Beacon Primary Care

Quality Report

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

Ratings

Overall rating for this service	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Beacon Primary Care Group on 26 May 2015. The Group has three locations and we visited two of these locations during our inspection Overall the practice is rated as outstanding.

Specifically, we found the practice to be outstanding for providing, effective and responsive and well led services. We have rated the practice as good for providing safe, caring services to patients.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice was actively involved in local and national initiatives to enhance the care offered to patients. They were proactive in trialling new ways of working to ensure they continued to meet the needs of the patients registered with the practice.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered after considering best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients

Summary of findings

- The practice had a clear vision that had improvement of service quality and safety as its top priority. High standards were promoted and there was good evidence of team working.

We saw several areas of outstanding practice including:

- The practice had introduced 'Patient Friends' who were reception staff who were available throughout the day to review and discuss any problems from the patient's perspective and use their knowledge of the practice to find a way of resolving issues quickly.
- The practice offered training to patients in the use of the automated electronic defibrillator.
- The practice staff had undergone training with the local Personality Disorder Team to allow them to effectively deal with patients who suffered with personality disorder conditions who were registered with the practice.
- The practice was working with the local nursing and residential homes to carry out training to integrate the care home staff into effective, up to date care delivery for patients registered with the practice.
- The practice had designed a Personalised Care Plan for older patients which demonstrated a holistic and not just incentivised approach to avoiding unplanned admission to hospital, which included a frailty assessment tool that reflected national good practice and included a detailed personal medical history including advanced care planning details. This had been shared with the CCG and other practices in the local area.
- The practice took an active lead in all Mental Capacity Act decisions for their patients including patients requiring a Deprivation of Liberty Order. They could demonstrate the involvement of Independent Mental Capacity Advocates for their patients.
- The practice used the skills of an Advanced Nurse Practitioner (ANP) to carry out minor surgical procedures within the practice in line with their registration and NICE guidance. The outcomes from patients accessing this service were closely monitored by the practice.
- The practice actively used SKYPE when staff could not attend meetings due to workload at other practices.
- On-line services include appointment booking and ordering repeat prescriptions and access to full medical records. At the time of the inspection records showed 1167 patients from the 11650 registered patients actively accessed their records on a regular basis.

However, there were also areas of practice where the provider needs to make improvements;

The provider should;

- Ensure environmental and fire risk assessments are updated and documented at all branches.
- Ensure daily checks on all areas of the practice and emergency equipment are appropriately documented to reflect completion of the checks.
- Ensure there is an auditable system for reviewing and monitoring the recording of serial numbers on all blank electronic and hand written prescriptions pads held in storage and once allocated to GPs. Ensure safe storage of all prescription pads across all sites.

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?

Good 

The practice is rated as good for providing safe services. The practice had systems in place for monitoring safety and learning from incidents and safety alerts to prevent reoccurrences. For example the practice carried out significant event audits to help clinician and practice based learning. All staff had received safeguarding training and staff we spoke with were aware of the safeguarding vulnerable adults and children policies in place. There were systems in place to ensure medication including vaccines, were stored correctly and in date.

The practice was clean and tidy. All equipment was regularly maintained to ensure it was safe to use. The practice had emergency equipment and medication available including oxygen and an automated electronic defibrillator. However daily checks on this equipment was not formally recorded at the time of the inspection.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. Our findings at our inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. The practice was using innovative and proactive methods to improve patient outcomes.

Are services caring?

Good 

The practice is rated as good for providing caring services. Patients we spoke with and those who completed the CQC comment cards were very complimentary about the service. They said all the staff (from receptionists to doctors) were kind, considerate and helpful. They told us they were treated with dignity and respect. We observed a patient-centred culture and found strong evidence that staff were motivated and provided kind and compassionate care. Staff we spoke with were aware of the importance of providing patients with privacy and of confidentiality.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure sustainable improvements to services. The practice had good facilities and was well equipped to

Summary of findings

treat patients and meet their needs. Information on how to make a complaint was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Patient friends were available at all times to assist patients to articulate the issues and reach a conclusion to their satisfaction. The practice operated a 'Talk and Treat service where all patients requesting on the day appointments were contacted by a GP or nurse within a set timescale. Their needs were assessed and appropriate actions identified which may result in the patient to attending the practice for a face to face consultation.

Are services well-led?

Outstanding 

The practice is rated as outstanding for providing well-led services. The practice had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to manage all activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which was acted upon. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events. The GPs at the practice were proactive in offering support and training to nursing and care homes where they had patients to support and enhance the care these patients received. The practice had a shared philosophy of what they wanted for their patients and everyone worked together to achieve this.

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

Outstanding ☆

The practice is rated as outstanding for the care of older people.

The practice kept a register of those patients 75years and older. The practice offered a named GP for these patients. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs. The practice used the Acute Visiting Service. This service was supported by local GPs who carried out acute or urgent visits to patients registered with the practice if their condition could not safely wait for a visit after usual surgery hours. The practice had designed a personalised care plan for older patients. This demonstrated a holistic and not just incentivised approach to avoiding unplanned admission to hospital which included family contacts, frailty assessment and a detailed personal medical history including advanced care planning details.

The practice was working with staff at the local residential and nursing care homes where they had registered patients to ensure staff were up to date with how to manage the on-going care needs of these patients.

The 'Talk and Treat' system allowed the practice to keep in contact with their elderly population and their relatives, without the disruption of having to travel to surgery when telephone advice will suffice.

The practice safeguarded older vulnerable patients from the risk of harm or abuse. There were policies in place, staff had been trained and were knowledgeable regarding vulnerable older people and how to safeguard them.

People with long term conditions

Outstanding ☆

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

The practice took a proactive approach to long term conditions (LTCs), reaching maximum points for the last two years on the Quality and Outcomes Framework. Practice statistics demonstrated a generally high prevalence of chronic diseases which they informed us was a result of proactive management and coding of chronic disease historically.

Patients with long term conditions were supported by a healthcare team that cared for them using good practice guidelines and were attentive to their changing needs. Patients had health reviews at

regular intervals depending on their health needs and condition. The practice maintained and monitored registers of patients with long term conditions for example diabetes, chronic obstructive pulmonary disease and heart failure. These registers enabled the practice to monitor and review patient conditions effectively and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed.

The practice implemented a "birthday review" approach to LTCs, whereby patients were invited in for a holistic assessment in the month of their birth. These were dedicated clinics, run by two health care assistants simultaneously, with a prescribing nurse overseeing the clinics and providing diagnostic and prescribing advice at the time of the review. Any bloods or investigations required were ordered in advance of the review clinic, and the process was overseen by an administrative member of staff.

The practice worked with partners in the voluntary sector, for example Skelmersdale Food Initiative, supporting their work in health promotion, and their "Walking Away from Diabetes" programme. They actively referred into diabetes education programmes. They also supported the local Breath Easy group, having a couple of patients who were active in this group.

