Beacon 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?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 6 October 2014 as part of our new comprehensive inspection programme.

The overall rating for this practice is requiring improvement. We found the practice to be good in the effective and caring domains and required improvement in the safe, responsive and well-led domains. We found the practice required improvement in the care they provided to the population groups of older people, people with long term conditions, working age people, people experiencing poor mental health and people in vulnerable circumstances.

.Our key findings were as follows:

- The practice had started to put systems in place to provide a better service for older people, those with long term conditions and those with learning disabilities. These systems had not yet had the time to be embedded in order to judge their impact.
- 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. The practice had been working with the Clinical Commissioning Group and Patient Participation Group (PPG) to address this issue.
- The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice.
- Evidence we reviewed demonstrated that most patients were satisfied with how they were treated and that this was with compassion, dignity and respect. It also demonstrated that the GPs were good at listening to patients and gave them enough time.

Summary of findings

- The practice had gone through a period of change in respect of staffing which had an impact on staff morale. It was clear from discussions with staff that morale had improved and they now felt valued and well supported.

There were areas of practice where Beacon Medical Practice needed to make improvements.

We have asked the practice to take action on three issues where we found that improvements were needed. The provider was in breach of the regulation related to assessing and monitoring the quality of service provision.

Importantly, the provider must:

- Review the infection control action plan and make it more robust with respect to timescales. It should also reflect the need for repair or replacement of equipment to ensure infection prevention and control. Staff should be made aware of relevant outcomes of the infection control audit.
- Have a system in place to audit the quality of data added to medical records and assess the appropriateness of a non clinical staff member having responsibility for assessing some incoming clinical information.
- Have a system in place to ensure that learning from incidents and complaints is identified and disseminated to staff appropriately and widely enough.

Additionally the provider should:

- Ensure that all staff are aware of who holds lead roles within the practice and the responsibilities of those roles.
- Review the length of appointment slots to ensure they meet the needs of patients.

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 requiring improvement for safe as there are areas where improvements should be made. Staff understood their responsibilities to raise concerns, and report incidents and near misses. However, when things went wrong it was not clear if lessons learnt were communicated widely enough to support improvement. Risks to patients who used services were assessed but systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. There was a process in place to deal with incoming communications from secondary care. However there was no system in place to audit the quality of data added to medical records and assess the appropriateness of a non clinical staff member having responsibility for assessing some incoming clinical information.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. NICE guidance is referenced and used routinely. People's needs are assessed and care is planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health. Staff have received training appropriate to their roles and further training needs have been identified and planned. The practice can identify all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Data from the most recent patient survey carried out by the practice showed patients rated the practice highly in several aspects of care. Patients said 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 also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requiring improvement for responsive as there are areas where improvements should be made. Although the practice have reviewed the needs of their local population it had not yet been able to put in place a plan to secure service improvements for all of the areas identified. Patient feedback reported that access

Summary of findings

to a named doctor and continuity of care was not always available quickly although urgent appointments were usually available the same day. The practice was equipped to treat patients and meet their needs. Accessible information was provided to help patients understand the complaints system.

Are services well-led?

Requires improvement

The practice is rated as requiring improvement for well-led. The practice had a vision and a strategy to deliver this, however not all staff were aware of this and their responsibilities in relation to it. There was a leadership structure documented and most staff felt supported by management but at times were unclear of whom to go to with issues. The practice had a number of policies and procedures to govern activity, however some of these were overdue a review. The practice proactively sought feedback from patients and had an active patient participation group (PPG). All staff had received inductions and staff had received regular performance reviews and attended some staff meetings. Issues raised by staff at meetings such as not considering the length of some appointment times to be enough had not been acted upon.

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

Requires improvement

The practice is rated as requires improvement for the care of older people. Nationally reported data showed the practice had good outcomes for most conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in Facilitating Timely Diagnosis and Support for People with Dementia and Avoiding Unplanned Admissions and Proactive Case Management.

The practice was responsive to the needs of older people, there was a housebound register and home visits were available and rapid access appointments for those with enhanced needs. However patients found difficulty with access to appointments and the practice had started to take steps to address the issue but their actions had not yet been fully implemented.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. The most vulnerable of patients with long term conditions had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Patients found difficulty with access to appointments and the practice had started to take steps to address the issue but their actions had not yet been fully implemented.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Some appointments were available

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outside of school hours and the premises was suitable for children and babies. We were provided with examples of joint working with midwives and health visitors. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Patients found difficulty with access to appointments and the practice had started to take steps to address the issue but their actions had not yet been fully implemented.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the population group of the working-age population and those recently retired (including 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 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 which reflects the needs for this age group.

