Marisco Medical Practice

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of the Marisco Medical Practice on 15 October 2014. The inspection team was led by a CQC inspector and included an additional CQC inspector, a GP specialist advisor and a practice manager.

The practice has a branch surgery located in Sutton-on-Sea which was not visited during the course of this inspection.

Our key findings were as follows:

The practice had comprehensive systems for monitoring and maintaining the care and treatment they provide to their patients. There was good use of monitoring templates for patients with long term conditions. The practice was proactive in helping people with long term conditions to manage their health and had arrangements in place to make sure their health was monitored regularly.

The practice engaged with other healthcare providers and professionals to ensure the best health outcomes for their patients.

The practice was clean and hygienic and had robust arrangements for reducing the risks from healthcare associated infections.

Patients said they were treated with dignity and respect. They felt that their GP listened to them and treated them as individuals.

The practice had recognised that there was a lack of patient satisfaction with access to appointments particularly during the peak holiday season due to an increase in the number of temporary residents. There was evidence of on-going monitoring and initiatives to respond to the situation to increase appointment availability although it remained a problem at peak times of the holiday season due to an influx of temporary residents.

Summary of findings

Recruitment procedures were not always adhered to, to ensure that staff were suitable to work in a healthcare environment.

Complaints and serious adverse incidents were not managed in a way that ensured learning was embedded and cascaded to staff.

There were no suitable arrangements in place to ensure that the service could continue to operate in the event of events such as fire, flood or loss of essential utilities.

Overall we rated the practice as 'requires improvement'.

The practice must:

Take action to ensure that recruitment procedures for clinical and non-clinical staff are followed to help ensure that patients are protected from the risks associated with unsuitable staff being employed.

Embed a system for managing and learning from complaints

Ensure that learning from serious adverse events is cascaded to staff to improve learning and help prevent any re-occurrence.

Have in place a contingency and business continuity plan to ensure that patients can continue to receive care and treatment that meets their needs in the event that the practice ceases to function through foreseeable events.

In addition the practice should:

Take action to ensure that containers containing clinical waste are locked at all times when not in use.

Monitor and record refrigerator temperatures in line with the practice's own policy to ensure the safe storage of medicines.

Have in place a system to ensure that relevant senior staff can access key documents and information held on the computer system when the practice manager was unavailable.

Ensure that patients are not put at risk, by implementing a system whereby GPs view blood test results that may potentially pose a clinical risk.

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?

Requires improvement

The practice is rated as requires improvement for safe as there are areas where improvements must be made. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. There was effective recording and analysis of significant events but lessons learned were not always shared among relevant staff. We found that the practice did not have a plan in place to deal with foreseeable events that may stop the practice from functioning properly. Recruitment procedures did not always provide assurance that staff employed at the practice were suitable to work in a healthcare environment. The practice had a good track record on safety. The practice had a range of safeguarding measures in place to help protect children and vulnerable adults.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. Patients' care and treatment took account of National Institute for Health and Care Excellence (NICE) and local guidelines. Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice was proactive in the care and treatment provided for patients with long term conditions such as asthma and diabetes and regularly audited areas of clinical practice. There was evidence that the practice worked in partnership with other health professionals. Staff received training appropriate to their roles and the practice supported and encouraged their continued learning and development.

Are services caring?

Good

The practice is rated as good for caring. Patients told us they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We saw that staff treated patients with kindness and respect and were aware of the importance of confidentiality. The practice provided advice, support and information to patients, particularly those with long term conditions, and to families following a bereavement.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for responsive. The practice was aware of the needs of their local population and

Summary of findings

engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these are identified. Patients reported that getting an appointment to see a GP was sometimes difficult but said that urgent appointments were available the same day. The practice had extensive facilities and was well equipped to treat patients and meet their needs. There was a complaints system with evidence demonstrating that the practice responded quickly to issues raised. We were shown a complaints log which summarised complaints but with limited details of learning and actions arising as a result of complaints. There was no audit of complaints to show whether themes had been identified and what actions had been taken.

Are services well-led?

Good

The practice is rated as good for well-led. There was a clear leadership structure and staff were aware of their roles and responsibilities. Some staff felt that they were not kept fully informed of issues affecting the practice. We found that there was no process in place to ensure that in the absence of the practice manager certain key documents and information was available.

