisation rates for the vaccinations given were either above or in line with CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 93.3% to 100% and five year olds from 85.7% to 97.6%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients, NHS health checks for people aged 40–74 as well as well-person health checks for those over 75 years of age. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

# Are services caring?

## Our findings

### Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. Notices were displayed in the patient waiting area advertising this fact.

All of the 34 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Many of the comments mentioned staff members by name to praise the service offered and to thank them for their support. As well as making positive comments about the practice, three cards also expressed some concern regarding the amount of time it could take to get an appointment with the GP of their choosing.

We spoke with four patients, one of whom was also a member of the patient participation group. 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 they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was mostly above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 91.7% said the GP was good at listening to them compared to the CCG average of 89.4% and national average of 88.6%.

- 85.9% said the GP gave them enough time (CCG average 87.9%, national average 86.6%).
- 95.7% said they had confidence and trust in the last GP they saw (CCG average 94.2%, national average 95.2%).
- 85.9% said the last GP they spoke to was good at treating them with care and concern (CCG average 83%, national average 85.3%).
- 94.15% said the last nurse they spoke to was good at treating them with care and concern (CCG average 78%, national average 90.58%).
- 89.9% said they found the receptionists at the practice helpful (CCG average 85.8%, national average 86.8%).

Staff were able to describe numerous situations where colleagues had acted beyond the remit of their role in order to ensure patients were treated with kindness and respect. Examples included working beyond contracted hours to ensure patients were not turned away, taking prescriptions out to patients waiting in their cars to avoid them needing to come into the practice building if they had mobility issues as well as delivering prescriptions by hand to patient's homes en route to or from the practice to ensure patients with mobility difficulties did not have to make more trips than necessary. Patients told us that they felt the practice staff prioritised their care and wellbeing.

We received feedback from other professionals such as the palliative care nurse and district nurse that was extremely positive and complimentary about the caring service offered by the practice.

The practice's Friends and Family Test results for the previous month indicated that 100% of patients who responded (34 respondents) would be likely or extremely likely to recommend the practice to their friends and family members. The practice told us that the lowest score achieved on the Friends and Family Test had been 93%.

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

Patients told us they felt involved in decision making about the care and treatment they received. A number of patients who had recently been diagnosed with a long term condition told us how treatment options were explained in detail by the clinician and that they as patients were involved in the decisions made. Where referrals to hospital were required, patients told us they were offered a choice

## Are services caring?

of where they would prefer to attend. 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.

The practice had developed a branded folder in which to give patients their copy of their care plan documentation. This made it easily identifiable and increased the patient's ownership of their care. It ensured the information around their care was accessible to themselves and to other professionals. These folders were used for patients identified on the practice's admissions avoidance register (108 patients), and we were told the practice was in the process of introducing their use for those with learning disabilities, mental health problems and dementia.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were mostly above national and local averages. For example:

- 90.2% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87.4% and national average of 86%.
- 93.4% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 91.2% and national average of 89.6%.
- 80.77% said the last GP they saw was good or very good at involving them in decisions about their care (CCG average 76%, national average 81.61%).

- 84.65% said the last nurse they saw was good or very good at involving them in decisions about their care (CCG average 66%, national average 85.09%).

Staff told us that translation services were available for patients who did not have English as a first language.

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

Notices in the waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 131 patients as carers (2.1% of the patient list). All carers were offered an annual review appointment with the practice nurse to ensure their needs were being met. Written information was available to direct carers to the various avenues of support available to them; there was a dedicated carers notice board in the waiting area. The practice had also invited staff from a local carers association to deliver a training session for practice reception staff so as to raise their awareness of the issues faced by carers and give them the skills to screen patients and identify those with caring responsibility.

Staff told us that where the practice was made aware of a bereavement, the GPs would, where appropriate, contact the family or carer to provide support and to signpost them to any relevant services.



# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice demonstrated it was highly aware of its higher than average proportion of older patients and had tailored the services offered to cater for their needs.