Patients found difficulty with access to appointments and the practice had started to take steps to address the issue but their actions had not yet been fully implemented.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the population group of people living in vulnerable circumstances. The practice held a register of patients living vulnerable circumstances including those with learning disabilities. The Practice had signed up to the learning disabilities health check service and had plans in place to invite patients with learning disabilities into the surgery for an assessment of their individual needs but this was not yet in operation.

The practice had started to work with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Most staff knew how to recognise signs of abuse in vulnerable adults and children. Most staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

Patients found difficulty with access to appointments and the practice had started to take steps to address the issue but their actions had not yet been fully implemented.

Summary of findings

People experiencing poor mental health (including people with dementia)

Requires improvement 

The practice is rated as requires improvement for the population group of people experiencing poor mental health (including people with dementia). People experiencing poor mental health were offered an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for people with mental health needs and dementia.

Patients found difficulty with access to appointments and the practice had started to take steps to address the issue but their actions had not yet been fully implemented.

Summary of findings

What people who use the service say

Beacon Medical had carried out a patient survey of 200 patients in February 2014. This showed that 97.5% of patients felt the GP or nurse they last saw listened to them. In comparison results from the national GP NHS patient survey regarding the practice which was carried out in 2012 – 2013, showed that 73% of respondents said the last GP they saw or spoke to was good at listening to them. The national survey also reflected that 73.7% of patients would recommend the practice to others. This figure was below the national average of 79.9%.

Patients we spoke with on the day of our visit told us they were happy with the care they received at the practice. However many told us they found difficulty in making appointments.

We received eight comment cards on the day of our inspection. Most of the comments were positive. Patients felt well looked after and described staff as wonderful and going the extra mile. We met with two members of the patient participation group (PPG). The PPG is a group of patients who highlight patient concerns and needs and work with the practice to drive improvement within the service. The PPG members told us they had worked with the practice to address the challenges to the practice and patients presented by the large number of temporary residents who register with the practice.

Areas for improvement

Action the service MUST take to improve

- The practice must review the infection control action plan and make it more robust with respect to timescales. It should also reflect the need for repair or replacement of equipment to ensure infection prevention and control. Staff should be made aware of relevant outcomes of the infection control audit.
- The practice must have a system in place to audit the quality of data added to medical records and assess the appropriateness of a non clinical staff member having responsibility for assessing some incoming clinical information.
- There must be a system in place to ensure that learning from incidents and complaints is identified and disseminated to staff appropriately and widely enough.

Action the service SHOULD take to improve

- The practice should ensure that all staff are aware of who holds lead roles within the practice and the responsibilities of those roles.
- Length of some appointment times should be reviewed following concerns raised by staff that in most cases five minutes was not long enough to carry out blood tests.

Beacon Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and the team included a GP, a GP practice manager, another CQC inspector, a CQC regional head of general practice and an Expert by Experience. An Expert by Experience is a person who has had experience of using this type of service and helped us to capture the views and experiences of patients.

Background to Beacon Medical Practice

Beacon Medical Practice is a GP practice which provides a range of primary medical services to around 23,000 patients from a main surgery in Skegness and branch surgeries in Ingoldmells and Chapel-St-Leonards on the east coast of Lincolnshire. Their services are commissioned by Lincolnshire East Clinical Commissioning Group (CCG). The service is provided by nine GP partners, two salaried GPs, six nurse practitioners, seven practice nurses, five health care assistants, a practice pharmacist, two dispensary team leaders and seven dispensers. They are supported by a practice manager, an operations manager, a data manager and a team of reception and administration staff.

Local community health teams support the GPs in provision of maternity and health visitor services.

The practice has one location registered with the Care Quality Commission (CQC). This is at Churchill Avenue, Skegness, Lincolnshire. PE25 2RN. We also visited the two branch surgeries which were Beacon Medical Practice Chapel St Leonards, Ancaster Avenue, Chapel St Leonards, Lincolnshire. PE24 5SL and Beacon Medical Practice Ingoldmells, Skegness Road, Ingoldmells**,** Lincolnshire. PE25 1JL.

The main surgery is in a modern two storey building with a large car park which includes car parking space designated for use by people with a disability near the surgery entrance.

We reviewed information from Lincolnshire East clinical commissioning group (CCG) and Public Health England which showed that the practice population is affected by higher deprivation levels than the average for practices within the CCG and the average for practices in England.

The practice has 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.

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.