The practice had well organised management systems and met regularly with staff to review all aspects of the delivery of care. The practice sought feedback from staff and patients and this was acted upon. The practice had an active patient participation group (PPG).

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

Good

The practice is rated as good for the care of older people. The practice had a high percentage of patients, 40%, over the age of 65. A new initiative had been instigated that provided twice weekly sessions that enabled patients to access advice on adult social care.

The GPs conducted weekly 'ward rounds' at three nursing homes to ensure continuity of care and to help reduce the number of unplanned admissions to hospital. GPs visited care homes as required to consult with patients.

People with long term conditions

Good

The practice is rated as good for caring for patients with long-term conditions. The practice had a high number of patients with long term health conditions, many having complex, multiple morbidities. The practice responded well to the challenges of meeting the needs of this population group. The practice worked with a number of other healthcare providers to provide dietary, weight loss, smoking cessation advice and access to exercise programmes. Patients coming to the end of their lives and their relatives were able to access help and advice that was provided by the St Barnabas Hospice day therapy staff within the surgery. The practice took part in the Gold Standards Framework, a care pathway for patients coming to the end of their lives and held monthly multi agency meetings with other healthcare professionals to discuss patients' care

Families, children and young people

Good

The practice is rated as good for caring for families, children and young people. The practice worked closely with district nurses, health visitors and the school nurse to meet the health care needs of babies and children.

Summary of findings

Children under the age of five years of age, presenting as unwell, were added to the GP list for them to be seen that day.

A family planning service weekly was provided in the surgery by Lincolnshire Community Health Services NHS Trust.

The practice offered a full range of immunisation services for babies and children.

Working age people (including those recently retired and students)

Good

The practice was rated as good for working age people. The practice offered a range of appointment options at two locations to cater for the needs of patients who may be at work. It also offered extended surgery hours on Thursday from 6.30pm to 8pm.

All new patients were offered a health check.

The practice participated in the NHS health check scheme and offered health checks to all patients aged between 40 and 74.

The practice was pro-active in referring patients to the Heelers exercise scheme that provided 12 weeks of supervised personalised exercise free of charge and thereafter reduced price membership at a local sports centre.

Consultant led out-patient clinics were held within the practice to enable working patients who may have difficulty in getting time off work and travel long distances to hospital to receive appropriate care and treatment.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for caring for patients whose circumstances may make them vulnerable. The practice hosted weekly meetings of Alcoholics Anonymous and Addaction drugs and alcohol addiction recovery support charity.

Patients who had identified learning difficulties were invited into the practice for an annual physical health check.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for caring for people experiencing poor mental health. The practice is proactive in working with other healthcare providers to enable patients in this population group to access advice and treatment that best met their needs.

A community psychiatric nurse was based at the surgery to allow referrals of those experiencing poor mental health to specialist care including cognitive behavioural therapy.

The practice worked proactively with the community mental health team to facilitate home visits for patients with dementia.

Summary of findings

What people who use the service say

Patients and carers we talked to told us that they felt well cared for by the practice and that their health needs were met. They said the surgery was clean with no unpleasant odours.

They expressed concerns regarding the availability of appointments to see a GP within a reasonable time for routine matters.

One patient told us that the next available appointment to see a GP was 21 days hence. They said they had been told by the receptionist to go to the Accident and Emergency department at hospital if they were not prepared to wait.

One patient had left a CQC comment card and had stated that although they found the clinical staff very professional, they found the reception staff rude and they did not respect their confidentiality.

We looked at the reviews of the practice that patients had left on the NHS Choices website. The two posted in the last 12 months were both complimentary and referred the quality of treatment and attitude and quality of staff.

Areas for improvement

Action the service MUST take to improve

The provider must have in place a contingency plan to ensure that patients can continue to receive care and treatment that meets their needs in the event that the practice ceases to function through foreseeable events.

Embed a system for managing and learning from complaints

Ensure that learning from serious adverse events is cascaded to staff to improve learning and help prevent any re-occurrence.

Take action to ensure that recruitment procedures for clinical and non-clinical staff are followed as per best practice to help ensure that patients are protected from the risks associated with unsuitable staff being employed

Action the service SHOULD take to improve

Take action to ensure that containers containing clinical waste are locked at all times when not in use.

