Beacon Primary Care

Quality Report

Sandy Lane Health Centre
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Skelmersdale
Lancashire
WN8 8LA
Tel: 01695 5736000
Website: www.beaconprimarycare.org.uk

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as requires improvement overall. (Previous inspection 26/05/2015 – Outstanding)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Requires Improvement

Are services responsive? – Requires Improvement

Are services well-led? – Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Requires Improvement

People with long-term conditions –Requires Improvement

Families, children and young people – Requires Improvement

Working age people (including those retired and students) – Requires Improvement

People whose circumstances may make them vulnerable – Requires Improvement

People experiencing poor mental health (including people with dementia) – Requires Improvement

We carried out an announced comprehensive inspection at Beacon Primary Care on 15 January 2018. This inspection was carried out under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider was 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.

At this inspection we found:

- There were established and comprehensive systems in place to manage and monitor risks to patients, staff and visitors. This included risks to the building, environment, medicines management, staffing, equipment and a range of emergencies that might affect operation of the practice.
- The practice routinely reviewed the quality, effectiveness and appropriateness of the care it provided. Care and treatment were delivered according to evidence-based guidelines.We saw that a wide range of clinical audit was carried out.

Summary of findings

- There was a formal system to audit clinical decision making and non-medical prescribing for clinicians working in advanced roles and staff felt well supported.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Staff understood their role in safeguarding vulnerable patients. They were fully aware they should go to the lead GP for safeguarding for further guidance. The GP held monthly meetings with health visitors, school nurses and practice staff. There was a regularly updated spreadsheet of all patients known to be at risk.
- The practice reviewed the needs of their local population and had initiated positive service improvements for patients. They implemented suggestions for improvements as a consequence of feedback from the patient participation group.
- There was evidence that innovation and service improvement was a priority among staff and leaders with evidence of strong team working and commitment to personal and professional development.
- The National GP patient survey results were generally below the CCG and national averages. It was unclear how the practice had responded to this.

We saw five areas of outstanding practice :-

- The practice had completed a wide ranging programme of clinical audits over the last 12 months which had resulted in improved patient outcomes. For example there were 17 care homes in the locality and all were provided with regular telephone advice and support. Weekly ward rounds were undertaken in seven of the homes which covered 161 of 198 patients registered in care homes. The practice pharmacist also visited these homes regularly to review patients' medications, especially after discharge from hospital. Practice staff had developed an enhanced health framework for patients in care homes including access to telemedicine advice. Audit activity demonstrated that all of these initiatives had reduced the high demand for individual visits.
- 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 had taken part in the Routine Enquiry into Adverse Childhood experience (REACH) feasibility project which had been carried out to investigate long term physical and mental health problems in a primary care setting. As a result staff had been trained to identify and offer support where appropriate.
- The practice had developed a Well Pathway for patients with dementia covering prevention, diagnosis, living with and supporting people and dying well, with hypertext links to local and national support organisations.
- The practice was a member of the North West Alliance Primary Care Home which aimed to improve services in communities and offer patients opportunities to maximise their health. They worked together with partner organisations in the voluntary, social care and faith sectors.

The areas where the provider **should** make improvements are:

- All GPs should monitor the expiry dates of medicines kept in their medical bags.
- Continue to identify and support patients who are also carers

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

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

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- GPs should monitor the expiry dates of medicines kept in their medical bags.
- Continue to identify and support patients who are also carers

Outstanding practice

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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 a GP specialist adviser

Background to Beacon Primary Care

Beacon Primary Care is located in Skelmersdale, Lancashire. The practice operates across four sites in the local area and patients can access appointments at any site of their preference. We inspected two of the four sites, the main site at Sandy Lane Health Centre and the site at North Meols Health Centre, Church Road situated in Banks, Southport. There are additional sites at Railway Road Ormskirk and Hillside Health Centre, Skelmersdale.

The link to the practice website is www.beaconprimarycare.org.uk.

There are 16307 patients on the practice list. The majority of patients are white British with a lower than average number of people over the age of 65, and a higher than average number of people under the age of 18 years. The practice is in the fourth least deprived decile. Level one represents the highest levels of deprivation and level ten the lowest.

The practice is part of the West Lancashire Clinical Commissioning Group (CCG). Services are provided under a general medical service (GMS) contract with NHS England. Sandy Lane Health Centre is housed in a two storey property owned by NHS Property Services and offers access and facilities for disabled patients and visitors. There are two additional GP practices which share the building. North Meols Health Centre merged with Beacon Primary Care in July 2016 and a service has been provided to students at Edge Hill University since September 2016. Beacon Primary Care has been caretaking the service at Viran Medical Centre now located in Tarleton since July 2017.

The practice offers appointments between 8am and 6.30pm every day except Wednesday when they also offer a late surgery until 8.30pm at Railway Road. The North Meols site also offers appointments until 8pm on Mondays. The practice offers appointments between 8am and 6.30pm every day except Wednesday when they also offer a late surgery until 8.30pm. 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).

Beacon Primary Care is part of the North West Alliance (NWA) which includes two practices in Southport and Formby Clinical Commissioning Group.