This provider had not been inspected before and that was why we included them.

Detailed findings

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
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We also reviewed information we had requested from the practice prior to our visit, as well as information from the public domain including the practice website and NHS choices.

We carried out an announced visit on 6 October 2014. During and subsequent to our visit we spoke with a range of staff including GPs, the management team, nurse practitioners, nurses, healthcare

assistants, reception and administration staff. We also spoke with patients who used the service. We observed how people were being cared for and talked with carers and family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

During our visit we spoke with representatives of the patient participation group to gain their views on the service provided by the practice.

Requires improvement

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.

Staff we spoke with were aware of their responsibilities to identify and report incidents and were able to correctly explain how they would report any incidents or concerns that they may have.

Learning and improvement from safety incidents

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

We looked at records of significant events that had occurred during the last twelve months. Significant events were discussed at a dedicated significant event meeting which occurred 3 monthly to review actions from past significant events. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues which were classed as significant events and were able to give examples of when they had done so.

Incident reporting and analysis forms, guidance and procedures describing the process for reporting significant events were available on the practice intranet. The practice manager showed us a summary of significant events for the last year. This demonstrated how events were managed and monitored. We saw records were completed in a comprehensive and timely manner. We spoke with a member of staff who described the process they had followed to report an error with a blood test result. Although incident records were evidenced as completed there was no learning evidence recorded.

Staff we spoke with told us that national patient safety alerts were disseminated by placing them on the front page of the practice intranet. One member of the nursing staff we spoke with told us they were not aware of how the information was disseminated but always kept themselves up to date and were able to give an example of recent alerts. We were also told that alerts were discussed at relevant practice meetings to ensure all were aware of any relevant to the practice and where action needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies. Contact details were easily accessible.

The practice had a dedicated GP appointed as lead in safeguarding vulnerable adults and children who had been trained to enable them to fulfil this role. However some staff we spoke with were not aware who the lead was but told us they would speak with their line manager if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments.

A chaperone policy was in place and posters promoting the availability of chaperones were visible in the waiting areas. Chaperone training had been undertaken by all nursing staff, including health care assistants. If nursing staff were not available to act as a chaperone. A number of receptionists had also undertaken training and understood their responsibilities when acting as chaperones.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system SystmOne which collated all communications about the patient including scanned copies of communications from hospitals.

We spoke with an administration assistant whose role it was to review incoming correspondence from hospitals. They told us that not all correspondence was seen by a GP as they checked incoming mail and only correspondence such as discharge summaries or hospital letters which stated medication needed to be reviewed would be tasked to a GP to action. We asked the administration assistant what training they had received to enable them to make these decisions and they told us they had received training in medical terminology. One of the GPs told us they had

trained specific administration assistants, which informed them which incoming correspondence needed to be seen by a GP. The staff we spoke with felt the system in place worked well. However the practice did not have systems in place to audit the quality of data added to medical records and the responsibility for actioning some incoming clinical information was held by a non clinical member of staff.

The practice manager told us that children and families living in disadvantaged circumstances, looked after children, children of substance abusing parents and young carers were usually cared for by the team of Health Visitors and supported by the doctors at the Practice. Health Visitors also carried out regular assessments of children's development and early identification of problems in the physical and mental wellbeing of children and young people and referred them into the Practice as required.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff.

Processes were in place to check medicines were within their expiry date and suitable for use. Expired and unwanted medicines were disposed of in line with waste regulations.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. The health care assistant also administered vaccines under directions which had been reviewed and approved in line with national guidance and legal requirements. We saw evidence that nurses had received appropriate training to administer vaccines.

There was a system in place for repeat prescribing which was in line with national guidance. Reception staff had been trained to generate repeat prescriptions. If a medication review was due they would alert the GP who would make a decision as to whether the patient needed to attend the practice for a review and if this was the case the GP would task the reception or administration staff to contact the patient for an appointment. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

Some patients we spoke with on the day of our inspection told us they had ongoing problems with getting repeat prescriptions on time. One patient said they rang to check their prescription was ready before coming to collect it as they were not usually ready on time. We raised this with the practice pharmacist who felt the practice had a timely process for issuing repeat prescriptions. However in light of the concerns raised they told us they would audit and review the process across all three surgeries and would include capturing data regarding patients who contacted the practice to check if their prescription was ready.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and kept securely at all times.

At the dispensing branches the practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. At one of the branch surgeries we found excess stationery and documents in the controlled drug storage cupboard. We pointed out that only the controlled drugs should be stored there and the paperwork was removed immediately.