Ensure that refrigerator temperatures are monitored and recorded in line with their policy to ensure the safe storage of medicines.

Ensure that patients are not put at risk, by implementing a system whereby GPs view blood test results that may potentially pose a clinical risk.

Have in place a system to ensure that relevant senior staff could access key documents and information held on the computer system when the practice manager was unavailable.

Marisco Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP and the team included an additional CQC inspector, a GP practice manager and an Expert by Experience.

An Expert by Experience is a person who has experience of using this type of service and helps to capture the views and experiences of patients and carers.

Background to Marisco Medical Practice

Marisco Medical Practice is located on two sites, the primary location being a purpose built medical centre. The practice moved into the building in 2008 with the vision of it being a 'one stop shop' to meet patients' varying healthcare needs including community nurses, consultant led out-patient clinics, minor surgery, health and fitness facilities and a dental surgery. It also acts as a meeting point for the local hospice day care service, Alcoholics Anonymous and Addaction drugs and alcohol addiction services.

The practice has a branch surgery at The Broadway, Sutton-on-Sea, LN12 2JN. Patients of the practice are free to use either surgery. The Sutton-on-Sea surgery was not visited during the course of this inspection.

The practice is within the area covered by Lincolnshire East Clinical Commissioning Group (CCG).

The practice holds a General Medical Services (GMS) contract. They have opted out of the requirement to provide GP consultations when the surgery is closed. The out-of-hours service is provided by Lincolnshire Community Health Services NHS Trust.

The geography of Mablethorpe dictates that patients need to travel considerable distances for hospital and other secondary care. Lincoln is 48 miles distant, Grimsby 22 miles and Boston 24 miles. Public transport links are poor.

The practice has a patient list of 14,000 but is weighted to 21,000. This reflects the very high healthcare needs of the patient population. Mablethorpe is an area of high social and economic deprivation, compared nationally. The practice population is much older than either the CCG or England average, with 40% of the practice population over the age of 65 years. Less than 50% of the working age population is in employment.

The percentage of patients with chronic long term conditions is well above the national average. This included patients with diabetes, heart disease and other chronic diseases. For example diabetes national average is 4.6%, Marisco is 12.3%. Chronic obstructive pulmonary disease nationally is 1.7%, Marisco 4.99%. Patients with heart conditions nationally is 1.5%, Marisco is 3.34%.

The area is traditionally used as holiday location for people from the midlands and south Yorkshire, some of who retire to the area. Many do not register with the practice and this results in the practice having a high and fluctuating number of temporary residents, particularly between April and September each year.

Recruitment and retention of GPs on the east coast of Lincolnshire is an ongoing problem. In September 2012 the practice had nine GP partners (7.25 whole time equivalent - WTE) but by December 2013, due to retirements and others leaving, this had decreased to 3.25 WTE. The practice is a

training practice and would normally expect to have GP registrars, but with only six of the 30 GP registrar places being filled in the Lincolnshire Vocational Training Scheme for 2014/15 the practice has only one part time GP registrar. A GP registrar is a qualified doctor who is undergoing further training to become a GP.

The spiralling costs of locum GPs to meet the shortfall in staffing has resulted in some financial concerns, and a programme of redundancy has seen six members of staff accept voluntary redundancy and a further six on short term contracts did not have them renewed. Staff have voluntarily reduced their hours. All these factors have combined to put even further pressure on the availability of appointments.

The practice has worked hard to fill the GP vacancies and at the time of the inspection there were four full time GP partners, two part time partners and one salaried full time GP. The staffing levels equated to GPs 6.6 WTE, nursing staff 3 WTE and healthcare assistants 8.05 WTE.

The surgery in Mablethorpe is spacious and well equipped. Access for patients with restricted mobility is good and the practice provides wheelchairs in the entrance area. There is very large car park and flat and level access throughout.

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. This 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.

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.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice. We carried out an announced visit on 15 October 2014. During our visit we spoke with a range of staff including GPs, nurses, healthcare assistants, reception and administration staff. We spoke with patients who used the service. We observed the interactions between patients and staff, and talked with carers and family members. We met with representatives of the patient participation group (PPG). The PPG is a group of patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care.

Prior to our inspection we had left comments cards to allow patients to share their experiences. One comment card was returned.