The practice has two GP partners, one female and one male. There are also four female and one male salaried GPs including a GP returner doctor. There are six female practice nurses, five nurse practitioners, four health care assistants, four phlebotomists, a clinical pharmacist, a practice manager, two deputy practice managers and a team of reception and administration staff. These staff work across all four sites to provide comprehensive cover at all times.

The practice offers placements to medical students, GPs in training, physician associate students and student nurses.

Good

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training.
- The practice had well established and comprehensive systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. Staff were fully aware they should go to the lead GP for safeguarding for further guidance. The GP held monthly clinical meetings at which safeguarding was a standard item and health visitors and school nurses were invited as appropriate to share information. The administrative team reviewed all correspondence relating to patients under the age of 18 years and following an established workflow process sent any concerns to the lead GP for review and any further action. An electronic safeguarding folder was used to store a regularly updated spreadsheet of all patients known to the practice and social services. A vulnerable patient template was used to identify and record details of any patient at risk. A safeguarding audit had been done to monitor patients who were vulnerable including those subject to Deprivation Of Liberty Safeguards (DOLS).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- The head of nursing was the infection prevention and control (IPC) lead and we saw that the practice looked clean and hygienic and regular "walkarounds" were done to monitor conditions. On the day of the inspection there was no evidence that IPC audits had been carried out at any of the sites and at North Meols Medical Centre we saw that three consultation rooms used to administer vaccinations and carry out cervical smears were carpeted. Staff were unaware of when the carpets were last cleaned. Within two working days of the inspection IPC audits had been completed, with review dates to achieve compliance within three months. This also identified action in respect of the carpeted areas.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste. We saw evidence of a range of health and safety risk assessments such as fire and legionella which were reviewed annually.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care

and treatment was available to relevant staff in an accessible way. A proactive care template had been introduced to ensure safe care for patients who were vulnerable or frail.

- The practice had an established workflow process including systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There were agreements in place to share patient information with the local hospital, community health services and the out-of-hours service.
- Referral letters included all of the necessary information and urgent referrals were made in a timely fashion and monitored to ensure that patient appointments were made.
- The nursing staff used a monitoring system to ensure patients discharged from hospital were followed up and worked jointly with the practice pharmacist and medicines management lead to ensure patients received the medicines prescribed.

Safe and appropriate use of medicines

The practice had generally reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines were monitored by the practice pharmacist, including vaccines, medical gases, emergency medicines and equipment. The practice had appropriate equipment to respond to any emergencies including emergency medicines in each clinical room and in reception. The practice kept prescription stationery securely and monitored its use. Staff worked within a prescribing hub to process requests from patients for repeat prescriptions, process new prescriptions from clinicians, and give advice in line with legal requirements and current national guidance.
- We saw that one salaried GP had out of date medicines in their medical bag. The medicines management team did not check doctors' bags which were the doctors' own personal responsibility. However it was the role of the medicines management team to provide all clinicians with emergency kits and to log the expiry dates of each bag. The individual GP in question had not collected the kit despite being notified of its availability. This was an individual, rather than a system failing. The out of date medications in the GPs bag were removed on the day of the inspection and a replacement supply was provided.
- Alerts were received by the GPs and the pharmacist who reviewed them and action was disseminated to all staff as required. This was confirmed at clinical meetings which were minuted and were available to all staff.
- The practice had audited prescribing of drugs used for inflammatory disease and anti- depressants to ensure regular reviews were carried out. Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines. Personal emergency kits were overseen by the medicines management team.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a comprehensive system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were systems for reviewing and investigating when things went wrong. The practice learned and shared lessons at practice meetings, identified themes and took action to improve safety in the practice. We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again. For example, when a pregnant member of staff became very anxious after sustaining a minor needle stick injury she was supported, provided with counselling, advice

taken from occupational health and she was offered blood tests which were clear. Staff reviewed the incident together, additional personal protective equipment was sourced and the protocol for management of sharps was updated.

- The practice learned from external safety events as well as patient and medicine safety alerts. Warnings issued by the Medicines and Healthcare products Regulation Agency (MHRA) were checked by the pharmacist who took necessary action to identify any patients at risk.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice, and all of the population groups, as good for providing effective services.

Effective needs assessment, care and treatment

The practice had effective systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- Prescribing data for the practice for 01/07/2016 to 30/06/2017 showed that the average daily quantity of Hypnotics prescribed per Specific Therapeutic group was comparable to local and national averages; 1.1, compared to 0.8 locally and 0.9 nationally. (This data is used nationally to analyse practice prescribing and Hypnotics are drugs primarily used to induce sleep.) The practice provided unvalidated data to indicate the quarterly figures for October-December 2017 for prescribing hypnotics were 0.2 compared to a CCG average of 3.1 in the same period,
- Similar data for the prescribing of antibacterial prescription items showed that practice prescribing was comparable with local and national levels; 0.86 compared to 0.88 locally and 0.98 nationally.The practice provided unvalidated data to demonstrate antibacterial items prescribed for October-December 2017 had reduced to 0.22 compared with 4.28 locally.
- Data for the prescribing of antibacterial prescription items that were Cephalosporins or Quinolones showed that practice prescribing was comparable with local and national levels; 11.7% compared to 9.6% locally and 8.9% nationally. Unvalidated data from the practice showed that Cephalosporins prescribed October-December 2017 were 12.7% compared with 9.6%
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- The duty GP reviewed all blood test results and ensured they were appropriately followed up.
- GPs were clinical leads for specific health conditions such as dermatology, gynaecology, child health and mental health. GPs were supported by members of the nursing team who also had clinical leadership roles for specific areas.