Practice staff undertook regular audits of controlled drugs. Staff were aware of how to raise concerns around controlled drugs.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. For those prescriptions not signed before they were dispensed they were able to demonstrate there was a process in place to minimise risk.

The practice had standard operating procedures in place which staff were aware of and followed in order to maintain a safe and accurate dispensing process. We looked at 3 of these procedures and found they were all due to have been reviewed in November 2013. The practice pharmacist told

us they had been reviewed but not uploaded onto the practice intranet. Following our visit we were provided with confirmation that the intranet had been updated with the reviewed standard operating procedures.

Members of staff involved in the dispensing process told us they had received appropriate training and regular checks of their competence had been undertaken.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had two leads for infection control who had undertaken training to enable them to provide advice on the practice infection control policy. However some staff members were not aware who the infection control lead was. All staff we spoke with said they had received induction training about infection control specific to their role and there after regular updates. We saw evidence of audits carried out over the last two years and the current audit had improvements identified for action. This included a rolling programme of refurbishment for internal building elements which would ensure that wall and floor surface coverings were impervious and washable. The infection control action plan needed review and did not include equipment for example examination couches that needed to be repaired or replaced to ensure infection prevention and control. Some staff were not aware an infection control audit had taken place at their practice or the outcome of the audit.

The practice manager showed us an infection control policy but when we asked two members of staff where the policy was they showed us a different policy on the practice intranet. We discussed this with the practice manager who told us the policy on the intranet was not up to date and should not have been there. Following our visit the practice manager sent us a revised policy and told us that this had been disseminated to all staff. The policy also covered needle stick injuries and staff were able to describe how they would follow the procedures in the policy to comply with national infection control guidance.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a system for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients. We were told by the maintenance technician that site visits for legionella risk assessments had been booked for the 2 branch surgeries.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment within the last year.

Staffing & Recruitment

Records we looked at contained evidence that recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (formerly the Criminal Records Bureau) Three of the files we looked at did not contain photographic identification. We spoke with the human resources manager who told us that since approximately December 2013 photographic identification had been sought when staff commenced employment. We looked at a file for a newly recruited member of staff and found that this did contain photographic identification. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

The practice manager 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 was enough staff on duty. Unexpected absences were covered by managers but holidays were

planned ahead to maintain an appropriate level of cover. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The lead for each department assessed the skill mix so that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see. and there was a member of staff who held responsibility for health and safety issues.

Staff told us the GPs and advanced clinical practitioners were able to respond to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment including accessing the mental health crisis team for urgent care. Reception staff were trained to recognise distressed patients in the surgery or on the telephone and immediately alert the duty GP. This also applied to advanced clinical nurse practitioners triaging calls. The practice manager told us further training programmes were planned to highlight mental health issues and emergencies to all clinical staff in the practice.

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 staff we asked knew of their location. These included those for the treatment of anaphylaxis and epileptic fits. At the Chapel St Leonards surgery we asked a member of staff to show us the anaphylaxis kit. They showed us a kit in which the contents were outside the expiry date. Another member of staff told us this was an old kit and showed us another kit in which the contents were within their expiry date. They told us the out of date kit should have been disposed of and did so immediately in order to avoid the risk of it being used in error.

A comprehensive business continuity plan was in place to deal with a range of emergencies that may have impacted on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, loss of phone system, loss of access to clinical data and access to the buildings. The document also contained relevant contact details for staff to refer to. For example, contact details of the communications supplier in the event of loss of the phone system.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken. On the day of our inspection there was an unexpected fire alarm at the main surgery and we were able to see that the fire marshals coordinated an effective evacuation of the building.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. We were told that new guidelines were disseminated via email and the implications for the practice's performance and patients were discussed at regular meetings led by the relevant GP lead and required actions agreed. We looked at a number of the templates used by the GPs to assist them in supporting patients. One of the GP partners we spoke with told us how they regularly updated these templates based on new guidance received.

The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. However the GP partners had agreed to lead on training for their clinical area and pass on their knowledge in the management of various chronic conditions to the other GPs and nurse practitioners. Once this training has been completed, the rota for clinicians will incorporate chronic disease clinics where GPs, nurse practitioners and health care assistants would run specific clinics to target patients with long terms conditions in order to deliver proactive monitoring, timely referrals onto specialists, and support the patient and/or carer with coordinated multidisciplinary care pathways.