In advance of our inspection we talked to the local clinical commissioning group (CCG) and the NHS England local area team about the practice. We also reviewed information we had received from Healthwatch, NHS Choices and other publically accessible information.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. For example we saw recent advice regarding the Ebola virus and the clinical manager explained and showed us how such alerts were cascaded to staff.

Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events.

We saw evidence of significant event analysis and staff told is that incidents were discussed at clinical meetings at two or three monthly intervals. However meeting minutes were not maintained and so we found no evidence around shared learning. We noted that the significant events log did not identify who raised the incident or which members of staff were involved. This would make it difficult to identify any trends or re-occurring issues with individual staff members.

Reliable safety systems and processes including safeguarding

The practice could not provide us with evidence that all the necessary checks, including Disclosure and Barring Service checks (DBS), formally known as Criminal Records Bureau (CRB) checks, were made when clinical staff were employed to work at the practice. DBS checks identify whether a person has a criminal record or is on an official list of persons barred from working in roles where they will have contact with children or adults who may be vulnerable.

The practice had not routinely carried out DBS checks for non-clinical staff. We were told that this was based on a risk assessment that these staff were rarely on their own with people who may be vulnerable, even when they did chaperone duties. However we were told that they had been researching this matter with a view to reviewing their policy because they recognised that it would be best practice to carry out DBS checks for staff who carry out chaperone duties.

The practice had a chaperoning policy and provided training for those staff who were asked to fulfil this role when needed. Staff we spoke with confirmed they had been trained for this role and showed that they understood their responsibilities. Staff told us that people were always offered the opportunity to have a chaperone at the start of any appointment involving a sensitive or intimate examination. Staff told us that a note was made in patient records when a chaperone was present to provide an audit trail.

The practice had a clear safeguarding policy which included information about the processes involved and important contact numbers for the child and adult safeguarding teams. The policy and protocols were available to all staff on the practice computer system. Staff we spoke with knew who the practice's safeguarding lead was and were clear about their duty to report abuse neglect. Staff including GPs had received training in safeguarding adults and children.

There was a whistleblowing policy and staff we spoke with were aware of it, what it meant and how to access it on the practice computer system.

Medicines management

The prescribing arrangements at the practice gave patients a variety of options for obtaining their repeat prescriptions. These included on-line ordering. There was a process for prompting patients who needed to have their medicines reviewed by a GP and this was done at suitable intervals depending on the patients' specific needs. This process was managed by the dedicated prescription team. We saw that a protocol was in place for repeat prescribing. GPs authorised repeat prescriptions through electronic prescribing. Medicines prescribed on repeat prescriptions were not issued without first being authorised by a clinician. GPs had protected time put aside to enable them to deal with repeat prescriptions. Prescribing patterns for some medicines had been monitored as part of a full clinical audit cycle looking at side effects for patients.

The practice held paper prescription pads. We saw 20 prescription pads were stored in an unlocked cupboard and were not accounted for. On some of the pads the name of a GP who had left the practice the previous year. We raised this with the clinical manager who immediately moved them to a secure cabinet and made arrangements

to have the pads returned for destruction. The practice recognised the need to make their audit trail for prescriptions more robust and said they would do this in line with NHS guidance.

Controlled drugs were stored securely and in line with best practice guidelines. The drugs were checked regularly and stock control sheets signed by staff. We examined the controlled drugs register and saw the figures tallied with the quantities of drugs held.

Refrigerators used to store medicines and vaccines had their temperatures monitored to ensure their efficacy. We saw that the practice had a robust 'cold chain' policy that ensured that medicines that needed to be refrigerated were. This entailed the temperature of refrigerators being checked twice daily; however we saw that this was not always carried out and that the temperature was being recoded on one occasion daily. We looked at medicines that were stored in the refrigerators and found them to be within the manufacturers' expiry dates. Fridges were locked.

Cleanliness and infection control

Patients commented on the high standard of hygiene and cleanliness at the practice. The practice was clean and tidy when we inspected.

We saw that the practice had a robust infection control and prevention policy.

The practice had a dedicated infection prevention and control (IPC) lead. We spoke to this member of staff who told us they had been on a two day accredited training course in infection control and prevention and met with other IPC leads on a quarterly basis to share good practice. We saw evidence that this was the case. They showed us a presentation that the IPC lead was due to give to members of staff on infection prevention and control.