Older people:

- Older patients who were frail or vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication. All the notes of the patients on the frailty register had been reviewed, approximately 265 patients in number.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.Over a 12 month period the practice had carried out 420ofthese checks.
- Where appropriate whole team visiting (including a GP, nurse and pharmacist) allowed increased and targeted contact with the housebound elderly.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- There were 17 care homes in the area and all were provided with regular telephone advice and support. Weekly ward rounds were undertaken in seven of the homes which covered 161 of 198 patients registered in care homes. The practice pharmacist also visited these homes regularly to review patients' medications, especially after discharge from hospital. Practice staff had developed an enhanced health framework for patients in care homes including access to telemedicine advice. All of these initiatives had reduced the high demand for individual visits.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review in the month of their birthday to check their health and medicines needs were being met. These reviews were run by two HCA's with a supervising nurse so patients experienced a one stop shop with

prescribing and nurse input on the day. For patients with the most complex needs, the GPs worked with other health and care professionals to deliver a coordinated package of care and reviews were done early to allow time to modify their treatment regimes.

- Staff who were responsible for reviews of patients with long term conditions had received specific training. One nurse had attended training in respiratory disease and diabetes, a health care assistant had attended training on reviews with patients with chronic obstructive pulmonary disease. Nurses had been trained in the initiation of insulin which prevented patients from having to be referred to secondary care when insulin initiation or change of insulin was needed.
- Blood measurements for diabetic patients (IFCC-HbA1c of 64mmol/mol or less in the preceding 12 months) showed that 84% of patients had well controlled a blood sugar level which was comparable with the clinical commissioning group (CCG) average of 81% and national average of 79.5%. Insulin reviews were done in house and enhanced diabetes care delivered.
- The percentage of patients with hypertension (high blood pressure) in whom the last blood pressure reading (measured in the preceding 12 months) was 150/90 mmHg or less was 88%,comparable with the CCG average of 86% and the national average of 83%.
- Staff used electronic summary care records, GP to GP transfer and EMIS community entries by the community matrons, podiatry, dieticians and heart failure service in order to see the whole clinical picture.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above the target percentage of 90% for all four indicators.
- Practice staff had received triage training to recognise sepsis and there was a prompt on patient records to remind clinicians to identify potential symptoms when seeing patients. One nurse had attended a course on assessment of the sick child and others were scheduled to do so.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines and pertussis vaccination was available.
- Appointments out of school hours were available.

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

- Talk and treat calls were taken from 8am in the morning each day and until 8.30pm one night per week to allow working people to access advice and help.
- The practice's uptake for cervical screening was 76%, which was below the 80% coverage target for the national screening programme. However the practice provided unvalidated for March 2018 which indicated they had reached 84% of target. The practice had taken comprehensive action to improve this by making contact with patients by telephone to check the addresses on record, sending out up to three invitations to those who do not attend, 8 weeks apart, to encourage the patient to make an appointment and taking on additional nursing staff to offer appointments for smears. The practice were aware of a vulnerable group of ladies with mental health and learning disabilities who did not engage. These patients were invited for a general review with a nurse who was a smear taker, and whilst they were having the review, the nurse sought consent for the procedure.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. For example a cerebrovascular disease programme had been established for patients who were at risk of stroke.
- A full range of health promotion and screening which reflected the needs for this age group was available. For example, Meningitis ACWY immunisation for new students.
- Students from Edge Hill University had access to healthcare facilities including sexual health both on the campus and at Railway Road surgery, Ormskirk.

People whose circumstances make them vulnerable:

- The practice had appointed a GP partner as a lead for vulnerable patients.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. GPs met in

the health centres with community staff such as district nurses to discuss palliative care for patients at the end of life. In conjunction with the hospice and community nurses the practice staff had carried out reviews with all patients expected to die within 12 months to make plans with the patient and family. Following recent training the practice nurses regarded cancer survivorship as a long term condition, they used an enhanced cancer template and staff felt palliative care meetings were better informed. The staff ensured that a wide range of information was made available to patients and their families and they were signposted to appropriate services. Protocols for the prescribing of anticipatory medicines ensured correct dosage and record keeping including the district nurse drug authorisation form.

- The practice had a follow up policy for any patients who did not attend hospital appointments.
- The practice held a register of patients living in vulnerable circumstances including women living in a refuge, static travellers and those with a learning disability.