Several practice clinical staff had attended a Diabetes Up-skilling course in the last year enhancing the care available to diabetic patients within the practice.

Families, children and young people

Good

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

Staff demonstrated a good understanding and were proactive in safeguarding and protecting children from the risk of harm or abuse. The practice had a clear means of identifying in records those children (together with their parents and siblings) who were subject to a child protection plan and who were in looked after conditions. The practice had appropriate child protection policies in place to support staff and staff were trained to a level relevant to their role. They had undertaken a review of children at risk and liaised effectively with other agencies and health and social care professionals in minimising risk for those children and ensuring updated records were always available. Systems were in place for identifying and following up children who were at risk. For example, children and young people who had a high number of A&E attendances.

Immunisation clinics for babies and young children were available on a weekly basis. Appointments both routine and urgent were

available outside school hours and the premises were suitable for children and babies. Children needing urgent appointments were seen as soon as possible at the surgery. Children and young people were treated in an age appropriate way and recognised as individuals.

The practice worked closely with the local women's refuge where they had registered patients. Families placed within the area under witness protection plans were appropriately registered and supported by the practice staff. Travelling families medical needs were also accommodated at the practice.

The population of under 18 year olds (0-18 years) accounted for 41% of the practice patient population which is higher than both the Clinical Commissioning Group (CCG) and the national averages for this age group (36.2% and 31.9%) . 22.4% of these were aged between 14-18 years of age compared with CCG averages at 20% and nationally 14.7%.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. The practice offered later health check appointments for working patients with the nurse and telephone talk and treat consultations were available during the day.

People whose circumstances may make them vulnerable

Outstanding

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

The practice was aware of, and identified their vulnerable patients. This was highlighted within patient records. The practice discussed any concerning patients as a team, safeguarding policies and protocols were in place and staff were trained in safeguarding vulnerable adults and children. The safeguarding lead were the two partner GP's and senior nurses who had received appropriate training at level 3.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. They carried out annual health checks for people with a learning disability and offered longer appointments and offered home visits if required.

Summary of findings

Health promotion leaflets were available in pictorial format and differing languages when requested and there was access to a loop system for patients who had a hearing deficit and there were also translation services for people whose first language was not English.

Patients at the practice who were homeless were registered with the practice address to enable them to access services.

The practice took part in the 'acute visiting service' available in the local area for their patients who requested home visits and it was felt they could not wait until the GP finished their clinic. This service ensured the patient was seen and treated appropriately in a timely manner where needed.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

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

Patients within this group received a timely recall for their annual physical health check. The practice took all reasonable measures to ensure high quality of mental health care was available to patients within the limitations of the local service available.

The practice monitored patients with poor mental health according to clinical quality indicators and in line with good practice guidelines. The practice regularly worked with multi-disciplinary teams and other mental health services in the case management of patients experiencing poor mental health, including those with dementia.

The practice had worked with the Improving Access to Psychological Therapies (IAPT) team to pilot the self referral form and to redesign the GP mental health referral form to allow patients to self-refer to the IAPT team. This empowered patients to take an active part in their treatments and to ensure they were fully informed of the treatments they were attending.

The practice was the only practice in the areas who looked after patients who had been removed from practices in the surrounding area due to violence or aggressive behaviour. These patents were managed in conjunction with the local police and consultations took place at the local police station until their behaviour was deemed appropriate to be seen in the practice environment.

The practice currently had a number of patients who they supported who were subject to deprivation of liberty orders or who were sectioned under the Mental Health Act. They also offered shared care packages with the Substance Misuse service offering shared care with the local community drug and alcohol team.

Summary of findings

What people who use the service say

During our visit, we spoke to 13 patients including two patients who were members of the patient participation group across the two sites we inspected. A member of the practice's patient participation group (PPG) told us that the practice listened to them and acted on their suggestions.

We received 24 completed CQC comment cards, all but one praised the practice, referring to staff, care and treatment. They told us staff were helpful, caring, and compassionate and that they were always treated well with dignity and respect. Patients told us they considered that the environment was clean and hygienic.

Patients had confidence in the staff and the GPs who cared for and treated them. The results of the National GP Patient Survey published in January 2015 demonstrated they performed well with 78.6% of respondents who described their overall experience of this surgery as good and 74.9% of respondents who said the last GP they saw or spoke to was good at involving them in decisions about their care (CCG 77.4% National 74.6%). 53.4% of respondents with a preferred GP said they usually got to see or speak to that GP (54.2% CCG & 53.5% National). These percentages were in line with the average results for the local Clinical Commissioning Group (CCG) and Nation data available.

The practice had analysed the results of the returned Friends and Family Test questionnaires for January 2015. (The Friends and Family Test is a NHS England initiative that provides patients with the opportunity to feedback on their experience). The comments from these questionnaires were analysed and the outcome reviewed and shared at team meetings. Actions to improve the service were identified.

Areas for improvement

Action the service SHOULD take to improve

- Ensure daily checks on all areas of the practice and emergency equipment are appropriately documented to reflect completion of the checks.
- Ensure environmental and fire risk assessments are updated and documented at all locations.
- Ensure there is an auditable system for reviewing and monitoring the recording of serial numbers on all blank electronic and hand written prescriptions pads held in storage and once allocated to GPs. Ensure safe storage of all prescription pads across all sites.

Outstanding practice

- The practice had introduced 'Patient Friends' who were reception staff who were available throughout the day to review and discuss any problems from the patient's perspective and use their knowledge of the practice to find a way of resolving issues quickly.
- The practice offered training to patients in the use of the automated electronic defibrillator.
- The practice staff had undergone training with the local Personality Disorder Team to allow them to effectively deal with patients who suffered with personality disorder conditions who were registered with the practice.
- The practice had in collaboration with the Improving Access to Psychological Therapies team (IAPT) redesigned the referral form to allow patients to self-refer to the IAPT team. This was to assist in the empowerment of patients to take an active part of their own care plan.
- The practice was working with the local nursing and residential homes to carry out training to integrate the care home staff into effective, up to date care delivery for patients registered with the practice.
- The practice had designed a Personalised Care Plan for older patients which demonstrated a holistic and not just incentivised approach to avoiding unplanned

admission to hospital, which included a relevant frailty assessment tool that reflected national good practice and included a detailed personal medical history including advanced care planning details. This had been shared with the CCG and other practices in the local area.

- The practice took an active lead in all Mental Capacity Act decisions for their patients including patients requiring a Deprivation of Liberty Order. They could demonstrate the involvement of Independent Mental Capacity Advocates for their patients.
- The practice used the skills of an Advanced Nurse Practitioner (ANP) to carry out minor surgical procedures within the practice in line with their registration and NICE guidance. The outcomes from patients accessing this service were closely monitored by the practice.
- The practice used SKYPE when available for staff who could not attend meetings due to workload at other practices.
- On-line services include appointment booking and ordering repeat prescriptions and access to full medical records. At the time of the inspection records showed 1167 patients from the 11650 registered patients actively accessed their records on a regular basis.