- The practice had ensured that members of the reception and administration team had attended a training course to raise awareness of how best to register migrants with the practice, in response to an anticipated influx of this population group into the area in the near future.
- There were longer appointments available for patients with a learning disability and those with other complex needs.
- Home visits were available for older patients and patients who would benefit from these.
- In recognition of the above average proportion of older patients on the list, the practice had taken on additional nursing capacity (three sessions per week) specifically to facilitate home visits and visits to residential care homes to carry out annual reviews, chronic disease management checks and other health checks. The nurse had a weekly home visit session set aside for elderly, housebound and frail patients. One of the GPs took the lead in overseeing this work, and an audit carried out in September 2015 identified that over the year since the nurse had begun offering this service, emergency hospital admissions from patients residing in nursing homes had reduced 33% (from 27 admissions in 2013/14 to 18 in 2014/15).
- Same day appointments were available for children and those with serious medical conditions.
- Patients could access a range of services online, such as ordering repeat prescriptions. Telephone consultations were also offered for those needing medical advice who could not make it into the surgery.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities, a hearing loop and translation services available.

- All patient services were offered on the ground floor of the premises, so access for those patients with mobility difficulties was accommodated.
- The practice offered an in house electrocardiogram (ECG; a test to check the rhythm and electrical activity of the heart) service via a telemedicine provider. The test was carried out on site at the practice, with the results being sent electronically. Patients received immediate feedback on their results from a consultant cardiologist. This facilitated timely diagnosis and swift initiation of treatment to manage a patient's condition.
- The practice also offered an in house 24 hour ambulatory blood pressure monitoring service, which meant patients did not need to wait between six and eight weeks for this to be done had a referral onto secondary care been necessary. The practice offered this service through an appointment with the practice nurse, with results being analysed by a GP within 24 hours of the test being completed.
- Review appointments for patients suffering multiple long term conditions were combined into a single, holistic review. This resulted in less visits to the practice for patients on numerous disease registers.

There was an active 'virtual' patient participation group (PPG), which the practice frequently engaged with via electronic communication such as email. We spoke with a member of the PPG who told us how the practice actively sought patient feedback and took on board patient views and suggestions through the circulation of survey forms and questionnaires. We were told of specific examples of how the practice had listened to feedback from patients about difficulties with telephone access. As a result the practice had modified the system used in October 2015 in order to facilitate patients' ease of access to the surgery by telephone. Once the new phone system had been installed, the practice sought updated patient feedback on the new system via a survey to ensure they were satisfied with the results. The practice had also asked patients what they would wish to see included in the practice newsletter, which was published on the practice website as well as being available in the practice waiting room.

### Access to the service

The practice was open Monday to Friday between the hours of 8am and 6:30pm. Appointments were offered from 8:30am until 11:30am in the morning, and between 2pm and 6pm in the afternoon (with some slight variation in

# Are services responsive to people's needs?

## (for example, to feedback?)

these times depending on the day of the week). In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. On the day of inspection, same day urgent appointments remained available. The next available routine pre-bookable appointment was in seven day's time.

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

- 77.8% of patients were satisfied with the practice's opening hours compared to the CCG average of 72% and national average of 78.3%.
- 85.31% patients said they could get through easily to the surgery by phone (CCG average 69%, national average 73.26%).
- 38.23% patients said they always or almost always see or speak to the GP they prefer (CCG average 42%, national average 36.17%).

People told us on the day of the inspection that they were able to get appointments when they needed them and had no difficulties seeing their preferred GP.

### Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- The complaints policy and procedures were mostly in line with recognised guidance and contractual

obligations for GPs in England, although we did note that written responses to complaints received did not signpost patients to the Parliamentary Health Service Ombudsman should they be dissatisfied with the outcome of their complaint. However, this information was available in the practice's complaints leaflet available on the practice website.

- The practice manager was the designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. A complaints leaflet was available at reception and from the practice website, and a complaints poster was displayed in the waiting room.

We looked at seven complaints received in the last 12 months and found these were dealt with in a timely way, with evidence of openness and transparency in the manner in which they were handled. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. For example, on realising that a trend of complaints had formed around how reception staff handled situations with patients, we saw evidence that this was addressed at staff meetings and that customer care training had been arranged for staff. We also saw that complaint trends were monitored and complaint outcomes reviewed at an annual complaint meeting to ensure that actions taken as a result had proven successful in preventing a repeat.



# 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 vision to deliver high quality care and promote good outcomes for patients.