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

- 87% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was comparable with the CCG average of 86% and national average of 84%.
- 92% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was 5% above the CCG average and 2% above the national average
- In conjunction with the World Health Organisation, NHSE and LCFT the practice had been funded to undertake a project entitled Routine Enquiry into Adverse Childhood experience (REACH) which had trained all staff to identify patients who were at much greater risk of suicide.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption was 94% of those registered with the practice; CCG average 91%; national average 91% and the percentage of patients experiencing poor mental health who had received discussion and advice about smoking cessation at the practice 98%; CCG 97%; national 95%.
- The practice had developed a single, all service referral form for mental health and a Well Pathway for patients with dementia covering prevention, diagnosis, living with and supporting people and dying well, with hypertext links to local and national support organisations.
- The practice supported the local CCG mental health awareness sessions in summer 2017 with GPs, nurses, health care assistants, the pharmacist and administrative staff all in attendance.
- The GPs supported several nursing homes where people were diagnosed with dementia. Independent Mental Capacity Advocates (IMCAs) were involved whenever appropriate.
- The practice used information about care and treatment to make improvements. For example following the impact of introducing nurse practitioners at other practices this practice also supported its nurse practitioners to train as advanced nurse practitioners (ANPs). The nurse practitioners ran the walk in clinics both at the health centres and at Edge Hill University, undertook medicine reviews and carried out talk and treat telephone consultations.

Monitoring care and treatment

The practice had a well-established comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

The practice pharmacist worked with members of the CCG pharmacy team to ensure that practice prescribing was carried out in line with local and national recommended guidelines.

A range of audits had been completed including cervical cytology, hypertension coding, and treatment of patients with vitamin deficiency, prescribing of anti-depressants, stroke prevention, several care home audits and an audit of the walk in clinics. Audits undertaken had led to improvements in clinical practice for example an audit of

Good

Are services effective?

(for example, treatment is effective)

the nursing home work showed reduced admissions to hospital, cost savings and improved quality of care. There were low referral rates to the community matrons and low use of the acute visiting service.

Audits were also completed covering home visits undertaken and use of message pages by the reception team. An external audit had been commissioned on the quality of coding with regard to chronic disease. This had increased prevalence figures and identified patients in need of monitoring.

The practice had devised a comprehensive work flow system that captured and validated information from the records of new patients summarised and coded it. This drove an accurate and effective recall system for management of long term conditions. A system was in place that was used to screen out excessive paperwork which need not be seen by GPs.

The most recent published Quality Outcome Framework (QOF) results were 100% of the total number of points available compared with the CCG average of 97.6% and national average of 96.5%. The overall exception reporting rate was 8.9% which compared with a CCG average of 7.4% and a national average of 9.6%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

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- The practice pharmacist carried out medicines audits to check practice prescribing and adherence to best practice guidelines.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. For example, n The health care assistants had been trained in reviews of patients with diabetes and respiratory disease carried out under the supervision of nurses.
- Practice staff used a competence matrix with administrative and nursing staff to plot key skills, determine career progression and standardise pay scales across the practices.
- Monthly study days were held for all staff and topics were guided by requests and needs identified.
- All staff had attended REACH training in order to raise awareness of mental health across the practice. Many staff had also attended mental health upskilling training over the summer of 2017.
- The practice provided staff with ongoing support. This included an induction process and buddying, one-to-one meetings, annual appraisals for all staff, coaching and mentoring, clinical supervision and support for revalidation.
- The induction process for healthcare assistants included the requirements of the Care Certificate.
- There was a formal system to audit clinical decision making and non-medical prescribing for clinicians working in advanced roles through meetings and supervision and staff felt well supported no formal system to audit clinical decision making and non-medical prescribing for clinicians working in advanced roles, however staff felt well supported with informal supervision and told us Staff told us the GP partners were very accessible for advice.
- There were clinical meetings including GPs and nursing staff on a monthly basis and nursing staff met as a team

Good

Are services effective?

(for example, treatment is effective)

at the beginning of the monthly study days to discuss complex cases, cascade new initiatives, review access to appointments and learn together from complaints and grievances.

- The reception team met monthly to discuss the effectiveness of systems, complaints and concerns and where systems might require improvement.
- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies. The practice held regular clinical team meetings with the input of community nurses and hospice staff to discuss the needs of complex patients, for example, those with end of life care needs.
- The practice also organised joint training sessions with nursing home, practice staff and community partners. These events were held in the local community to help staff become aware of the activities available for local people and to discuss how to improve care coordination and delivery to care home residents.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice was a member of the North West Alliance Primary Care Home which aimed to improve services in communities and offer patients opportunities to maximise their health. They worked together with partner organisations in the voluntary, social care and faith sectors. They had attended an event which had decided that the group's first project should be establishing healthcare navigation to enable staff to use the many services appropriately and effectively.
- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. The practice provided specialist care in diabetes and was able to refer patients who had been identified as at risk of developing diabetes to a national diabetes prevention and management programme. A diabetes prevention programme targeted patients with fluctuating glucose levels.
- The practice encouraged patients to attend national cancer screening programmes. We saw that 49% of invited patients had undertaken bowel screening compared to the CCG average of 56% and 54% nationally.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. A detailed consent form had been produced by practice staff for patients undergoing minor surgery to raise patient awareness of the interventions proposed and ensure their understanding.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Requires improvement

Are services caring?