We asked one of the GP partners about the practice's prescribing performance in an area that had been assessed as lower than expected. The practice were able to describe what actions they had taken to respond to this in order to increase their prescribing levels in line with national guidance.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

GPs we spoke with used national standards for referrals to secondary care and one of the GPs personal assistants we spoke with explained the review system they used in order to ensure that patients who had received an urgent referrals had been seen within two weeks.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with staff 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

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the management team to support the practice to carry out clinical audits.

The practice showed us seven clinical audits that had been undertaken in the last two years. Five of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example the practice had carried out an audit of malignant melanoma related to excision in primary care as a minor surgical procedure. Some of the initial resulting actions were to arrange training in management of skin lesions and referral to the practice minor surgery service and to produce a template on the practice computerised system for practice minor surgery referrals. Other examples of clinical audits included an audit of clopidogrel prescribing to ensure GPs were prescribing in line with NICE guidance and to identify areas of improvement to provide a higher quality of patient care.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example the practice had carried out an audit of the prescribing of an antibiotic and some of the resulting actions were for an alert to be placed on the computer system to remind prescribers to consider alternative antibiotics and a monthly monitoring graph disseminated to prescribers to allow regular review of the impact of the changes that had been made.

Good

Are services effective?

(for example, treatment is effective)

The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, the practice met all the minimum standards for QOF in diabetes. This practice was not an outlier for any QOF (or other national) clinical targets.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. Two patients we spoke with on the day of our inspection told us they had not been reviewed in the last year in relation to their long term condition. The practice manager told us the practice had introduced a new recall system in March 2014. Patients were now sent an invitation to attend the practice for their review in their month of birth. If the patient did not respond to the first invitation, two further attempts would be made to contact the patient.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes comparable to other services in the area.

Effective staffing

Practice staffing included 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. There was a good skill mix amongst the GPs. All doctors 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 every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

Staff we spoke with told us and records we saw confirmed they had received an annual appraisal which identified their learning and development needs. Staff confirmed that the practice provided training as required. For example a nurse practitioner we spoke with told us about the current training programme being undertaken to ensure that all clinical staff received training in all long term conditions to enable the practice to provide dedicated specific long term condition clinics led by a GP and supported by a nurse practitioner.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of adult and childhood vaccines and cervical cytology. Those with extended roles such as seeing patients with long-term conditions such as asthma or diabetes also confirmed they had received appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically, by fax and by post.

The practice was commissioned for the new enhanced service to reduce unplanned admissions to secondary care and had put a process in place to follow up identified patients discharged from hospital. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract).

The practice held multidisciplinary team meetings on a monthly basis to discuss the needs of complex patients such as those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and was a useful means of sharing important information.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

Good

Are services effective?

(for example, treatment is effective)

The practice had systems in place to provide staff with the information they needed. An electronic patient record SystmOne was used by all staff 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.

Consent to care and treatment

We found that some staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. 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.

Clinical staff we spoke with demonstrated an understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health Promotion & Prevention

It was practice policy to offer all new patients registering with the practice a health check with a health care assistant. The GP was informed of all health concerns detected and these were followed-up. GPs were able to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering referral to a smoking cessation service which held sessions in the practice. The practice also offered NHS Health Checks to patients aged 40-75.

Systems were in place to promote current guidance and encourage patients to attend relevant screening programmes, for example at the time of our inspection the practice were promoting chlamydia screening for younger people.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and had signed up to the enhanced service for Learning Disabilities health checks. The practice was in the process of establishing a dedicated clinic in order to invite patients into the surgery for a full assessment of their individual needs. A Learning Disability & Health Liaison Nurse from Lincolnshire Partnership NHS Foundation Trust would attend the surgery once a month to assist with the dedicated clinic and to roll-out training to clinicians at the practice who would then also deliver the service.

Similar mechanisms of identifying at risk groups were used for patients receiving end of life care. These groups were offered further support in line with their needs.

For patients who were aged over 75 or other vulnerable patients an identifier has been added to their electronic record. Should a patient or carer contact the surgery, the identifier would alert staff to facilitate telephone access to a clinician on the same day if required.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance Last year's performance for all immunisations was below average for flu vaccinations in the CCG.

All patients aged 75 years had been informed by letter that they had a named, accountable GP assigned to them who took responsibility for ensuring that all appropriate services were delivered to each of their patients. A system had also been introduced to monitor the identification of patients who turned 75 so a letter could be sent to inform them who their accountable GP was.

