

Kingsway 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

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



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 Kingsway Surgery on 7 October 2016. Overall the practice is rated as good but requires improvement for providing safe services.

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

- The practice was in a converted residential property and the provider was aware of the limitations of the premises. Although clinical areas were reasonably acceptable, work could be done to improve the premises in terms of basic décor and decluttering of the premises to make the environment safer.
- There were some systems in place to mitigate safety risks including analysing significant events and safeguarding. The practice had a defibrillator for treatment of some medical emergencies but no oxygen. This was purchased after our inspection.
- The practice was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

- Patients' needs were assessed and care was planned and delivered in line with current legislation.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. The practice sought patient views about improvements that could be made to the service; including having a patient participation group (PPG) and acted, where possible, on feedback.
- Staff worked well together as a team and all felt supported to carry out their roles.

There were examples of outstanding practice. These included:

- The practice manager had audited the attendances of patients experiencing poor mental health and with learning disabilities. As the practice did not have the benefit of external agencies regularly attending, the practice and the patient participation group set up an informal group to support patients.
- The practice recognised preferences of elderly patients, not wanting to attend later in the day,

Summary of findings

especially in the winter months when it is darker. The practice had spread the appointments across the day making appointments accessible in the early afternoons.

- The practice manager had met with all staff to discuss their career progression in the form of a five year strategic plan.

However, the provider should:

- Address the backlog of letters from other clinics to be scanned on to patient records and ensure there is one system in place that all staff work from.
- Increase the monitoring of the cleanliness and safety of the premises and remove excess clutter from non-patient areas within the building to reduce fire hazards and promote a better working environment for staff.

- Monitor complaints in order to ensure patients are given a timely response, and where there are foreseeable delays, issue a holding letter to the patient to explain the reason for the delay.
- Carry out performance appraisals for the healthcare assistant even though they receive these from their other employer.
- Have an overview of all training completed by clinicians to ensure everyone is up to date with their mandatory training.
- Periodically review all complaints and significant events with the staff team to identify any trends.
- Monitor the storage of blank prescription pads used for home visits.
- Consider holding regular staff meetings for the whole team.

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 took the opportunity to learn from internal incidents and safety alerts, to support improvement. There were other systems, processes and practices in place that were essential to keep patients safe including medicines management and safeguarding.

However, the monitoring of the cleanliness and safety of the premises needed to be improved as we found for example, non-clinical areas were cluttered with paper waste which was a potential fire hazard. There were no stock records for blank prescriptions used for home visits. The practice had a defibrillator for treatment of some medical emergencies but no oxygen. This was purchased after our inspection.

Good



Are services effective?

The practice is rated as good for providing effective services. Patients' needs were assessed and care was planned and delivered in line with current legislation. Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were comparable to the national average. Clinical audits demonstrated quality improvement. Staff worked with other health care teams. However, there was a backlog of letters to be scanned on to patients' record. Staff received training suitable for their role, but the practice did not have an overview of training received by clinicians or carry out any performance appraisals for the health care assistant.

Good



Are services caring?

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

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. Information about how to complain was available and easy to understand. Learning from clinical complaints was shared with staff. However, there was no system in place to check complaints had been responded to in a timely fashion and within the time frame outlined in the practice complaints policy.

Good



Summary of findings

Are services well-led?

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. The practice proactively sought feedback from staff and patients and had an active PPG. Staff had received inductions and attended staff meetings where possible and events. The practice manager had met with all staff to discuss their career progression in the form of a five year strategic plan.

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

The practice is rated as good for providing services for older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and offered home visits and care home visits. The practice recognised the needs of the elderly not wanting to attend later in the day, especially in the winter months when it is darker. The practice had spread the appointments across the day making appointments accessible in the early afternoons.

The practice participated in meetings with other healthcare professionals to discuss any concerns. There was a named GP for the over 75s and the practice participated in a local 'frailty' scheme to ensure patients received a full assessment of their health and social needs.

Good



People with long term conditions

The practice is rated as good for providing services for people with long term conditions. The practice had registers in place for several long term conditions including diabetes and asthma. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good for providing services for families, children and young people. The practice regularly liaised with health visitors to review vulnerable children and new mothers. 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.

Good



Working age people (including those recently retired and students)

The practice is as rated good for providing services for working age people. The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible. There were online systems available to allow patients to make appointments and the practice offered appointments from 8am on some days and had extended hours opening on Thursday evening until 7.30pm.

Good



Summary of findings

People whose circumstances may make them vulnerable

The practice is rated as good for providing services for people whose circumstances make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks and longer appointments were available for people with a learning disability.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for providing services for people experiencing poor mental health. Patients experiencing poor mental health received an invitation for an annual physical health check. Those that did not attend had alerts placed on their records so they could be reviewed opportunistically. The practice manager had audited the attendances of patients experiencing poor mental health. As the practice did not have the benefit of external agencies regularly attending, the practice and the patient participation group set up an informal support group to encourage patients to attend. One of the GP partners was a dementia care home lead GP.