Our findings

We rated the practice, and all of the population groups, as requires improvement for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. For example:

- Staff understood patients' personal, cultural, social and religious needs. All staff had trained in understanding equality and diversity.
- Alternative means of communication were available to patients such as text and email. Translation services and extended appointment duration were offered and the practice had facilities for patients with a hearing loss.
- The practice gave patients timely support and information.
- Members of the reception team had been identified as Patient Friends due to their stronger people skills and whenever possible they dealt with concerns and first stage complaints from patients.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff assisted patients in need for example, when an older patient lost her purse a collection had been taken to help her. Prescriptions were delivered to and samples collected from the house-bound.
- We received 16 patient Care Quality Commission comment cards completed by patients. Nine cards we received were positive about the service experienced and the kindness of staff. Patients expressed concerns about reordering prescriptions, the difficulty in seeing a GP and the time delay to get a face to face appointment (usually 2 weeks). Results of the NHS Friends and Family Test for 2016/17 indicated that 66% of patients would recommend the practice.
- The practice had organised charitable fundraising to purchase an externally wall mounted defibrillator for community use outside the Railway Road surgery in Ormskirk and with North West Ambulance Service ran a joint maintenance programme for the equipment.
- The PULSE café in Skelmersdale for people with unseen illness was supported with visits from GP partners and trainees and with charitable donations.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. A total of 288 surveys were sent out and 97 were returned. This represented about 0.7% of the practice population. The practice was generally comparable or lower than others for its satisfaction scores on consultations with GPs and nurses. For example:

- 75% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 73% of patients who responded said the GP gave them enough time; CCG - 73%; national average - 86%.
- 88% of patients who responded said they had confidence and trust in the last GP they saw; CCG – 95%; national average – 95.5%.
- 74% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG – 85%; national average – 85.5%.
- 89% of patients who responded said the nurse was good at listening to them; (CCG) - 93%; national average - 91%.
- 88% of patients who responded said the nurse gave them enough time; CCG - 88%; national average - 92%.
- 96% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 97%; national average - 97%.
- 87% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 92%; national average - 91%.
- 83% of patients who responded said they found the receptionists at the practice helpful; CCG - 86%; national average - 87%.

Patients we spoke with commented on the friendly, helpful staff even at times of high demand.

The practice in conjunction with the patient participation group (PPG) carried out a consultation regarding the planned merger between North Meols Medical Centre with

Requires improvement

Are services caring?

Beacon Primary Care in June 2017. This included letters, questionnaires and meetings. The support for the merger was very strong and patients requested more support for specialist conditions, no increase in travel distance to the practice and improvements to the telephone system, all of which had been delivered. Additionally a dedicated phone line has been provided for all Beacon patients to order repeat prescriptions thereby taking pressure off the call centre handling appointment requests. Daily walk in clinics have been introduced at each site to improve same day access and feedback from patients and staff was continually monitored. A specific feedback questionnaire was used at walk in clinics to monitor recommendation rates (76%) and comments received included concerns about waiting times but praise for the service.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available. Staff were alerted to patients with visual or hearing difficulties by means of alerts on patient clinical records.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice proactively identified patients who were carers by discussing their caring roles during consultations and health checks and using posters in waiting areas asking them to inform the practice of their role. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 167 patients as carers (1.1% of the practice list).

- Newly identified carers were identified by staff through opportunistic appointments when a carer's template was completed. They were offered an annual health check to assess their needs and a self- help advice leaflet signposting them to access support of various kinds. With their permission they were referred to a carer support organisation. Annual flu vaccination was also available. A member of staff with personal experience as a carer acted as carers lead.
- Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and by giving them advice on how to find a support service.

Results from the national GP patient survey were lower than average about patient involvement in planning and making decisions about their care and treatment.

- 71% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG – 81.5%; national average - 82%.
- 81% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 90%; national average - 90%.
- 76% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 87%; national average - 85%.

The practice told us they felt the perceptions of patients were influenced by the high number of talk and treat appointments when perhaps phone access felt less personal and caring and that appointments with nurses were not valued as highly as with a GP.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as requires improvement for providing responsive services across all population groups.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences. Staff understood the needs of its population and tailored services in response to those needs. For example:

- Appointments were available from 8am until 6.30pm every day except Wednesday when they also offered a late surgery until 8.30pm at Sandy Lane and at Railway Road. The North Meols site also offered appointments until 8pm on Mondays. when they also offered a late surgery until 8.30pm.
- Receptionists had received training in symptoms which they should urgently respond to either by escalation to a clinician or by calling "999".
- Online access was promoted via posters in the waiting room, by reception staff on the telephone and on the practice website. The website had been developed with animations and digital training had been provided for patient participation group (PPG) members. This had led to an increase in patient online uptake.
- A talk and treat telephone consultation service was offered where patients booked a call back with a clinician. The patients' concerns were identified in that call and 50% required no further treatment. The call might result in a face-to-face appointment with an appropriate member of staff and the urgency of the intervention required was built into this assessment.
- The practice had created reasonable adjustments when patients found it hard to access services. For example walk- in sessions were available at each site at least once a week, and patients could access walk in clinics every day at one of the sites.
- Consultations with GPs could be extended according to the needs of the patient. We saw evidence that consultations of 45 minutes were available if required Consultation appointments with GPs could be extended to 20 minutes to discuss complex concerns, prescriptions could be delivered to patients' homes and flu vaccines and health checks could be carried out on home visits.
- The practice staff used easy read information for patients with difficulties in reading including a leaflet to explain the information kept in care records.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services and directly accessible from practice staff.
- The practice were members of the North West Health Alliance which placed emphasis on collaborative, innovative care within the community. The GP partners and staff worked with a variety of community based providers such as Well Skelmersdale to offer local, holistic care.
- Self-care leaflets were in use by practice staff to help patients to maintain healthy lifestyles and keep their condition stable.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice offered home visits, telephone consultations and weekly telephone calls to care homes to determine if a GP visit was required. Each care home had an allocated GP who maintained regular telephone contact at their respective homes and undertook weekly ward rounds when required, and medication reviews were carried out by the practice pharmacist. An enhanced health framework ensured a comprehensive assessment, shared care planning multidisciplinary support and structured risk assessment.
- Patients with complex needs were offered longer appointments.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment and consultation times were flexible to meet each patient's specific needs.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- The practice held regular meetings with the local district nursing team and community matron to discuss and manage the needs of patients with complex medical issues.
- The practice offered an enhanced service to diabetic patients that involved both the GP and the practice nurse specialist in diabetes and referred patients to the diabetic education programme which was run locally. Patients had no need to go to the local hospital in Ormskirk unless their needs were very complex.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this. All children and young people identified by staff as at risk were identified to the lead GP for safeguarding, discussed at the next clinical meeting and the details updated in the online tracker.
- All parents or guardians calling with concerns about a child under the age of five years were offered a same day appointment and children aged 5-18years could access a same day appointment when necessary .The practice ensured that appointments were always available after 3pm each day to accommodate children who had become ill while at school.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, 2000 students from Edge Hill University were registered with the practice and saw clinicians both on site and at Railway Road surgery in Ormskirk and made use of the talk and treat service from the university and from their parents' home. This included advice on sexual health and mental health support and a walk in clinic was available. We saw evidence the University staff valued the partnership with Beacon Primary care and stated the team were willing to listen, discuss and adapt services to meet their patients' needs.
- Walk in clinics for all patients were open from 8.30 am to 10 am and 1.30 to 3pm on Mondays and Fridays, 8.30 to 10am Tuesday, Wednesday and Thursday. Talk and treat was available 8am until 6pm during the week and 8.30pm on Wednesday which enabled patients to call from their workplace.
- Patients could book appointments and order repeat prescriptions online.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including static travellers and those with a learning disability.
- A worker with a refugee resettlement programme praised the practice's professionalism and responsive input to the families they supported.
- Patients with complex needs were offered longer appointments.
- There were monthly meetings with other health and social care professionals to discuss the care and treatment of vulnerable patients. Staff placed emphasis on responding to patients' wishes, for example producing an advanced care plan detailing where they wished to die. Each patient was assessed according to their needs for support and a clinician was identified to take responsibility for this.
- Patients who had been discharged from hospital were followed up by the pharmacist and nursing staff who ensured that their medicines were reviewed and that a follow up appointment with a clinician was offered. If the patient did not attend their appointment further contact was made.

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

- There was a named GP lead for mental health. Staff interviewed had a good understanding of how to support patients with mental health needs. Patients with mental health problems got an extended appointment slot to give them time to discuss their concerns.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- Staff described how the practice supported families where older parents with dementia could no longer live independently, by working jointly with social services.
- Self- referral was being piloted for talking therapies which were available at the practice preventing the need for journeys into Ormskirk or Southport. The practice also signposted patients to support groups, voluntary and community organizations.
- The Routine Enquiry into Adverse Childhood experience (REACH) feasibility project had been carried out to investigate long term physical and mental health problems in a primary care setting. The report was in draft with the University of Cardiff.
- Practice staff generated local contacts personalised for each patient either for general support or in a crisis scenario.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed as appropriately as possible. There was a two week wait for non-urgent appointments which were triaged by GPs by telephone. After this call 50% of patients did not need a face-to-face appointment. Practice staff were well aware that patients were not always happy with this delay, however the process prioritised those most urgently in need of care and ensured the most appropriate management.
- Walk in clinics provided same day access for exacerbations of chronic conditions.
- Practice staff told us that some patients did not feel the appointment system was easy to use due to the volume of calls. A recent change to ordering medicines online only was reducing the calls to the practice.

Results from the July 2017 annual national GP patient survey showed low patients' satisfaction with how they could access care and treatment was comparable with local and national averages. This was supported by observations on the day of inspection and completed comment cards.

- 67% of patients who responded were satisfied with the practice's opening hours which was comparable with the clinical commissioning group (CCG) average of 75% and the national average of 80%.
- 46% of patients who responded said they could get through easily to the practice by phone; CCG – 71%; national average - 71%.
- 56% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 74%; national average 76%.
- 44% of patients who responded said their last appointment was convenient; CCG - 79%; national average - 81%.
- 37% of patients who responded described their experience of making an appointment as good; CCG - 71%; national average - 73%.
- 83% of patients who responded find the reception staff helpful; CCG -83%;national average 87%
- 37% of patients who responded said they don't normally have to wait too long to be seen; CCG - 56%; national average - 58%.