In line with NHS England guidance, Lincolnshire East CCG had invested in the care of people aged 75 and over. The Practice outlined how they would focus on improving the quality of service to patients aged 75 and over in order to reduce avoidable admissions into secondary care. The practice had employed a nurse practitioner to lead on the development and on-going monitoring of the health and care of this group of patients supported by clinical and non-clinical teams and was producing a register of 30% of the most vulnerable patients aged over 75 who were not captured in the patient group classed as the most vulnerable 2% of all patients under the enhanced service which related to unplanned admissions to secondary care.

The top 2% of the practices most vulnerable patients had been identified and it was planned that by the end of October 2014 each person on this register would have had a care plan formed by one of the GPs at the practice. When the new nurse practitioner had taken up their post they

Good

Are services effective?

(for example, treatment is effective)

would be tasked with producing individually tailored care plans for those 75 and over, who are not identified on the most vulnerable register. These would be regularly reviewed as agreed with the patient and if appropriate their carer.

From November onwards, any patients with the identifier, who had been discharged from hospital were going to receive a follow-up contact three days after the discharge summary had been received by the practice. Additionally following an unplanned admission or readmittance to hospital or attendance at A&E they would be reviewed.

The practice had a register of patients with mental health illnesses who were invited annually to have a mental health review. This included a mental health and wellbeing assessment where their current home circumstances as well as social and community mental health team support would be recorded as part of their care plan. Physical health was also discussed and checked including blood pressure, height, weight, BMI, smoking status, alcohol intake and lifestyle. A medication review and routine blood tests were carried out annually as part of the review to identify any underlying conditions.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey from 2012-2013 and a survey of 200 patients undertaken by the practice's Patient Participation Group in February 2014. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, results from the practice's own survey showed that 97.5% of patients felt the last GP or nurse they saw was good or satisfactory at listening to them. Data from the national patient survey of 2012-2013 showed the practice was just below average for its satisfaction scores on consultations with doctors and nurses with 73% of practice respondents saying the GP was good at listening to them and 79% saying the GP gave them enough time.

Patients completed CQC comment cards to provide us with feedback on the practice. We received eight completed cards and these were positive about the care they experienced. Patients said they felt that overall the practice offered a good service and staff were friendly, helpful and caring. They said staff treated them with dignity and respect. One patient responded very positively to the care they had received when suffering mental illness and felt GPs had put themselves out to attend to them. Another patient described how the thorough care and concern they had received was particularly important as a wheelchair user. We also spoke with ten patients on the day of our inspection. Nine out of 10 of them 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.

In consulting rooms and treatment rooms curtains were provided so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. There was a system in place to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it was effective in maintaining confidentiality.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists had received training in conflict resolution.

Care planning and involvement in decisions about care and treatment

The patient survey information from 2012-2013 we reviewed showed varied patient responses to questions about their involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed 63% of practice respondents said the GP involved them in care decisions and 72% felt the GP was good at explaining treatment and results. These results were below the national average. On the other hand 80% of patients said the last nurse they saw or spoke to was good at explaining tests and treatments and this was above the national average. In comparison the more recent results from the practice's own satisfaction survey showed that 92% of patients who answered the question said they were sufficiently involved in making decisions about their care.

Eight out of ten 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 feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. The practice website could also be translated into over 80 different languages

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection and the comment cards we received reflected that patients felt

Good

Are services caring?

they had received help to access support services when needed. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also signposted people to a number of support groups and organisations.

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 practice was responsive to people's needs and had 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 practice used the Frailty Index Reporting tool within their patient administration system (SystmOne), which helped doctors detect and prevent unwanted outcomes for patients. This helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities.

The NHS Local Area Team (LAT) and 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 practice meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

The practice manager told us how they had installed a new telephone system in response to the length of time patients had to wait for their call to the practice to be answered and costs to patients being incurred as a result. The new system meant that calls could be automatically distributed to any staff member logged in to the system and to meet demand at peak times more staff across all three sites would be logged in to the system. The practice manager acknowledged some patients still found problems contacting the practice by telephone.

The practice responded to patients needs after delays were reported with patients obtaining their prescriptions relating to smoking cessation, from the surgery. The practice investigated this and implemented a new system using a Nicotine Replacement Therapy (NRT) formulary on the practice computer system. This meant that reception staff and dispensers could safely process the administrative aspects of NRT requests. The practice pharmacist told us that since the implementation of this process there had been no issues raised by patients or healthcare professionals regarding the timeliness of these type of prescription issues.

The practice had agreed to participate in a CCG initiative called 'neighbourhood teams'. The purpose was to create a single team of multi disciplinary professionals working together with patients and carers to better support and manage their health and care needs. The teams would include health and care professionals like social workers, mental health practitioners, GPs, community nurses and therapists.