Beacon Primary Care

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included another CQC inspector, a GP, a specialist advisor who was a practice manager and an Expert by Experience (ExE). Experts by Experience are people who have experience of using or caring for someone who uses health and/or social care services.

Background to Beacon Primary Care

Beacon Primary Care is situated in Skelmersdale Lancashire. It is part of the NHS West Lancashire Clinical Commissioning Group (CCG.) Services are provided under a general medical service (GMS) contract with NHS England. There are 11650 registered patients and this is the largest practice in the CCG. The practice operates across three sites in the local area and patients can access appointments at any site of their preference. The buildings for two sites (Sandy Lane Health Centre and Hillside Health Centre) are owned and managed by an external company with the practice partners owning and managing the Railway Road building. We inspected two of the three sites, the main site at Sandy Lane Health Centre and the site owned by the GP partners at Railway Road Ormskirk.

The practice population includes a lower number (24%) of people over the age of 65, and a higher number (41%) of people under the age of 18, in comparison with the national average of 30.6% and 36.2% respectively. The practice also has a lower percentage of patients who have caring responsibilities (13.9%) than both the national England average (18.4%) and the CCG average (20.2%).

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

The practice telephone lines opens from 8.00 am to 6.30 pm Monday to Fridays except Wednesday when they close at 1pm but an emergency line is still available. Appointments are offered between 8.30am and 6pm every day except Wednesday when they also offer late surgeries at one sites until 20.30. They also held seasonal Flu vaccination clinics at certain times of the year. Patients requiring a GP outside of normal working hours are advised to contact an external out of hour's service provider Out Of Hours West Lancashire C.I.C (OWLs)

The practice has two GP partners, one female and one male. There is also three female and one male salaried GP, one male locum GP, nine female practice nurses, five health care assistant, a practice manager, senior receptionists and reception and administration staff. These staff are work across all three sites to provide comprehensive cover at all times.

On-line services include appointment booking and ordering repeat prescriptions and access to full medical records. At the time of the inspection records showed 1167 patients actively accessed their records on a regular basis.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. This inspection was planned to check whether the provider was meeting the legal

requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and to look at the overall quality of the service 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 (QOF) 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 living in vulnerable circumstances

People experiencing poor mental health (including people with dementia)

Before visiting the practice, we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice manager provided before the inspection.. We carried out an announced inspection on 26 May 2015.

We spoke with a range of staff including three GPs, three practice nurses, the medicines co-ordinator, an Advanced Nurse Practitioner, a patient advocate, a Patient Friend, reception staff and the practice manager. We sought views from patients and representatives of the patient participation group, looked at comment cards, and reviewed survey information.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. This included investigating reported incidents, checking national patient safety alerts and sharing comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Reports and data from NHS England indicated that the practice had a good track record for maintaining patient safety.

We reviewed safety records and incident reports. The practice manager, clinicians and any other relevant staff investigated and reported on the incidents and events. Documented evidence confirmed that incidents were appropriately reported. Staff we spoke with all said that there was an open and 'no blame' culture at the practice that encouraged them to report adverse events and incidents.

Minutes of meetings recorded in 2015 provided evidence that incidents, events and complaints were discussed. We saw that where it was appropriate actions were taken and protocols adapted to minimise re-occurrence of the incident or complaint. Records were available that showed the practice had consistently reviewed and responded to significant events, incidents and complaints.

Staff informed us that daily checks on the environment and equipment were undertaken. These were not formally recorded so staff could not verify these checks had been carried out. Senior staff assured us they would ensure these would be recorded in the future.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred during the previous 12 months. There was evidence that the practice had learned from these and adapted or change procedures as required. Staff spoken with including practice nurses and the medicine management coordinator provided recent examples where procedures had changed following investigation of a significant event.

We saw evidence to confirm that, as individuals and a team, staff were actively reflecting on their practice and critically looked at what they did to see if any improvements could be made. Significant events, incidents and complaints were investigated and reflected on by the GPs and practice manager and learning disseminated to the whole team where relevant. We looked at a number of recent significant events from 2014 to 2015, which had been analysed, reported and discussed with relevant staff.

National patient safety alerts were disseminated by the Clinical Commissioning Group or the practice manager to relevant staff. Nursing staff we spoke with gave examples of recent alerts/guidance that were relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

Staff had access to contact details for both child protection and adult safeguarding teams. We saw evidence of such information displayed in all clinical, reception and administrative areas. The practice policies and procedures were available electronically for staff. Both GP partners and the senior nursing team were the leads for safeguarding and had undertaken level three safeguarding training as required for this role. These staff covered safeguarding at all three sites used by the practice team. The practice could articulate the exact numbers of children on their child protection and looked after registers. Staff members we spoke with did not have recent experience of reporting concerns to the safeguarding teams but they provided examples from the past. Staff showed us how information was recorded on the electronic patient record and told us about the other health care professionals they shared their concerns with, such as the health visitor.

The practice also had patients who were currently part of the witness protection scheme and who were resident in the local women's refuge who they cared for. All these patients had flags on their electronic record system which alerted staff on opening the record to their particular circumstances. All other staff had received up to date training, at a level suitable to their role. All staff we spoke with were knowledgeable about the types of abuse to look out for and how to raise concerns.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as support and a safeguard and witness for a patient and health care professional during a medical examination or procedure). The practice

manager confirmed that only staff who had received training in the role and responsibilities of chaperoning carried out this role. However some staff we spoke with could not recall when they had undergone this training. The practice manager assured us they would ensure a refresher session was added to the next practice study session for all staff. All staff who undertook this role had criminal records check through the Disclosure and Barring Service (DBS). Patients spoken with told us they were aware of the availability of a chaperone if required.

Medicines management

We checked medicines stored in the treatment rooms and fridges at the Sandy Lane Health Centre and Railway Road branch surgery. We found that they were stored appropriately. There was a current policy and procedures in place for medicines management including cold storage of vaccinations and other drugs requiring this. We saw the checklist that was completed daily to ensure the fridge remained at a safe temperature and staff could tell us of the procedure in place for action to take in the event of a potential failure of the cold chain. A cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was in place for the safe management of vaccines. All medicines that we checked were found to be in date.

The practice employed a medicines co-ordinator who worked closely with the Clinical Commissioning Group (CCG) medicine management team to ensure that medicines prescribed to patients were reviewed following receipt of national alerts, followed national guidance and were cost effective. The medicine co-ordinator provided a recent example of an audit undertaken following an alert of patients over the age of 60 prescribed an antidepressant medicine (Citalopram). All changes to prescribing practice and patients prescriptions were authorised by the GPs at the practice.