- The practice had a clear statement of purpose which was displayed in numerous areas around the practice building and staff knew and understood the values it contained and were able to articulate them.
- The practice had a robust strategy and supporting five year business plan document which reflected the vision and values and were regularly monitored and updated as appropriate.
- The practice was aware of the limitations placed on it by the premises it currently occupied and was proactively exploring avenues for expansion and improvement of the premises. We saw that a premises improvement action plan had been produced and that the practice was working through the action points.
- The vision was supported through frequent meetings that facilitated good communication channels. The practice held weekly meetings that were attended by GPs, practice nurses and the practice manager. In addition, monthly non clinical team meetings were held, with a GP attending when required. A rolling programme of planned topics were discussed at these meetings. Community healthcare professionals were invited to a weekly open multidisciplinary team meeting each Friday.
- Feedback from staff, patients and the meeting minutes we reviewed showed regular engagement took place to ensure all parties knew and understood the vision and values.

### Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and excellent quality of care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities and how they contributed to the practice's vision of delivering patient centred care.

- GPs had lead clinical responsibilities and also for other areas such as clinical governance lead and Caldicott Guardian (the Caldicott Guardian is the lead person responsible for protecting the confidentiality of patient information and enabling appropriate information sharing).
- Practice specific policies were implemented and were available to all staff. These policies were managed and updated regularly and appropriately to reflect the needs of the practice.
- A comprehensive understanding of the performance of the practice was maintained and management proactively identified areas where improvements were needed and formulated action plans to address these.
- A thorough programme of continuous clinical and internal audit which was used to monitor quality and to make significant improvements which were measurable against patient outcomes.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. Once identified, clinical risks were assigned to a nominated GP partner who would take the lead in their management, and administrative time was ringfenced to support audit activity so that changes to processes and resulting changes to patient outcomes could be effectively measured and monitored.
- The practice engaged with the Clinical Commissioning Group (CCG) and attended meetings to contribute to wider service developments. One GP partner was a CCG executive and governing body member.

### Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care and recognised the need for strong leadership to ensure the practice's priorities were realised. The partners were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents

# Are services well-led?

Outstanding



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

When there were unexpected or unintended safety incidents:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- They kept written records of verbal interactions as well as written correspondence.

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

- Staff told us the practice held regular team meetings and we saw agendas and minutes of these meetings to confirm this.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so and felt supported if they did.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. 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.

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

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active 'virtual' PPG consisting of 92 patients, which the practice regularly consulted regarding updates to patient services. The PPG members completed patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG members had highlighted concerns regarding patients' ability to contact the surgery by telephone; in response to this the practice had updated the telephone system in October 2015 in order to streamline patients' access. PPG members reported this had resulted in noticeable improvements and confirmed that the practice had sought further feedback from them once the new system was implemented in order to gauge its success.

- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run. We were given numerous examples by staff of how the practice had altered procedures in response to staff feedback. For example, staff feedback led to a phased release of pre-bookable appointments in order to improve patient access. In addition, feedback from staff had resulted in a change in process whereby there was a shared responsibility between two or three staff for particular tasks, rather than just one staff member alone. Staff told us how this had improved workforce capability to cope with both planned and unplanned absences. We also saw evidence in meeting minutes that staff had been consulted and invited to contribute to the practice's five year business plan.

## Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example the practice had been a pilot site for electronic prescribing and had been invited to pilot a new initiative around electronic pathology tests. The practice was aware of impending pressures due to proposed extended patient access (seven day opening) and associated workforce resilience. In light of this the practice was taking the lead in the CCG area in setting up a locality-wide bank of locum GPs to support local practices.

All GPs in the practice received five days paid study leave entitlement per year. When any courses were attended, the GP disseminated learning to colleagues during the weekly clinical meetings. All GPs attend the monthly CCG protected learning time meetings, and the nurses are encouraged to attend the practice nurse forum meetings.

The practice manager was one of two practice manager leads on the West Lancashire CCG executive board, and also sat on the West Lancashire CCG patient experience group in an effort to drive improvements in patient experience across the wider geographic area.

# Are services well-led?

Outstanding



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

One of the GP partners was also one of six clinical leads on the West Lancashire CCG executive as well as being a member of the West Lancashire CCG governing body.

The practice was championing the use of increased technology following the success of telemedicine in the

practice around ECGs. We were told of a vision to implement similar technology around diagnosis of dermatological conditions. The practice were also due to pilot the use of portable devices that could be taken on home visits allowing access to full patient records.