Good



Summary of findings

What people who use the service say

The national GP patient survey results published in July 2016 (from 116 responses which is approximately equivalent to 2% of the patient list) showed the practice was performing in line with local and national averages in certain aspects of service delivery. For example,

- 68% of respondents described their experience of making an appointment as good (CCG average 69%, national average 73%)
- 62% patients said they could get through easily to the surgery by phone (CCG average 67%, national average 73%).
- 94% said the last GP they spoke to was good at treating them with care and concern (CCG average 85%, national average 85%).

In terms of overall experience, results were higher compared with local averages. For example,

- 91% described the overall experience of their GP surgery as good (CCG average 81%, national average 85%).

- 76% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 71%, national average 78%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 89 comment cards, of which 88 were very complimentary about the service provided. Patients said they received an excellent, caring service and patients who more vulnerable were supported in their treatment. There were however, an additional nine comments about difficulties in making appointments and two expressed dissatisfaction about communications with staff.

We reviewed information from the NHS Friends and Family Test which is a survey that asks patients how likely they are to recommend the practice. Results for January to October 2016 from 72 responses showed that, 71 patients were either extremely likely or likely to recommend the practice and one response said they were unsure.

Kingsway Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector and included a GP specialist advisor and observed by the CQC's Primary Medical Services Deputy Chief Inspector for the North.

Background to Kingsway Surgery

Kingsway Surgery is based in a residential area of Crosby. There were 4904 patients on the practice register at the time of our inspection.

The practice is managed by two GP partners (one male, one female) and one salaried GP. There are two practice nurses and one healthcare assistant. The practice was in the process of recruiting another nurse. Members of clinical staff are supported by a practice manager, reception and administration staff.

The practice is open 8am to 6.30pm every weekday with the exception of Thursdays when the practice is open until 7.30pm. The practice is closed one Wednesday afternoon per month for staff training. Patients requiring a GP outside of normal working hours are advised to contact the practice where their call is diverted to the out of hours provider, Go to doc.

The practice has a General Medical Services (GMS) contract and has enhanced services contracts which include childhood vaccinations.

Why we carried out this inspection

We inspected this service as part of our 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

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)

Detailed findings

- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

The inspector :-

- Reviewed information available to us from other organisations e.g. the local clinical commissioning group (CCG).
- Reviewed information from CQC intelligent monitoring systems.

- Carried out an announced inspection visit on 7 October 2016.
- Spoke to staff.
- Reviewed patient survey information.
- Reviewed the practice's policies and procedures.

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

There was an effective system in place for reporting and recording significant events and incidents. 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. Significant events were discussed at clinical meetings. Further improvement could be made by: - lowering the threshold of what constitutes an incident; discussing these with all the staff team to improve shared learning; reviewing all incidents periodically to identify any trends and evaluate any actions taken.

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

Overview of safety systems and processes

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead GP for safeguarding vulnerable adults and children. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. The practice had a Health Visitor who attended the practice on a weekly basis and the practice was able to discuss any concerns.
- A notice in the waiting room advised patients that chaperones were available if required. Only clinical staff acted as chaperones and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice was in a converted residential property and the provider was aware of the limitations of the premises. However, although clinical areas were reasonably acceptable, much could be done to improve the premises in terms of basic décor and decluttering of the premises to make the work place safer. The health care assistant was the infection control clinical lead.

There was an infection control protocol and staff had received up to date training. As a result of an external infection control audit, some improvements had been made in the cleaning of the premises. However, there was still some work to be completed such as the installation of new taps and suitable flooring for some rooms. Cleaning schedules were in place but the practice was not scheduled for a deep clean of some of the rooms until January 2017. Monitoring and auditing by the practice needed to be improved as some of the mop heads were dirty and the external audit had identified that these should be changed once a week. There were spillage kits and appropriate clinical waste disposal arrangements in place. However, during the inspection, we found a full sharps box on the floor of a store room which could have potentially been hazardous for staff entering the room.

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice 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. Emergency medication was checked for expiry dates. Blank prescription pads were securely stored and there were systems in place to monitor the stock and use of the blank prescription forms for printers but not for prescription pads for home visits.
- 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 DBS.