The practice were aware that some of these results indicated low satisfaction with access to services and were trying to reconcile the high quality of clinical care and access rate with patient expectations. The phone systems were under constant surveillance via live screen monitoring in the call centre which handled all incoming calls and there was a dedicated call supervisor. Multiple types of access were available including online, walk in clinics, talk and treat and booked appointments. On the day of inspection appointments were available at two walk in clinics and through talk and treat. General appointments were available the following day with nurses and the pharmacist.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately. Patient Friends dealt with concerns

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

and complaints at the first stage and advised patients about the process if they wished to formalise the issue. We saw that 70% of complaints were resolved after contact with a Patient Friend.

- The complaint policy and procedures were in line with recognised guidance. Thirty five complaints were received in the last year. We reviewed all of these complaints and found that they were satisfactorily handled in a timely way. All complainants received an apology for their experience.
- Spot checks were undertaken to ensure staff were able to respond to complaints and located the appropriate forms.

The practice learned lessons from individual concerns and complaints and also from an annual thematic analysis and review of trends. It acted as a result to improve the ongoing quality of care. For example, a direct number had been given to the local walk in centre to avoid delays in communication between the two agencies. These concerns were discussed at practice meetings and decisions regarding actions were minuted.

Are services well-led?

Good

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

Our findings

We rated the practice, and all of the population groups, as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders at all levels demonstrated high levels of experience, capacity and capability needed to deliver good and sustainable care.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. The GP partners had been instrumental in expanding the North West (NW) Alliance which focussed on locality-wide health improvements in collaboration with the voluntary sector.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. Staff reported a positive, happy atmosphere and easy access to advice and support.
- The practice had effective processes to develop leadership capacity and skills, including the appointment of two deputy practice managers who were being developed in-house as potential successors to the current manager.
- There was a commitment to developing the staff team with a view to increasing the practice's expertise to meet future challenges. The practice offered placements to medical students, physician associates and nursing students in order to encourage recruitment in the future.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. This vision was "to improve services in our communities and offer patients opportunities to maximise their health". The practice leaders met every week to discuss performance, finance and service strategy and had a supporting business plan to achieve identified priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population, for example working with the NW Alliance and making partnerships with community organisations such as Well Skelmersdale.
- The practice monitored progress against delivery of the comprehensive business development plan 2016-2019 by reporting on the challenging but achievable goals and objectives which were regularly updated. Each area of work had a staff lead person; measures towards achievement were quantified and scheduled. Progress was discussed with the Patient Participation Group (PPG) and at practice meetings and a newsletter updated patients and the local community.

Culture

The practice had a culture of providing open, friendly care and going the extra mile to provide support.

- There were high levels of staff satisfaction despite a challenging working environment and staff stated they felt respected, supported, valued and could voice their views and ideas at meetings and with leaders. They were proud to work in the practice, described a family atmosphere with positive relationships between staff teams and felt that there was good teamwork. We saw that many of the staff had worked for the practice for many years.
- We saw that the practice focussed on the needs of patients. All monthly clinical staff meetings were minuted with detailed actions to improve the quality of care for patients.
- Leaders and managers acted on behaviour and performance which was inconsistent with the vision and values. They communicated an inspiring, shared purpose and motivated staff to succeed.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Patients were offered apologies wherever appropriate and were invited to the practice to discuss

Are services well-led?

Good

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

any outstanding concerns. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. For example, holding regular meetings to share events and complaints and to learn from what took place and offering apologies to patients who made complaints.

- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. Staff told us they got good and immediate support if patients became distressed or angry and the practice manager's door was open to staff queries and concerns.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year which were clearly documented. Staff were supported to meet the requirements of professional revalidation where necessary.
- The practice used a competence matrix with administrative and nursing staff to plot key skills, determine career progression and standardise pay scales across the practices
- Clinical staff including nurses were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work. All clinical staff had time set aside for administration and group supervision. All surgery staff were able to train together at professional development sessions on a monthly basis.
- There was a strong emphasis on the safety and well-being of all staff. Staff were all involved in a summer party at one of the partner's homes, birthdays were marked with cards and presents and a Christmas meal helped to bond the team. The recent REACH project had highlighted issues for some staff and appropriate support was provided.
- There was strong collaboration, team-working and support across all functions and a common focus on improving quality and sustainability of care and people's experiences.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The management team met weekly to oversee the management of partnerships, joint working arrangements and shared services which promoted interactive and co-ordinated person-centred care. Every month GPs, nurses, the pharmacist, data coordinator and representatives from the district nursing team met to share knowledge about patients, discuss concerns and identify improvements needed. Staff were clear on their roles and accountabilities including in respect of safeguarding.
- Regular meetings were held with Edge Hill University staff to review and monitor services provided to the student population.
- Practice leaders had established comprehensive policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were a number of clear and effective processes for managing risks, issues and performance.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. Staff at all levels had the skills and knowledge to use the systems effectively.
- The practice had developed a strong safeguarding system with a lead GP, regular clinical meetings with practice and community staff, review of all correspondence relating to patients at risk of safeguarding and a spreadsheet to capture information about vulnerable patients.
- The practice had some processes to manage current and future performance. For example, Practice leaders had oversight of Medicines and Healthcare products

Are services well-led?