There had been a number of changes in the practice staff over the past 18 months which had impacted on continuity of care and accessibility to appointments with a GP of choice. However longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one and the practice kept a register of housebound patients

The practice had achieved and implemented the gold standards framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

The practice had acted on suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). Following the annual survey two of the issues identified were appointment availability and the impact of temporary residents on the practice and registered patients. An action plan was produced to tackle these concerns. As a result the practice had employed fourth nurse practitioner and an existing practice nurse had become a nurse practitioner. This provided an extra two clinicians who were able to prescribe and make referrals in order to provide greater appointment availability for patients. Regarding temporary residents the practice had been and continued to raise the issues with stakeholders in an attempt to find a solution to the increased demands placed on the practice and the impact on registered patients.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services.

The practice website could be translated into 80 different languages and the surgeries had access to telephone translation services.

The practice provided equality and diversity training via e-learning.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

The premises at the main surgery were purpose built and the two branch surgeries had been adapted as far as possible to meet the needs of people with disabilities. However during our visit to the Chapel St Leonards surgery we were told that a patient with a walking frame had been assessed and treated by a GP in the communal hallway as they were unable to access the treatment room due to limited access to and around the building. This meant the patient's privacy and dignity were not upheld.

Access to the service

Appointments were available from 8am to 6.30pm on weekdays. The practice also provided extended opening hours with appointments available until 8pm three nights of the week. The appointment system offered a mixture of pre-bookable appointments for patients who wished to see a specific GP which could be made up to 4 weeks in advance. Same-day appointments were also available. There was an online booking system and telephone consultations where appropriate. There was a daily triage system operated by the duty GP to manage requests for same day appointments.

The practice's extended opening hours three days per week was particularly useful to patients with work commitments. This was confirmed by comments received. One patient described how staff always endeavoured to meet their needs around their professional commitments.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

A common theme raised through discussions with staff and the public related to the availability of appointments and the length of time waiting for an appointment. The practice manager described how this was the direct result of a lack of GPs and that this issue was particularly challenging during the summer months when a high number of temporary residents accessed the service. There had been actions taken to recruit more GPs, however they had been unsuccessful. Many patients told us how difficult it was to get an appointment at the practice and how they had raised this as a concern, this remained a problem on the day of our inspection. Patients told us, it was easier to travel and go to reception in person that to use the telephone system and that the easiest way to get an appointment was to join the queue outside the surgery before 8am.

The main surgery was situated on the ground and first floors of the building. Lift access was provided to the first floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

There were a high number of temporary residents who accessed the practice, especially during the spring, summer and autumn. The patients who were registered permanently have raised concerns that they were not treated fairly and that the temporary residents got better access to appointments than they did. The practice manager told us how following their PPGs campaign relating to temporary residents, Public Health Lincolnshire had commissioned an investigation into the subject, which was still in progress. The PPG highlighted the unfairness of funding and appointment problems relating to the population of Skegness increasing fourfold during the peak summer months. Challenges have also arisen as a result of then number of long stay occupants in a number of caravan complexes in the area. The PPG has worked closely with the local authorities in relation to this problem, as well as the CCG and it was unresolved but ongoing at the time of our inspection.

The majority of the practice population were English speaking patients though it could cater for other different languages through translation services.

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 responsible person 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 either in the practice

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

or via the website. This gave clear guidelines to patients as to how to raise a complaint, what they could expect from the practice in response to a complaint and information about support available to make a complaint, including advocacy services. There was also contact details of the Ombudsman for patients if they were not satisfied with the outcome of their complaint to the practice.

Evidence seen from reviewing a range of feedback about the service, including complaint information and supporting operational policies for complaints and whistleblowing, showed the practice responded quickly to issues raised. We looked at the summary of 44 complaints and saw that the complaints had been grouped by type in order to identify trends and outcomes recorded. The outcomes demonstrated that the practice had responded in a timely manner, actions taken were detailed and apologies were given where appropriate.

None of the patients spoken with had ever needed to make a complaint about the practice.

The practice manager told us the information gathered was analysed and lessons learnt were fed back to relevant staff at team meetings. If a new policy or protocol has been implemented as a result of a complaint this would be disseminated via the practice intranet. We were told that conflict resolution training had been booked for front line staff in order to support staff and avoid complaints.

We saw an annual summary of complaints which grouped the complaints into areas such as appointment availability or dispensing errors but it did not identify any themes or learning from the complaints received.

Are services well-led?