All prescriptions were reviewed and signed by a GP before they were given to the patient. The nurse practitioner was appropriately trained to prescribe some medicines. However blank prescription forms were not stored in accordance with national guidance.

At the time of the inspection there was no auditable system for reviewing and monitoring the recording of serial numbers on all blank electronic and hand written prescriptions pads held in storage and once allocated to GPs. The practice manager and GP assured us this would be addressed as soon as possible.

Medicines for use in medical emergencies were kept securely in the treatment rooms. We were told that stock levels and expiry dates were checked on a regular basis. There was oxygen kept by the practice for use in case of an emergency. The practice also had emergency medicine kits for anaphylaxis (a severe, potentially life-threatening allergic reaction that can develop rapidly). Staff knew where these were held and how to access them. Oxygen and an automated external defibrillator (AED) were kept by the practice for use in an emergency. These were checked regularly. An AED is a portable device that is used to treat cardiac arrest by sending an electric shock to the heart to try to restore a normal rhythm. However written records to demonstrate checks had been carried out on all medicines, the defibrillator and the oxygen were not available. .

One practice nurse had responsibility for ensuring medicine including vaccines were stored correctly and had not exceeded their expiry date. A tracking system was available to ensure sufficient stock.

The practice had recently installed electronic prescribing which meant that patient prescriptions could be sent automatically to the patient's preferred pharmacist. This reduced the need to use paper prescriptions.

Cleanliness and infection control

We saw the premises were clean and tidy at both branches we visited. There were cleaning schedules in place and cleaning records were kept. Comments recorded by patients on CQC comment cards referred to the practice as being clean, welcoming and hygienic. We saw the results of a recent infection control audit which had been carried out by a practice nurse experienced in IPC who worked locally, it demonstrated the practice had improved since the previous audit and we saw an action plan was in place for meeting the outstanding actions. Records were also available demonstrating that staff had received training in use of personal protective equipment.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. Staff received training about infection control specific to their role and those we spoke with understood their role in

Good

Are services safe?

respect of preventing and controlling infection. We saw that policies and procedures were up to date, and these were stored on the practice's electronic shared drive. Procedures included the safe storage and disposal of needles and waste products and the management of specimens.

We saw that all areas of the practice were clean and processes were in place to manage the risk of infection. We noted that all consultation and treatment rooms had adequate hand washing facilities. Instructions about hand hygiene were available, with hand gels in clinical rooms. We found protective equipment such as gloves and aprons were available in the treatment/consulting rooms. Couches were washable and privacy curtains in the treatment rooms were changed in accordance with a planned schedule. Nursing staff we spoke with told us about the cleaning they undertook between patient appointments to reduce the risk of cross infection.

The practice had a risk assessment for the management of Legionella (a bacterium that can grow in contaminated water and can be potentially fatal). However since refurbishment at the Railway Road site this needed to be reassessed, the practice manager once we made her aware of this told us she would address as soon as possible.

Equipment

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment used during minor surgical procedures was single patient use and disposed of in line with manufacturers guidelines after use.

All equipment was tested and maintained regularly and we saw equipment maintenance logs, contracts and other records that confirmed this. Contracts were in place for annual checks of fire extinguishers and portable appliance testing (PAT). We saw that annual calibration and servicing of medical equipment was up to date.

Emergency drugs were stored in each treatment room. There was an oxygen cylinder and access to an automated external defibrillator. These were maintained and checked regularly at both practices we visited.

Staffing and recruitment

The practice had an appropriate recruitment policy.

We looked at a sample of eight staff recruitment files to see if the practice's recruitment practices were safe. We saw from the employment files for newer members of the staff team that all reasonable checks had been undertaken to ensure these new employees were fit to work with people who were potentially vulnerable. We saw all interview records, references and identification checks were available and all new staff were subject to disclosure and Barring checks (DBS). However some DBS checks for clinical staff who had been employed for long periods of time were due for repeating in line with guidelines. We saw that when staff were promoted within the practice the practice did not follow the recruitment policy by retaining interview notes to demonstrate appropriate selection processes had been followed. The practice manager assured us they would ensure this was retained in future.

Professional registrations of all professional staff were monitored and checked as required.

Staff told us there were enough staff to maintain the smooth running of the practice and there were enough staff on duty to keep patients safe. Staff told us that they worked regularly at all three surgeries. They said the rota had recently following feedback from staff, been changed so that they would spend a full day at the same surgery instead of half days at two surgeries. Staff told us that they preferred this. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The staff worked well as a team and as such supported each other in times of absence and unexpected increased need and demand. The practice manager and GP oversaw the rota for clinicians and we saw they ensured that sufficient staff were on duty to deal with expected demand including home visits and chaperoning.

The practice had developed clear lines of accountability for all aspects of care and treatment. Clinical staff had lead roles for which they were appropriately trained. The diversity and skill mix of the staff was good; each person knew exactly what their role was and undertook this to a high standard. Staff were skilled and knowledgeable in their field of expertise and were able to demonstrate how they could support each other when the need arose.

Monitoring safety and responding to risk

Good

Are services safe?

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. All new employees working in the three sites were given basic induction information for the buildings, which covered health and safety and fire safety.

There was a health and safety policy available for all staff, however this was being reviewed and updated. We were told workplace risk assessments had been undertaken but were not formally recorded.

Arrangements to deal with emergencies and major incidents

An appropriate business continuity plan (Continuity and Recovery Plan) and supporting risk assessment was in place and up to date. This comprehensive plan covered business continuity, staffing, records/electronic systems, clinical and environmental events. Key contact numbers were included and paper and electronic copies of the plan were kept in the practice. Staff we spoke with were knowledgeable about the business continuity plan and could describe what to do in the event of a disaster or serious event occurring.

Staff had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). This was updated annually. There was suitable emergency equipment available. Emergency medicines were available and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and asthma. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

There was a current up to date fire policy in place. Weekly fire alarm tests were carried out and equipment maintained by a contracted company at the managed sites and maintained by the partners at the Railway Road site.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All the staff we spoke with at both sites were familiar with, and using current best practice guidance. The staff we spoke with and evidence we reviewed, confirmed that care and treatment delivered was aimed at ensuring each patient was given support to achieve the best health outcomes for them. Each clinician confirmed that they had online access to NICE guidance.

We found clinicians and staff were familiar with the needs of each patient population group and the impact of the socio-economic environment where patients lived. The partner GPs at the practice proactively monitored the service they provided against a range of local and national benchmarking tools to measure their effectiveness. This information was used to assist the development and or improvement of the services they delivered. One such development was that other GP practice patients could choose to attend the Beacon Primary Care practice for their minor surgery needs. This was by referral from their own GP and through the 'choose and book' system. This service had proved to be well utilised by patients from all local GP practices.