We saw the last IPC audit that had been completed in April 2014. Each room was also subject to individual periodic audit, the latest being in September 2014. Any area for improvement had been highlighted in action plans to be implemented.

The practice had an up to date legionella risk assessment which had established that the building had low levels of risk in relation to legionella bacteria.

There were cleaning schedules in place and we saw that audits on the effectiveness of cleaning were incorporated in the in the practices on going risk assessments.

The practice had a contract with a specialist company for the collection of clinical waste and we looked at the storage area which consisted of a padlocked area in the car park. We saw that five bins containing clinical waste, including sharps were unlocked. We spoke with the Registered Manager about this who informed us that the bins were shared with other healthcare providers but they would ensure they were reminded of their responsibilities in ensuring the bins were locked when not in use.

We saw that the practice had evidence of the hepatitis B status of all staff, including cleaning staff.

Equipment

We established that the practice had the equipment they needed for the care and treatment they provided and that this was maintained and re-calibrated as required. Portable electrical equipment and fire fighting equipment had been tested.

Staffing and recruitment

The practice could not demonstrate that appropriate checks had been undertaken prior to employment. For example references, registration with the appropriate professional body and evidence of their suitability to work in a healthcare environment were not present in all the staff files we looked at. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We found that the recruitment procedures carried out did not comply with the practices' own policy.

The practice was unable to give us access to the recruitment and staff files of GPs as the practice manager had not made any provision for them to be accessible during their absence.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure they were enough staff on duty.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always

Good

Are services safe?

enough staff on duty to ensure patients was kept safe, although here was an acknowledgement that the difficulty in recruiting GPs and the loss of staff through redundancy had placed extra pressures on remaining staff members.

Monitoring safety and responding to risk

The practice had arrangements for identifying those patients who may be at risk for whatever reason. There were practice registers in place for people in high risk groups such as those with long term conditions, mental health needs, dementia or learning disabilities. The practice computer system was set up to alert GPs and nurses to patients in these groups and to adults and children who may be at risk due to abuse or neglect.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia Processes were also in place to check emergency medicines were within their expiry date and suitable for use.

There was no business continuity plan in place to deal with a range of foreseeable emergencies that may impact on the daily operation of the practice, for example loss of utilities, telephones, fire or flood that would prevent the practice from operating normally. We were told that a plan was being worked on and was in draft form. We were not given access to the draft plan. We were told than only the practice manager, who was not present at the time of our inspection, had access to the document.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurses we spoke with told us how they followed evidence based practice. They accessed guidelines from the National Institute for Health and Care Excellence and from local commissioners. All the GPs interviewed were aware of their professional responsibilities to maintain their knowledge.

Patients had their needs assessed and care planned in accordance to best practice. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

We looked a number of monitoring templates for patients with long term conditions which had been designed and set up by the practice. They had been designed with a built in hierarchy so that a maximum of two would be used for any one patient. This avoided multiple clinical reviews for patients with complex multiple chronic disease and lessened the need for multiple appointments for both patient and the practice.

We saw good evidence of how the practice catered for the healthcare needs of patients with long term conditions for example those in receipt of anti-coagulant therapy (used to prevent blood clotting) and measuring how well it was working using the international normalisation ratio, commonly referred to as INR. We saw that INR testing was conducted by healthcare assistants who had received training and on going assessment and supervision to ensure their competence. The process was overseen by a practice nurse. A GP was always available during INR clinics in the event that the results were 'out of range' in which event they would be consulted for clinical advice.

Vaccinations for influenza were historically well organised, although the take up of vaccinations was lower than the national average, 66% at the practice compared with a national average of 73%. This reflected the trend in more deprived areas with high percentages of older patients. The practice held documented evidence to show that 8.4% of the target population had declined the vaccination.The target for this year's vaccinations was 7,400. This represented more than 50% of the total patient list and reflected the complex needs and demands on the practice.

The practice had sought the views of patients who had received an influenza vaccination in the previous winter and the results showed that patients were satisfied with the way the practice had organised the vaccination clinics.

The practice referred patients appropriately to secondary and other care in the community services. The practice had worked hard to ensure patients received care and treatment at the surgery rather than having to travel considerable distances for hospital out-patient appointments. For example the practice held a contract for minor surgical procedures and parts of the building were used by Grimsby Hospital outreach clinics to help negate the need for patients to travel long distances.