Monitoring risks to patients

- There were some procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety notice available which identified local health and safety representatives. This was found on the floor in the staff area during the inspection. There was a health and safety policy available, but this wasn't practice specific.
- The practice had a fire risk assessment in 2014 that identified an electrical fixed wiring safety test for the

Are services safe?

building was required. The safety test had been carried out prior to our inspection and the practice was awaiting the safety certificate. The practice did carry out regular fire safety equipment tests and fire drills, but not all staff had participated in these. Staff were aware of what to do in the event of fire and had received fire safety training as part of their induction. However, non-clinic areas were cluttered with boxes and paper items which was a fire hazard, especially in areas where there was a lot of electrical equipment.

- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health (COSHH). The practice had recently had a legionella risk assessment done but documentation outlining any actions required had not yet been received by the practice. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

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

- All staff received annual basic life support training and there were emergency medicines available.
- The practice had a defibrillator but no oxygen. We were told that the practice did have oxygen up until three years ago. The practice had looked at whether oxygen was required and advised us the oxygen had only been used once in ten years and it was removed. Although medical emergencies in general practice are relatively rare, without oxygen on the premises, it would be difficult for the practice to respond to an emergency especially if there was a delay in the paramedics responding. Current resuscitation guidelines emphasises the use of oxygen, and this should be available whenever possible. The practice purchased oxygen after our inspection.
- There were first aid kits and an accident book available.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice 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.

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

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 practice had good systems in place to ensure they met targets. Results from 2014–2015 were 98% of the total number of points available.

Performance for mental health related indicators was comparable or better than local and national averages for example:

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2014 to 31/03/2015) was 100% compared to local average of 88% and national averages of 88%.

Performance for diabetes related indicators was comparable or better than local and national averages for example:

- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading

(measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2014 to 31/03/2015) was 84% compared with a local average of 80% and national average of 78%.

The practice carried out a variety of audits that demonstrated quality improvement. For example, medication audits and clinical audits. Audit work we reviewed included appointment audits, cancer audits and child attendance at A&E audits.

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 learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. Training included: safeguarding, fire safety awareness, equality and diversity, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules. Staff told us they were supported in their careers and had opportunities to develop their learning. There was however no practice overview of what training clinicians had received.
- Staff received annual appraisals with the exception of the health care assistant who was employed part time elsewhere and received appraisals from their other employer.

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.
- 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

Are services effective?

(for example, treatment is effective)

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 meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

However, we identified there was an issue with regards to how letters from hospitals were received by GPs as there seemed to be more than one system being used in addition to having duplicate information received electronically and by post. We found a back log of letters to be scanned onto patient records; and one member of staff when asked could not tell us how they knew whether the letters had been seen by the GP. There was therefore a potential risk that important information about a patient may be missed. We discussed this with the practice. They were aware of the issue and told us due to staff holidays this had been a problem but that it would be addressed.

Consent to care and treatment

Patients' consent to care and treatment was sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act

2005. The practice was aware of patients who had a Deprivation of Liberty Safeguard (DoLS) in place. GPs were aware of the relevant guidance when providing care and treatment for children and young people.

Supporting patients to live healthier lives

Patients who may be in need of extra support were identified by the practice. This included patients who required advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service. In addition the practice had run a clinic with a GP and the health care assistant to specifically help patients tackle obesity.

The practice carried out vaccinations and cancer screening and performance rates were comparable with local and/or national averages for example, results from 2014-2015 showed:

- Childhood immunisation rates for the vaccinations given to two year olds and under ranged from 74% to 93 % compared with CCG averages of 83% to 97%. Vaccination rates for five year olds ranged from 83% to 94% compared with local CCG averages of 90% to 97%.
- The percentage of women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding 5 years was 74% compared to a national average of 82%.

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.

Results from the national GP patient survey published in July 2016 (from 116 responses which is approximately equivalent to 2% of the patient list) showed patients felt they were treated with compassion, dignity and respect. For example:

- 96% said the GP was good at listening to them compared to the CCG average of 87% and national average of 89%.
- 93% said the GP gave them enough time (CCG average 86%, national average 87%).
- 94% said the last GP they spoke to was good at treating them with care and concern (CCG average 85%, national average 85%).
- 91% said the last nurse they spoke to was good at treating them with care and concern (CCG average 92%, national average 91%).
- 89% said they found the receptionists at the practice helpful (CCG average 67%, national average 87%)

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. 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 comparable or above local and national averages. For example:

- 91% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 86%.
- 87% said the last nurse they saw was good at involving them in decisions about their care (CCG average 87%, national average 85%)
- 90% said the last GP they saw was good at involving them in decisions about their care (CCG average 80%, national average 82%)

Staff told us that telephone translation services were available.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient 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 a register of 61 carers on its list. Information was available in the waiting room to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them and patients were signposted to local counselling services available.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

- There were longer appointments available for people with a learning disability or when interpreters were required.
- Home visits were available for elderly patients.
- Urgent access appointments were available for children and those with serious medical conditions.
- The practice was aware of the Accessible Information Standard and there was large print and easy read formatted information available.