The practice had a clear understanding of the different population groups they provided service for. They provided facts, figures and the support arrangements for patients on their register who had specific needs such as those on the substance misuse scheme, the violent patient scheme, patients living at a women's' refuge, patients subject to a Deprivation of Liberty Safeguarding (DoLS) plan, and travellers.

The GPs and practice nurses had completed accredited training for checking patient's physical health and the management of various specific diseases. The practice took part in the avoiding unplanned admissions scheme. All their registered patients living in residential and nursing care homes within their catchment area had had their healthcare needs reviewed and assessed by a GP and a care plan recorded. The care plan template had been adapted by the practice to focus holistically on the needs of the patient so that a more comprehensive picture of the patient and their needs was recorded this included assessing frailty in older patients. The amended template had been shared by the practice with their Clinical Commissioning Group and had been shared with other local GP practices as good practice.

Clinical staff told us the practice was focused on learning and development to improve outcomes for patients. Weekly clinical meeting were held between GPs and nursing staff where clinical needs of patients and the services provided by the practice were reviewed. Nursing staff said that GPs were accessible when they needed advice or support. Monthly multi-disciplinary team (MDT) meetings were held and members of the MDT attended as their schedules allowed or as a patients needs changed and needed discussion.

The practice had read coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register and palliative care register. The practice referred patients appropriately to secondary care and other services. Test results and hospital consultation letters were received into the practice either electronically or by paper. These were then scanned onto the system daily and distributed to the relevant GP.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients' care and treatment. It used the Quality and Outcomes Framework (QOF) to assess its performance and undertook regular clinical audits. QOF data showed the practice performed above the national average for the local clinical commissioning group and the England average. For 2013/14 the practice achieved 100%. In addition the practice actively monitored its performance alongside the Clinical Commissioning Group (CCG) and bench marking against quality frameworks.

GPs carried out clinical audits. Several examples of clinical audit were provided which demonstrated where change had taken place to enhance the patients care. The practice was found to be good at identifying Dementia amongst their older people population as a recent audit t into dementia prevalence demonstrated they were the highest prevalence practice in the CCG with dementia prevalence of 97.3% of the expected cases identified against the CCG average prevalence of 67%. Practice staff had reviewed their coding process for patients with dementia to see how

they could enhance their assessment of frail elderly patients who were not able to attend memory clinics. 181 patients were identified during the audit and were treated and diagnosed in a patient centred appropriate manner. A further audit was identified as an on-going process due to high number of patients who resided in care or nursing home establishments in the local catchment area. An audit of patients who were diagnosed with atrial fibrillation (irregular and fast heart beat) and whose only medication was aspirin was undertaken. As Aspirin only treatment for this condition is not considered best practice patients within the audit who were highlighted as having this as their treatment needed a review of their medication. The practice had highlighted the need to train the senior nursing staff to assist in the monitoring of these patients to allow patients to be fully monitored and supported by a wider clinical team. This training had been completed, supported by the practice and the local CCG.

The practice held regular multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw evidence of these meetings. Special patient information notes were used to inform out of hours services of any particular needs of patients who were nearing the end of their lives or who had a specific urgent need at that time.

The Advanced Nurse Practitioner (ANP) with a training academy qualification in minor surgery undertook minor surgical procedure clinics within the practice in line with their registration and NICE guidance. A GP was always available on the premises for support where needed during these clinics. Ongoing monitoring and audit of these clinics was carried out on a monthly basis with the ANP reporting and discussing any anomalies with the GP partner team. The health care assistant who assisted at these clinics monitored histology results and reported as required to the ANP and the GPs.

The practice had redesigned their referral form to allow patients to self-refer with support from the GP to the Improving Access to Psychological Therapies (IAPT) team. This allowed the patients to highlight the care they felt they needed from the IAPT team and ensured they were fully informed about their condition and had been seen to ensure patients adhered to regimes put in place. Practice statistics suggested 77 patients in a three month period in 2014 had been given the referral form and 28 of these had actually contacted IAPT which demonstrated a 36.4% success rate with this process. The 49 patients who did not contact IAPT were actively followed up at their next GP appointment and their reasons for not contacting were recorded. Formal referrals continued to be made by the GP if this was appropriate to the patient's needs.

Practice staff had been trained in appropriate ways to deal with patients suffering from personality disorders, this had changed the way the practice now dealt with patients suffering from this condition. It included using diffusion techniques to talk to the patient and to calm them down. As a result of this training the practice could demonstrate where this process had been effective in reducing attendance at A&E and at the practice by one particular patient.

The practice took part in the acute visiting service which allowed patients requiring GP assistance but who could not wait until after the practice clinic sessions to be seen by a GP from another practice within a shorter time period. This ensured patients' needs were met in a timely manner.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that these were comprehensive. All staff had online access to policies and procedures including employment, whistleblowing and safeguarding policies. Staff were up to date with attending mandatory courses such as annual basic life support. Nurses we spoke with confirmed their professional registration with the Nursing Midwifery Council (NMC) was up to date and that the practice manager checked this. Staff were supported to complete further training required to ensure they could maintain their registrations with their awarding bodies for example one practice nurse was completing a return to practice course after a lapse in her registration status.

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. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Staff we spoke with confirmed they received an annual appraisal that identified learning needs from which action plans were documented. Our interviews with staff

confirmed that the practice was proactive in providing training for relevant courses. One staff member told us that the practice supported them with additional training. They said they were booked on a Clinical Examination and Assessment course for later this year.

Practice nurses and health care assistants had defined duties and were able to demonstrate that they were trained to fulfil these duties. The feedback from staff we spoke with was positive. They said they felt supported and trained to provide a good standard of service to patients. There was enough staff to meet the demands of the practice at the time of the inspection

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services both electronically and by post.

Systems were in place to ensure that other services were promptly notified of matters of mutual interest that impacted on patient care. For example, regular updates were sent to the out of hour's service in relation to patients receiving palliative care and if patients had signed Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms.

The practice had a close working relationship with West Lancashire Clinical Commissioning Group (CCG) and worked collaboratively on a number of local initiatives. The practice highlighted some of their good practices that had been shared by the CCG with other GP practices in the CCG area.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, patients on the risk register hospital admissions and discharges and attendance at A&E. District nurse, health visitors, mental health practitioners and community matrons had an open invitation to these meetings subject to their diary availability. If a specialist practitioner could not attend a meeting to discuss a particular patient the practice ensured effective communication over the phone or by email to ensure the patients' needs were fully met. We saw minutes of these meetings. The practice had links with the local women's refuge and witness protection teams to ensure their patients were safe and well cared for.

The practice worked with partners in the voluntary sector, for example Skelmersdale Food Initiative, supporting their work in health promotion, and their "Walking Away from Diabetes" programme. They actively referred into diabetes education programmes. They also supported the local Breath Easy group, having a couple of patients who were active in this group.