Requires improvement

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

Our findings

Vision and Strategy

The practice had been holding 'strategy meetings' and had discussed developing a 2-5 year strategy but this was still in the very early stages. The practice manager was able to describe how the practice was run and the underlying principles; however the vision and values were not clearly defined. The practice manager explained how this was the essential next step to ensure that planning could be focussed and actions measured.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the practice intranet on any computer within the practice. Staff were able to refer us to the relevant policies when asked and knew where to get further information if required. When policies were updated they were emailed to staff as a notification and staff indicated they had been read. There was no system in place to check that the learning had been embedded.

When we asked about the governance structure and how risks were identified and decisions were made this couldn't be clearly articulated. There were a number of different meetings being held during the month and minutes and action points were recorded for some of these. For those meetings where minutes were not recorded it was not possible for others to know the content of the meeting and understand how decisions were made. We saw evidence that there were discussions around performance, quality and risk at meetings, however there was no systematic process for managing any risks identified. Staff were able to describe the purpose of the different meetings they attended but were not able to describe how they fitted into the overall communication and governance structure of the practice. Most staff said the meetings were used to share information and to cascade messages, however some staff told us that they didn't always feel involved in decision making about how the practice was run and that they would have liked to be more involved.

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.

Leadership, openness and transparency

The Practice Manager, had overall management responsibility for Beacon Medical Practice, leading a team of staff, which included a practice pharmacist, operations manager, IT & data quality manager, a human resources officer, a maintenance technician, reception and administration staff.

It was clear from discussions with staff during the day that lead roles had been assigned, however there was no formal system in place to manage this. This carried the risk of causing some confusion, for example staff didn't all know who the lead was for infection control or safeguarding. We spoke with over 20 members of staff and they were all clear of their own roles and responsibilities in the practice and also an understanding of others roles who they worked closely with. The majority told us that they felt valued and well supported within their teams and knew who to go to in the practice with any concerns.

Most of the staff talked about a period of change that the practice had recently gone through and the impact it had on morale. It was clear that morale was starting to improve and the practice manager was able to describe their intentions to continue to address this, they were aware that this was work in progress and that further developing communication within the practice was a high priority.

Practice seeks and acts on feedback from users, public and staff

The practice had an active patient participation group (PPG) who met on a monthly basis; the minutes of the meetings were available on the practice website up until June 2014. The PPG were representative of the local population, with the exception of younger people, the PPG were considering ways that they could further engage youngsters through working in partnership with local schools. Both the PPG and practice manager described a positive working relationship and how they worked together to ensure that patients views were heard and acted on.

The practice had gathered feedback from patients through patient surveys carried out by the Patient Participation Group (PPG), comment cards and complaints received. We saw evidence that the practice had taken some actions to respond to this, for example more nurse practitioners had been employed and there is work planned to run some special clinics for people with long term conditions. The

Are services well-led?

Requires improvement

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

PPG also advertised and promoted an easy-to-follow guide on the different ways patients can book appointments in response to patients' saying that they didn't understand the different ways of getting appointments.

The minutes of the PPG meeting held in May 2014 referred to patients needing to wait a long time for appointments, this problem continues despite the issue being raised within the practice and an action being recorded that patients would be better communicated with if they needed to be kept waiting.

Following a review of nursing provision in 2013 some appointments such as for blood tests had been reduced to five minutes in an attempt to improve the service. Staff had raised their concerns about this as they did not feel it was workable but there had not been any changes made. When we discussed this with the practice manager they said that they would be taking into account the staff feedback on this and the timings would be reviewed.

In 2013 the Practice recruited an Emergency Care Practitioner and through the peak season they were based at the Ingoldmells branch surgery as the majority of temporary residents were located in that area.

The practice had a whistle blowing policy which was available on any computer within the practice, however, staff we spoke with were not able to describe how they would raise any concerns they had.

The practice had gathered feedback from staff generally through staff meetings, appraisals and discussions. One member of staff told us that they had asked for specific training to be given around phlebotomy and this had happened.

Management lead through learning & improvement

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

The practice was a GP training practice but at the time of our visit there were no registrars in place.

The practice had completed reviews of significant events and other incidents including complaints and shared learning with some staff via team meetings or on a one to one basis to facilitate improved outcomes for patients.

The GPs were able to describe the learning from any clinical events, however this was not evident from speaking to other clinical staff.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **Service users, and others who may be at risk, were not protected against the risks of inappropriate or unsafe care and treatment because effective systems were not in place to regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity.**

This section is primarily information for the provider

Enforcement 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.