National data showed the practice was in line with national standards on referral rates for all conditions. Patients we spoke with told us that referrals to secondary care were timely.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice has a system in place for completing clinical audit cycles.

The practice undertakes minor surgical procedures in line with their registration and National Institute for Health and Care Excellence (NICE) guidance. The staff were appropriately trained and kept up to date. They also regularly carried out clinical audits on their results and use that in their learning. We saw an audit on minor surgical procedures for the years 2009 to 2014. We also saw evidence that the practice had carried out clinical audits in stroke prevention, in atrial fibrillation and integrated care and two week referrals for patients to confirm or exclude a cancer diagnosis.

We saw that the practice had carried out an audit on the delivery of influenza vaccinations to measure their method of delivery and ease for patients.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

The practice had adopted a 'pod' system to promote safe and effective care and treatment. Each pod consisted of four rooms with a GP, a nurse practitioner and a healthcare assistant working alongside each other as a team to ensure consistency of care and provide support for each other.

The practice had an appropriate number of key staff including medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. A good skill mix was noted amongst the doctors with some being the identified leads in areas such as coronary vascular disease, heart failure and hypertension. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation.

We were aware that the practice had experienced extreme difficulty in recruiting GPs to replace GPs who had retired or otherwise left the practice. This had impacted on the availability of appointments and locum GPs and nurses had been engaged to maintain effectiveness in patient care and treatment. The situation had improved over the few months prior to our inspection and the practice had a more stable GP mix. Two nurse practitioners had been recruited and were to start work shortly.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. The GP Registrar had access to a senior GP throughout the day for support.

Working with colleagues and other services

We looked at the 'task list' on the computer system which contained details of referrals and saw they were dealt with in a timely manner.

Incoming correspondence relating to clinical matters such as diagnostic and blood test results were entered onto the computer system. Results pertaining to diabetes management, for example, were sent to the nurse practitioner having oversight in that particular area of care. Other results such as blood tests were referred to the GP who initiated the test. Very abnormal test and pathology results were referred to the duty GP to deal with that day. However we noted that GPs did not routinely see what were regarded as 'normal' results so they would not be aware of trends that could be clinically relevant. For example haemoglobin could usually be 'high normal' but suddenly fall to 'low normal' without a clinician being aware. We spoke to a GP about this and they said they always made a forward dated task on the computer system to remind them to view the test results of patients that caused them concern. They accepted that a person not causing concern may be overlooked.

We looked at correspondence that had come into the practice either by mail or facsimile and saw they were scanned onto the practice computer system. We saw some letters that were awaiting scanning dated back to 24 September. None had been marked as urgent and we were assured that all would be on the computer system by the time the patient saw the GP.

Information sharing

The practice had systems for making information available to the out- of- hours service about patients with complex care needs, such as those receiving end of life care.

Staff had done training about information governance to help ensure that information at the practice was dealt with safely with regard to peoples' rights as to how their information was gather, used and shared. An in-house messaging system was used for sharing information internally. Staff were alert to the importance of only sharing information with patients or with patients' consent.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. We saw that clinical staff had received appropriate training.

Health promotion and prevention

The practice faced major challenges in promoting healthier lifestyles given their aging patient population and number of patients with complex, chronic and multiple morbidities. The practice worked closely with other providers to help people live healthier lives and made full use of other providers who were housed in the same building. The practice worked with the Northern Lincolnshire and Goole Hospitals NHS Trust to develop hospital services in the community and a number of clinics operated from the practice premises. These included ear, nose and throat;

Good

Are services effective?

(for example, treatment is effective)

audiology; gastroenterology; gynaecology, urology and orthopaedics. In addition the practice also had Lincolnshire Community Health Services Trust located in the building providing amongst other services, family planning clinics.

The practice acted as a meeting point for Alcoholics Anonymous, Addaction (drug and alcohol support service) and Lincolnshire Intermediate Musculo-Skeletal Service.

The practice worked alongside East Lindsay District Council, and in a joint initiative hosted the Heelers fitness programme enabling patients to be referred for a free 12 week fitness programme. Patients were then able to access a local sports centre where they received reduced fees.