Information sharing

Information about significant events was shared openly and honestly at practice meetings and if appropriate at MDT meetings. The GP's attended CCG meetings and shared what they had learned in clinical team weekly meetings. Staff practice meetings were held monthly.

The practice website had a large amount of information for patients including signposting, services available and latest news. There were numerous information leaflets available within the practice waiting room and at the request of any of the clinicians if a patient required more information

The practice used electronic systems to communicate with other providers. They shared information with out of hour's services regarding patients with specific special needs. They communicated and shared information regularly between themselves, other practices and community health and social care staff at various regular meetings.

Practice staff had recently delivered training within the local nursing and care homes to ensure staff in these areas were up to date with the care for their patients. Staff told us the communication between the practice and all the care establishments was effective and the care homes regularly rang for advice or support with particular problems.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Access to patient information was dealt with in accordance with NHS guidelines. The practice follows the guidelines of Caldicott principles, the Data Protection Act (1998) and Freedom of Information Act (2000). This supported staff to

ensure that only appropriate and secure information sharing took place when appropriate to do so and that information would not be given to any other bodies without first gaining the patient's consent.

All staff completed mandatory training which included; information governance (IG) and confidentiality training.

Consent to care and treatment

We found there was an appropriate consent policy and staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. GPs, practice manager and nurses we spoke with confirmed that they had received training in the Deprivation of Liberty Standards (DoLS). Staff demonstrated a clear understanding of DoLS and the role and responsibility of a GP in relation to patients subject to this safeguard. The practice maintained a register of all patients on DoLs Safeguards and we saw evidence these were reviewed at timely intervals with all staff concerned in their care.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). The practice were working with other agencies to look at ways to address issues relating to young adults being deemed competent under the Gillick guidelines to consent to their own treatment and wellbeing but their parents as their guardians still having access to their full electronic records. This was centered around family planning decisions which the parent may not be aware of. At present young people requiring contraceptive services who were under 16 years of age would be supported to include parents in their decisions where possible and if this was not possible they would be supported to attend the local family planning clinic to maintain their confidentiality.

The practice were working with nursing and care homes in the local area to allow specific professional from their services to access the GP electronic notes for patients registered with the practice. This would support the on-going care of these patients and ensure care followed the recognised care plan developed for the patient.

The practice carried minor surgical procedures, vasectomies and insertion of intra-uterine devices (coils). For these procedures, a patient's verbal consent was documented in the electronic patient notes and this was supported by a signed paper consent form which was scanned directly into the patient's record.

The 2015 national GP patient survey indicated 81.2% of people at the practice said the last GP they saw or spoke to was good or very good at explaining tests and treatments, 88.3% said the last GP they saw or spoke to was good or very good at giving them enough time and 92% had confidence and trust in the last GP they saw or spoke to.

Staff informed us they had access to interpreter translation services for patients who needed it. There was guidance about using interpreter services and contact details available for staff to use. The practice staff also had access to a loop system to ensure effective communication with patients who were profoundly deaf. The practice also had pictorial information which could be used with patients who had learning disabilities' to ensure they understood what had been discussed with them.

Health promotion and prevention

All new patients were offered a consultation and health check with the nurse or health care assistant. This included discussions about their environment, family life, carer status, mental health and physical wellbeing as well as checks on blood pressure, smoking, diet and alcohol and drug dependency if appropriate.

The practice placed a strong emphasis on health promotion by having a variety of patient information available to help patients manage and improve their health.

The practice nurses held a variety of clinics including a weekly baby clinic and for specific problems and general health checks. For patients with long term conditions such as diabetes and asthma the practice provided regularly clinics. Appointments were provided to patients at times suitable to their needs.

The practice also offered NHS Health Checks to all its patients aged over 40. The practice offered a full range of

Outstanding ☆

Are services effective?

(for example, treatment is effective)

immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Performance from 2013 to 2014 for children's immunisations was slightly below average for the CCG for all ages up to and including pre-school immunisations.

The practice identified patients who needed on-going support with their health. The practice kept up to date disease registers for patients with long term conditions such as diabetes, asthma and chronic heart disease, which were used to arrange annual health reviews. The practice also kept registers of vulnerable patients such as those with mental health needs and learning disabilities and used these to plan annual health checks.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy.

Staff we spoke with were aware of the importance of providing patients with privacy and of the importance of confidentiality. The computers at reception were shielded from view for confidentiality and staff took patient phone calls in a location away from the main reception.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. There were privacy curtains for use during physical and intimate examinations and a chaperone service was available. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Staff and patients informed us they were aware there was an interview room available if patients or family members requested a private discussion.

We received 24 completed CQC comment cards. All except one comment card were complimentary about the service they received from reception, nursing staff and GPs. We spoke with 13 patients. They all spoke positively about the GPs and nurses working at the practice.

The results of the National GP Patient Survey published in January 2015 demonstrated 84.2% of respondents stating the last nurse they saw or spoke to was good at giving them enough time (CCG average 79.9%); 81% of respondents said the last nurse they saw or spoke to was good at explaining tests and treatments (CCG average 77.8%) and 92% of respondents said they had confidence in the GP and 90.2% in the nurse they last saw (CCG average 86.2%).

The patient electronic recording system included flags on patient records to alert staff to patient needs that might require particular sensitivity. For example, where a patient had a learning disability or was on the child protection register/ looked after child.

The practice offered patients a chaperone prior to any examination or procedure. Information on the chaperone service was seen displayed in the reception area and all treatment and consultation rooms.

The practice had carried out its own patient survey in 2015 to ensure patients were aware of changes that had been made at the practice and posted the results of this on their website. Only 31 patients completed the survey from the practice population. It had been designed to ensure patients were aware of the new processes such as 'Talk and Treat' and electronic prescription services. The result varied so the patient advisor was planning further awareness sessions with a social base for example a tea dance to try to raise awareness and also to reach patients who did not have access to the intranet.

The practice had introduced 'Patient Friends' who were available throughout the day to review and discuss any problems from the patient's perspective and use their knowledge of the practice to find a way of resolving issues quickly. As a result of this service there was a high number of complaints recorded but very few required further investigation once they had been discussed with the patients fully. Patients we spoke with were aware of this service however none had had cause to use it.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey showed that 81.2% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments and 92% said they confidence and trust in the last GP they saw or spoke to and 88.9% the last GP they saw or spoke to was good at listening to them.

Patients we spoke with told us that health issues were discussed with them, treatments were explained, they felt listened to and they felt involved in decision making about the care and treatment they received. Patient feedback we received indicated they felt listened to and supported.

GPs confirmed that all patients over 75 years had a named GP. An electronic coding system maintained registers of patients with particular conditions or vulnerabilities, for example, diabetes, mental health issues and learning disabilities.