There were examples of outstanding practice in terms of responding to patients' needs, including:-

- The practice manager had audited the attendances of patients experiencing poor mental health. As the practice did not have the benefit of external agencies regularly attending, the practice and the patient participation group set up an informal support group (Kingsway Support Group) to encourage patients to attend. The practice had identified that 25 patients required reviews and on their first support group meeting had managed to liaise with five patients. Further support meetings had been arranged to encourage patients to attend and provide any additional support.
- The practice recognised the needs of the elderly not wanting to attend late in the afternoon, especially in the winter months when it is darker. The practice had spread the appointments across the day making appointments accessible in the early afternoons from 2pm.

In addition:-

- The practice nurse and a GP together visited housebound or patients in residential /nursing care to simultaneously carry out flu vaccinations and full medical review. In the week prior to our inspection they had seen over 70 patients. One of the GP partners was a dementia care home lead GP.
- The practice took part in a local initiative to provide a one stop frailty assessment for all patients over 75 years

of age. This consisted of an appointment with the health care assistant to complete a questionnaire to identify any needs. The patients were then seen by the GP at the same visit. The appointments were up to an hour long to ensure both medical and social needs were addressed.

Access to the service

The practice is open 8am to 6.30pm every weekday with the exception of Thursdays when the practice is open until 7.30pm. The practice is closed one Wednesday afternoon per month for staff training. Patients requiring a GP outside of normal working hours are advised to contact the GP practice and they were put through to the out of hours provider, Go to doc. Appointments could be made in person, by phone or online. There was a text messaging reminder service for appointments.

Results from the national GP patient survey published in July 2016 (from 116 responses which is approximately equivalent to 2% of the patient list) showed that patient's satisfaction with how they could access care and treatment were comparable to or lower than local and national averages. For example:

- 72% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 76%.
- 87% of respondents were able to get an appointment to see or speak to someone last time they tried (CCG average 81%, national average 85%).
- 62% patients said they could get through easily to the surgery by phone (CCG average 67%, national average 73%).
- 68% said they usually waited 15 minutes or less after their appointment time to be seen (CCG average 63%, national average 65%).
- 78% of respondents described their experience of making an appointment as good (CCG average 77%, national average 73%)

The practice had responded to the low data with regards to getting through on the telephone by altering the system available. Audits of the appointment system were carried out to identify the busiest times and the practice had responded by altering the clinic times to meet the demand.

Are services responsive to people's needs?

(for example, to feedback?)

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Information about how to make a complaint was available in a practice information leaflet in the waiting room and on the practice

website. The complaints policy clearly outlined a time frame for when the complaint would be acknowledged and responded to and made it clear who the patient should contact if they were unhappy with the outcome of their complaint.

The practice discussed complaints at clinical staff meetings. We reviewed a log of previous complaints and found complaints were recorded and written responses included apologies to the patient and an explanation of events. However, one clinical complaint we reviewed had not been responded to until the patient had enquired further.

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

The primary aim of the practice was to provide quality care and access to all patients. All staff understood the values of the practice. There were regular partners meetings and the practice had business plans in progress.

Governance arrangements

Evidence reviewed demonstrated that the practice had:-

- A clear organisational structure and a staff awareness of their own and others' roles and responsibilities.
- Practice specific policies that all staff could access on the computer system.
- Meetings which were planned and regularly held including: monthly partnership meetings and monthly reception and administration meetings. However, the health care assistant could not attend meetings. Although there were issues with staff availability and time constraints, the practice would benefit from full team meetings, in order to improve team work and shared learning. Other meetings included: palliative care meetings with other healthcare professionals.
- A system of reporting incidents without fear of recrimination and whereby learning from outcomes of analysis of incidents actively took place.
- A system of continuous quality improvement including the use of audits which demonstrated an improvement on patients' welfare.
- Proactively gained patients' feedback and engaged patients in the delivery of the service and responded to any concerns raised by both patients and staff.

Leadership, openness and transparency

Staff felt supported by management. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues with the practice manager or GPs and felt confident in doing so. The practice had a whistleblowing policy and all staff were aware of this.

The practice was aware of and had systems in place to ensure compliance with the requirements of the duty of candour, (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

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

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 when possible.

- There was an established PPG and the practice had acted on feedback. For example, installing a new telephone system.
- The practice used the NHS Friends and Family survey to ascertain how likely patients were to recommend the practice and also had other practice surveys.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

Clinicians kept up to date by attending various courses and events. The practice manager had a lead role for practice managers within the locality. The practice manager had met with all staff to discuss their career progression in the form of a five year strategic plan.

The practice took an active part in South Sefton Crosby Locality Group. For example, the practice took part in the Respiratory Community Project and Nursing Home Initiative.