Good

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

Regulatory Agency (MHRA) alerts, incidents, and complaints. The practice had employed a full time clinical pharmacist who had, with the medicines management and reception teams reviewed the prescription system and updated it to improve patient safety, ease of making requests, speed and efficiency of processing orders and substantially reduced prescribing costs.

- There was a formal system of supervision for clinical decision making and prescribing undertaken by nurse practitioners.
- Infection prevention and control audits had not been carried out prior to the inspection. One of the GPs bags contained emergency drugs which were out of date.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The outcomes of work in nursing homes had been measured. The nursing home rounds were found to be very effective in terms of improving holistic care, reducing unnecessary admissions to hospital (48% fewer admissions in three homes) reducing urgent GP visits (31%) and reducing attendance at Accident and Emergency (48%). A recent event had been attended by care home staff, practice staff, a Consultant in elderly care and community nurses in order to prioritise the next steps in improving this service. This included a dedicated weekly session from the consultant, further improvements in IT links for nursing home access to the practice patient records and consideration of co-employment of staff.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented ongoing service developments and where efficiency changes were made this was with leadership from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients. For example staff carried out a weekly audit of access rates with reference to nationally recognised good practice relative to list size.
- Quality and sustainability were discussed in monthly meetings with clinical staff and we saw formal minutes of these meetings.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used well developed information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required and routinely shared records with trusted partners in order to support decision making and ensure continuity of care.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

There were high levels of constructive engagement with staff and people who used services, including all equality groups. Rigorous and constructive challenge from people who use services, the public and stakeholders was welcomed and seen as an important way of holding services to account. Services were developed with the full participation of those who used them, staff and external partners as equal partners. For example:-

- There were regular Patient Participation Group (PPG) meetings, NHS Choices feedback received consistent responses, Friends and Family Test (FFT) responses were monitored and staff attended clinical commissioning group (CCG) and locality meetings. A PPG representative told us clinical staff were well represented at PPG meetings with GPs and the practice manager in regular attendance. There were virtual members in the PPG such as students who preferred to input their views

Are services well-led?

Good

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

online or those who could not attend meetings. A direct telephone line was introduced for the prescribing hub at the suggestion of the PPG which had freed up access for booking appointments. PPG members acknowledged the improvements made at North Meols Health Centre since Beacon Primary Care had become the providers of the service.

- Staff ideas were listened to and implemented, for example the lead nurse suggested that long term annual reviews were done in the month of the patient's birthday.
- The service takes a leadership role in its health system to identify and proactively address challenges. For example, the NW Health Alliance Primary Care Home was a partnership with two other practices in Southport in order to combine the experience and good practice of staff. It aimed to improve services and access by working together with organisations in the voluntary, health and social care sector. The first joint project to develop healthcare navigation had just commenced.
- Joint training sessions were held for nursing home, practice staff and community partners. These events were held in the local community to help staff become aware of the activities available for local people. A nurse manager from one of these care homes stated the collaboration with Beacon Primary Care had had a very positive benefit for their residents as had the joint training.
- A worker with a refugee resettlement programme praised the practice's professionalism and responsive input to the families they supported.
- The service was transparent, collaborative and open with stakeholders about performance including sharing lessons learnt from serious events and the recording system they had adopted.

Continuous improvement and innovation

There were embedded systems and processes for learning, continuous improvement and innovation.

There was a focus on continuous learning and improvement at all levels within the practice, this included development of protocols following serious events, improving administrative systems after complaints, responding to data in relation to prescribing and an ongoing review of how to offer better access to appointments.

- The practice was committed to working with other practices participating in NW Alliance and CCG forums. This demonstrated a clear, systematic and proactive approach to embedding new and more sustainable models of care. This sharing of work enabled staff to compare their performance with that of similar surgeries in the area and share learning with a view to improving outcomes. The Primary Care Home was in the process of developing a healthcare navigation programme to help hard to reach groups.
- The practice had developed a single, all service referral form for mental health which had been shared with the CCG as was a Well Pathway for dementia template.
- Two advanced nurse practitioners had been recently appointed specifically to address two clinical areas of need, mental health and dermatology. Routine dermatology at the local trust had been withdrawn and the practice had recognised the need to make provision for patients in this area.
- West Lancs CCG stated the successful bid for two advanced practitioners had built on the supportive approach already in place towards individual and team development. A specialist mental health ANP had been recently recruited to support all staff, in particular to offer a service to the student population.
- Practice staff had liaised with the local mental health team to pilot psychological therapies for long term conditions via group work held within the surgery.
- A GP partner sat on the CCG Council of Members and the other partner was a GP specialist lead. The practice manager and practice nurses attended regular CCG forums. The practice head of nursing attended the CCG medicines management team meeting in order to share updates and safety concerns with the practice. This meant staff were kept up to date with new initiatives and were frequently involved in piloting new services.