The practice participated in the avoidance of unplanned admissions scheme and worked closely with residential or nursing care environments where they had registered patients. All their patients living in these care homes had care plans in place, which were regularly reviewed.

The practice held a register of patients who were subject to DoLS and where possible they involved care/residential home staff, family and relatives in the care of these patients to ensure the patients personal wishes were fully addressed.

Good

Are services caring?

The practice had redesigned their referral form to allow patients to self-refer with support from the GP to the Improving Access to Psychological Therapies (IAPT) team. This allowed the patients to highlight the care they felt they needed from the IAPT team and ensured they were fully informed about their condition.

Patient/carer support to cope emotionally with care and treatment

There were health promotion and prevention advice leaflets available in the waiting rooms for the practice including information on strokes and immunisations.

Detailed information was also available on the practice's website and practice leaflet.

The practice nurses held a variety of clinics for specific problems and general health checks. The health care assistant, supported by a GP and the practice nurse ran some clinics. Comments and feedback praised in particular the nurse and health care assistant.

Information for carers was available on the 'care wall' in the reception area. The practice maintained a register of patients who were carers and offered them annual health checks. Practice staff told us it was sometimes difficult to maintain a full register of carers as some patients would not class themselves as carers if they were looking after their spouse or parent they thought this was the expectation. Support and advice was offered as appropriate to this group of patients.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice held information and registers about the prevalence of specific diseases within their patient population. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions and mental health conditions.

Patients with dementia, learning disabilities and enduring mental health conditions were reviewed annually. They were encouraged to bring carers with them to these reviews. The practice had implemented the 'named GP' for patients over 75 to support continuity of care. The practice was proactive in contacting patients who failed to attend vaccination and screening programmes.

All their registered patients (2% of patient population) living in the local residential and nursing care homes within their catchment area had their healthcare needs reviewed and assessed by a GP and a care plan recorded. The care plan template had been adapted by the practice to focus holistically on the needs of the patient so that a more comprehensive picture of the patient and their needs was recorded. In addition, we heard that the close working with staff in in some of the local nursing and residential care home had promoted better working relationships. This had resulted in the practice undertaking training with the care home staff so that they were better able to meet the changing needs of the patients living in the care home. The practice had carried out a multi-disciplinary review of all patients in residential and care home settings who were over 82years of age, a total of 37 patients. These patients had had their complete care reviewed including a medicine review to ensure their care was meeting their changing needs.

The practice worked proactively to support both staff and patients in managing and supporting people with mental health and personality disorders. For example reception staff had undergone training with the local Personality Disorder Team to allow them to effectively deal with patients who suffered with personality disorder conditions. This had changed the way the practice now dealt with patients suffering from this condition. It included using diffusion techniques to talk to the patient and to calm them down. As a result of this training the practice could demonstrate where this process had been effective in reducing attendance at A&E and at the practice.

The practice had redesigned the referral form to allow patients to self-refer to the Improving Access to Psychological Therapies (IAPT) team. This had resulted in an increase use of the service. Further the practice was proactive in supporting patients who required support under the Mental Capacity Act and were subject to Deprivation of Liberty Standards (DoLS) safeguarding plan. They could demonstrate their involvement of Independent Mental Capacity Advocates for their patients.

The practice held an up to date register of all patients within the practice who had learning disabilities (LD) Their care was reconciled and reviewed annually with the local LD team. The practice used pictorial leaflets to support understanding with this group of patients.

The practice was currently training patients in the use of an automated electronic defibrillator.

Tackling inequity and promoting equality

Action had been taken to remove barriers to accessing the services of the practice. The practice had taken into account the differing needs of people by planning and providing care and treatment service that was individualised and responsive to individual need and circumstances.

The practice had systems in place to ensure people experiencing poor mental health had received an annual physical health check. The practice took all reasonable measures to ensure high quality of mental health care was available to patients within the limitations of the local service.

The practice was the only practice in the CCG area to take patients who had been removed from other practices due to violence or aggressive tendencies. These 14 patients were initially seen at the local police station accompanied by the local police. They were moved to being seen at the Sandy Lane practice when they were deemed not to be at risk of causing disruption to other services. Staff at the

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

practices had received training to assist them to deal with violent and aggressive patients and had access to panic alarms if they felt they or other patients were at risk of harm.

The practice also had a small number of travellers registered with the practice who accessed their services on a regular basis. Homeless patients used the practice address to ensure they could access support for their on-going needs.

Staff had undergone training in managing patients with personality disorders and staff were able to discuss with us times when they had used the technique's in the training to support patients at the practice.

The practice offered three surgeries at three different addresses, two in Skelmersdale and one in Ormskirk. We visited the surgery at Sandy Lane Health Centre Skelmerdale and Railway Road Ormskirk. Both surgery locations provided disabled access in the reception and waiting areas, as well as to the consulting and treatment rooms. Sandy Lane provided ground floor access to treatment and consultation rooms. The surgery on Railway Road in Ormskirk had recently been refurbished and provided elevator access into the building and to the first floor treatment and consultation rooms. Both surgeries offered patient suitable sized and appropriate waiting areas. Baby changing and disabled toilet facilities were available and induction hearing loops were in place at both locations we visited.

The practice analysed its activity and monitored patient population groups. They had tailored services and support around the practice populations needs and provided a good service to all patient population groups. Staff told us that they had access to translation service (language line) if needed.

Access to the service

Information about access to appointments was available via the practice information leaflet and on the practice web site.

The practice phone line was open 8am - to 6.30 pm Monday to Fridays except Wednesday when they close at 1pm but an inhouse emergency line remains open until 6.30pm. Appointments are offered between 8.30am and 6pm every day except Wednesday when they offer late surgeries at one site until 20.30. They also held seasonal Flu vaccination clinics at certain times of the year. Patients requiring a GP outside of normal working hours are advised to contact an external out of hour's service provider Out Of Hours West Lancashire C.I.C (OWLs)

Appointments were tailored to meet the needs of patients, for example those with long term conditions and those with learning disabilities were given longer appointments. Home visits were made to care homes, older patients and those vulnerable housebound patients.

Patients ringing the practice on the day were triaged using a 'talk and treat' service, this service involved the receptionist taking a note of the issues affecting the patient. This was then allocated to a GP who rang the patient and discussed their needs and either offered an alternative solution or asked the patient to attend the surgery to be seen by one of the clinical staff. Patients were allocated to the most appropriate member of the clinical team to deal with their need. Some patients we spoke with gave us negative comments regarding this process as they felt they would be seen by the GP who triaged them on the phone however all patients said they received treatment appropriate to their needs.

The patient advocate who co-ordinated the PPG activity, had recently audited the 'did not attend' (DNA) statistics from one week in May 2015 which demonstrated 76 from 591 consultations both 'talk and treat' and face to face did not take place. This equated to 13% of the available appointments being wasted which in turn was 19 hours of clinical time not used to its full advantage. This information was to be shared with staff and the patient participation group and suggestion sought to assist in this problem. (Talk and treat DNAs were when the GP rang the patient back and there was no answer.)