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant / practice nurse. The GP was informed of all health concerns detected and these were followed-up appropriately.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations which were offered to all over the age of 65, those in at risk groups and pregnant women.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients we spoke with on the day of our inspection all told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The reception area had barriers and a notice to help ensure that conversations between patients and receptionists could not easily be overhead. The availability of a private room to maintain confidentiality was displayed.

Sample bottles were available in an area away from the reception desk with instructions regarding the process of leaving them at reception in a designated receptacle. This ensured that patients didn't have to queue to ask for a bottle or to hand it in with the sample.

Care planning and involvement in decisions about care and treatment

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Patient/carer support to cope emotionally with care and treatment

Bereavement counselling and spiritual support was provided by a team from St Barnabas Hospice who visited the practice weekly and held a day centre in the practice training room. They provided support to palliative care patients and their relatives.

Staff told us that they could also signpost the bereaved to other services.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the service was responsive to people's needs and had sustainable systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The Clinical Commissioning group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

Tackling inequity and promoting equality

The practice had an established group known as Friends of Marisco. This group held regular coffee mornings at the practice to encourage people to get involved in the patient participation group. Other activities including raising funds for desirable equipment such as portable heart monitors. We heard from one of the organisers how the group had been successful in encouraging people in vulnerable circumstances to attend and play an active part in the group.

The practice provided good access to persons with restricted mobility with automatic opening doors, wide corridors and level access. The large car park had ten spaces marked for the use of disabled persons. Wheelchairs were provided by the practice to negate the need for people with mobility scooters to use them within the building to lessen the risk to patients and others from their use in confined spaces.

Hearing loops were fitted. Toilets suitable for use by wheelchair users were provided on both floors of the practice. A passenger lift that accommodated wheelchairs was provided.

Translation services were available for patients who did not have English as a first language.

The patient handbook was available in large print for those with impaired vision.

The practice had a charter which was published in the patient information leaflet. The charter stated in clear terms what patients could expect from the practice and what the practice expected from patients, such as cancelling unwanted appointments, arriving on time for appointments and notifying the practice of changes of name or address.

The practice had a robust policy that informed staff on their responsibilities in promoting equality and diversity.

Access to the service

Prior to our inspection we were aware that patients had expressed concerns about the difficulty in getting an appointment to see a GP. One person we spoke with told us that the next available appointment was three weeks hence and that they had been advised to go to Accident and Emergency if they could not wait. During the course of our inspection we looked at the availability of pre-bookable appointments with two of the GPs. We found that for one GP, the next pre-bookable appointment was 7 November (17 days) for another GP it was 4 November (14 days).

We looked at the appointments system and found there were several ways in which a patient could get to see a GP.

This consisted of pre- booked, some of which could be accessed on-line, same day appointments as result of triage by a GP and same day appointments that were booked by the practice receptionists. A further 25 pre-booked and same day and urgent appointments were available with the GP who was designated as on call for the day. Telephone triage appointments were available daily for those patients unable to book a face to face consultation.

The senior partner assured us that this regime, although seemingly complicated had proved to be effective in making the maximum number of appointments available to patients whilst at the same time having a marked effect on the number of patients failing to keep their appointments.

We saw that the patient handbook contained a comprehensive list of charges for none NHS treatments and services that were available at the practice such as vaccinations, medical reports and access to records.

The practice had an informative website that contained a range of information for patients including how to access appointments, policies, details of the patient participation group and specialist clinics and services.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The practice manager was designated as the person responsible who handled all complaints in the practice.

Accessible information was provided to help patients understand the complaints system. There was a complaints procedure leaflet available to patients in the practice and some information via the website. The leaflet gave guidelines to patients as to how to raise a complaint and what they could expect from the practice in response to a complaint. There were also details of NHS England and the Ombudsman available for patients to contact if they were not satisfied with the outcome of their complaint to the practice. However the information in the leaflet contradicted the practice policy which specifically stated escalation of a complaint to NHS England was not an option if a patient was dissatisfied with the outcome.

We were shown a complaints log which summarised complaints but with limited details of learning and actions arising as a result of complaints. There was no audit of complaints to show whether themes had been identified and what actions had been taken. We were told that complaints were escalated as a significant event if necessary and any learning would be then be cascaded to relevant staff as required. The complaints log demonstrated the practice had responded in a timely manner to issues raised.