Practice statistics demonstrated 10% (1167) of the practices patients accessed their website to book appointments with 516 of these patients accessing their medical records. GPs told us they had had to adapt the way they made entries into patient notes to ensure they were made in plain English and did not use medical jargon to ensure patients could understand their entries.

Listening and learning from concerns and complaints

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

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.

We reviewed how the practice managed complaints within the last 12 months. The practice had introduced 'Patient Friends' who were available throughout the day to review and discuss any problems from the patient's perspective and use their knowledge of the practice to find a way of resolving issues quickly. This had impacted positively on the number of formal complaints received by the practice. Records were available of each of the issues dealt with by a patient friend.

Investigations into complaints were seen to address the original issues raised and action was taken to rectify problems. We saw that information was available to help patients understand the complaints system in the form of a summary leaflet and on the practice web site and was part of the practice leaflet.

The staff we spoke with were very clear about the complaints procedures and how to direct patients to the Patient Friend in the first instance to try and resolve a patent's concern quickly. Staff told us that if a complaint involved them then they were involved in the investigation, informed of the outcome of the investigation and if required supported to change or improved their performance.

Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had needed to make a complaint about the practice

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice had a clear vision to improve services and outcomes for patients. Staff we spoke with were eager and enthusiastic to help develop and improve the service. Staff were able to articulate the vision and values of the practice. The GP partners demonstrated enthusiasm and commitment in their discussions with the team during the inspection and had a detailed insight into the different needs and vulnerabilities of their local communities. It was clear they shared this enthusiasm and commitment with all the staff and that they also had this as their ethos. The philosophy of the practice was evident in all our conversations with practice staff.

All staff were clear on their roles and responsibilities and each strived to offer a friendly, caring good quality service that was accessible to all patients.

There was an established leadership structure with clear allocation of responsibilities amongst the GPs, practice manager and the practice staff. We saw evidence that showed the GPs met with the Clinical Commissioning Group (CCG) on a regular basis to discuss current performance issues and how to adapt the service to meet the demands of local people.

All staff we spoke with demonstrated a commitment and enthusiasm and were engaged in providing a high quality service. The partner GPs shared their vision of providing holistic quality services to patients.

The practice actively used SKYPE when staff could not attend meetings due to workload at other practices. Staff told us this assisted them to stay up to date and join the meetings when off site. This was used primarily by practice staff at other sites as other health professionals did not always have access to facilities to support SKYPE.

Governance arrangements

The practice had policies and procedures in place to govern activity and these were available to staff on the computer shared drive. Policies and procedures we viewed were dated and reviewed appropriately and were up to date. Staff confirmed they had read them and were aware of how to access them. Staff could describe in detail some of the policies that governed how they worked for example the safeguarding children's policy and procedures.

There was a clear organisational and leadership structure with named members of staff in lead roles. We spoke with staff of varying roles and they were all clear about their own roles and responsibilities. They all told us there was a friendly, open culture within the practice and they now felt very much part of a team. They all felt valued, well supported and knew who to go to in the practice with any concerns. They felt any concerns raised would be dealt with appropriately.

Staff we spoke with were motivated and wanted to be part of improving the service they provided.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed the practice performed well when compared with other practices for the local clinical commissioning group and the England average in 2013/14. The practice achieved 100% of QoF points available.

Clinical audits were undertaken by the GPs and nurse throughout the year to audit their performance and change practice as required for the benefit of patients they supported. One example was medication reviews for patients currently on the heart failure register were investigated to ensure their medication and care plan was effectively managing their condition.

The practice had arrangements in place for identifying and managing risks. However monitoring of general workplace risk assessment could be developed further by fully documenting checks undertaken by staff on a daily and weekly basis. Some environmental risk assessments were outstanding following recent refurbishment of the Railway Road location but the practice manager assured us these would be addressed as soon as possible.

Leadership, openness and transparency

There was a well-established clearly identified management structure with clear lines of responsibility. We spoke to staff with differing roles within the service and they were clear about the lines of accountability and leadership. The senior staff demonstrated a holistic model of leadership with everyone working towards the same goals, the whole team worked effectively under the leadership of the senior team.

Staff felt well supported in their role. They felt confident in the senior team's ability to deal with any issues, including

Are services well-led?

Outstanding ☆

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

serious incidents and concerns regarding clinical practice. All the staff we spoke with told us they felt they were valued and their views about how to develop the service acted upon.

The practice had a protocol for whistleblowing and staff we spoke with were aware of what to do if they had to raise any concerns. The practice had identified the importance of having an open culture and staff were encouraged to report and share information in order to improve the services provided. Staff we spoke with thought the culture within the practice was open and honest.

Staff told us where they highlighted issues they were listened to and a solution was agreed as a team. They highlighted they felt moving around the three practice sites for half day sessions was not effective and as a result they now spent a full day at the sites.

The practice held a number of various meetings at regular intervals that were documented. These included clinical, administrative, organisational, managerial and business meetings. Examples of various meeting minutes demonstrated information exchange, improvements to service, practice developments and learning from complaints and significant events.

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

The practice investigated and responded to complaints in a timely manner, and records indicated that complainants were satisfied with the outcomes. They were discussed at staff meetings and were used to ensure staff learned from the issues raised.

Results of surveys, significant events and complaints were discussed at clinical and staff meetings. Patients told us that the practice was patient centred and staff were happy to have patients involved and they could express their opinions at any time to any member of staff and were confident they would be listened to.

There was an active Patient Participation Group (PPG) which had a good relationship with the practice. They felt listened to and valued with the practice acting on suggestions put forward by the PPG where appropriate.

The practice reception staff and patient friends encouraged all patients attending the practice to complete the new Friends and Family Test as a method of gaining patients feedback. A patient friend was available throughout the day to assist patients in completion of their survey forms if required.

Management lead through learning and improvement

The practice worked well together as a team and supported each other as required.

GPs were all involved in revalidation, appraisal schemes and continuing professional development. We saw that staff were up to date with annual appraisals which included looking at their performance and development needs. Staff told us appraisals were useful and provided an opportunity to share their views and opinions about the practice.

The practice had an induction programme for new staff and a rolling programme of mandatory training was in place for all staff. Staff undertook a wide range of training relevant to their role and responsibilities relevant training. Records of staff training and copies of training certificates were available.

Staff told us they had good access to training and were well supported to undertake further development in relation to their role. The practice had training and development half days each month. The practice was a GP training practice although trainees were currently placed with the practice.

The practice had completed reviews of significant events, complaints and other incidents and shared the learning from these with staff at meetings to ensure the practice improved outcomes for patients.