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 practice had defined their strategy when they undertook to commission and move into the new purpose built surgery in 2008 with the objective of making healthcare across a wide spectrum available to patients without the need to travel excessive distances. The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We talked to staff who all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at a sample of these policies and procedures and saw they had been reviewed regularly.

The practice held monthly partnership meetings that were recorded. We saw minutes of meetings that had been held for reception staff, nursing staff and partners.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards.

The practice had arrangements for identifying, recording and managing risks. We saw the risk assessment files that were held electronically which addressed a wide range of potential issues including fire risk, health and safety, laundering of uniforms and modesty curtains and waste segregation. An external organisation had been engaged to visit the practice three times a year to support the practice in ensuring the health and safety of patients, staff and others.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and the senior partner was the lead for safeguarding. The members of staff we spoke with were clear about their own roles and responsibilities. They all told us they knew who to go to in the practice with any concerns.

We asked to see certain documents and were told that some documents were kept securely and only the practice manager had access to them and that in their absence they were not available to anyone at the practice. Similarly we were told that certain records held on the computer were only accessible to the practice manager. We found that this lack of a system for ensuring that key information was accessible placed the practice at risk being unable to function appropriately in the event that the practice manager was unavailable for any protracted period of time.

Staff told us they had the opportunity and were happy to raise issues of concern or with ideas to improve the service. However some staff members told us that they felt they had not been sufficiently updated on issues affecting the practice during the difficult times, especially around the area of redundancy and job security.

The practice manager attended the CCG Executive meetings where they represented the seven practices in the Skegness and Coast Clinical Commissioning Locality.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, including a policy that related to Discrimination and Equal Opportunities which were in place to support staff. They were held on the computer system. Staff we spoke with knew where to find these policies if required.

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

The practice had an active patient participation group (PPG), which normally met on a monthly basis. The PPG is a group of patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care. The PPG membership reflected the demographics of the patient population. We met with three members of the PPG including the chairman who told us that their meetings were regularly attended by 12-15 members. They assured us that their views were taken into consideration, for example they expressed their concerns when it had been proposed that all appointments be switched to 'sit and wait'. They said that the practice manager was a keen supporter of the group.

We saw the results of the annual patient survey for 2013/14. 400 patients had responded to the survey. Results had been mixed with overall satisfaction being high with 96% saying it was good or very good, whereas there were low levels of satisfaction in respect of getting appointments.

Are services well-led?

Good

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

The poor results were acknowledged by the senior partner and resulted from the difficulties in recruiting GPs. The practice had responded by reviewing the appointment booking systems as well as continuing to actively seek to recruit additional GPs. Patients we spoke with acknowledged this area was improving.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Two members of staff told us that despite the problems encountered by the practice in the last year, the practice had continued to provide a good service and things had improved markedly with less pressure on appointment availability.

Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Staff told us that the practice listened to what they had said. For example we saw how staff had been given training in conflict resolution to help them deal with some patients.

The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place. Staff told us that the practice was very supportive of training.

The practice was a training practice providing GP training places for GP Registrars. Only approved training practices can employ GP Registrars and the practice must have at least one approved GP trainer. Marisco Medical Practice had one full time and two part time trainers. A GP Registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice. We spoke with the practice's current GP Registrar. They confirmed that they had a named GP trainer at the practice and felt well supported by the whole team. They confirmed that they had an induction and "settling in" period when they first arrived.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person must have procedures in place for dealing with emergencies which are reasonably expected to arise from time to time and which would, if they arose, affect or be likely to affect, the provision of services, in order to mitigate the risks arising from such emergencies to service users.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person must protect service users and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to identify, assess and manage risks relating to the health, welfare and safety of service users and others who might be at risk from the carrying on of the regulated activity by** **(a) embed a system for managing and learning from complaints and,** **(b)ensure that learning from serious adverse events is cascaded to staff to improve learning and help prevent any re-occurrence**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The registered person must-**

This section is primarily information for the provider

Compliance actions

Surgical procedures

Treatment of disease, disorder or injury

(a) operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity unless that person-

1. is of good character
2. has the qualifications, skills and experience which are necessary for the work to be performed, and
3. is physically and mentally fit for that work

(b) ensure that information specified in Schedule 3 is available in respect of a person employed for the purposes of carrying on a regulated activity and such other information as appropriate.