Coniston Medical Practice

Quality Report

Wraysdale House,
Coniston,
Cumbria,
LA21 8ER
Tel: 01539 441205

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Coniston Medical Practice on 19 May 2015

Overall, we rated the practice as outstanding. Specifically, we found the practice to outstanding for providing caring and responsive services; and good for providing safe, effective and well led services.

Our key findings were as follows:

- Staff knew their patients and the remote and rural area covered by the practice very well, and provided a holistic service which met their needs;
- Feedback from patients was overwhelmingly positive; they told us staff treated them with respect and kindness;
- Patients reported exceptional access to the practice.
- Patients we spoke with told us they felt they had sufficient time during their appointment;
- Patients' needs were assessed and care was planned and delivered following best practice guidance;
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, reviewed and addressed;
- There was a clear leadership structure and staff felt supported by the management team. The practice actively sought feedback from patients;
- The practice was clean and hygienic, and good infection control arrangements were in place.

We saw several areas of outstanding practice including:

- The surgery was embedded in and was an essential part of the local community. Staff regularly liaised with the local primary and secondary schools and were first on call for any health concerns. This helped to avoid unnecessary ambulance call outs and A&E attendances.
- Arrangements had been made to carry out joint home visits with district nurses and carers. This provided patients with a more co-ordinated care service.

Summary of findings

- Both of the GPs lived above the practice and often treated people outside of normal opening hours, this prevented many patients from having to travel to access hospital services, which were a considerable distance away.
- The practice offered a range of compassionate services to address social isolation amongst its patient population.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good 

The practice is rated as good for providing safe services.

The nationally reported data we looked at as part of our preparation for this inspection did not identify any concerns relating to safety. Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The GP partners took action to ensure lessons were learned from any incidents or concerns, and shared these with staff to support improvement. There was evidence of good medicines management. Good infection control arrangements were in place and the practice was clean and hygienic. Safe staff recruitment practices were followed and there were enough staff to keep patients safe.

Are services effective?

Good 

The practice is rated as good for providing effective services.

Care and treatment was being delivered in line with current published best practice. Patients' needs were assessed and care was planned and delivered in line with current legislation and best practice guidance produced by the National Institute for Health and Care Excellence (NICE), and the local clinical commissioning group (CCG). Staff had received training appropriate to their roles and arrangements had been made to support clinicians with their continuing professional development. There were systems in place to support multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the information and equipment they needed to deliver effective care and treatment.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services.

Patients were respected and valued as individuals and were partners in their care. Feedback from patients was overwhelmingly positive. Patients we spoke with and those who completed CQC comment cards were overwhelmingly complimentary about the practice. They said they were treated with dignity and respect and they were involved in care and treatment decisions.

The GPs provided a compassionate service for their population. Both of the GPs lived above the practice and often treated people outside of normal opening hours. They said they would rather see patients themselves and treat any illnesses or minor injuries than send them to hospital.

Summary of findings

Accessible information was provided to help patients understand the care available to them. We found there was a patient-centred culture and staff treated patients with kindness and compassion. For example, those patients receiving palliative care and their families were given the GPs personal mobile telephone numbers and were encouraged to contact them whenever they needed to. Staff we spoke with were aware of the importance of maintaining patient confidentiality.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services.

The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. The practice had strong links with the local community and the services had been designed to reflect the needs of the rural population. The practice was a member of the local 'care scheme', as part of this the GPs regularly called in to check how patients and their carers where and whether they needed anything. We saw several examples of how patients had been supported to remain in their own homes.

The practice had taken an innovative approach to providing integrated person-centred pathways of care. Arrangements had been made to carry out joint home visits with district nurses and carers. This provided patients with a more co-ordinated care service.

Patients could access appointments in a way and a time that suited them. Each morning, a GP held an open access clinic. Patients were able to see the GP without having to make an appointment. Bookable appointments were available every afternoon. The most recent National GP Patient Survey (January 2015) showed 98% (compared to 73% nationally and 77% locally) of respondents were able to get an appointment or speak to someone when necessary.

Are services well-led?

Good

The practice is rated as good for providing well-led services.

The leadership, management and governance of the practice assured the delivery of person-centred care which met patients' needs. The practice had a clear vision which was shared by all staff. There was an effective governance framework in place, which focused on the delivery of high quality care. We found there was a high level of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients and had a very active patient participation group (PPG).

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Outstanding ☆

The practice is rated as outstanding for the care of older people. This is because the practice is rated as outstanding for providing caring and responsive services, and the good practice that led to these ratings apply to everyone using the practice, including this population group.

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with chronic obstructive pulmonary disease (COPD). This was 0.4 percentage points above the local clinical commissioning group (CCG) average and 2.1 points above the England average.

There was a high proportion of older people within the practice population. Staff placed an emphasis on supporting people to live in their own homes for as long and healthily as possible. Care and support was provided out of hours as this helped to prevent older people having to travel long distances to the nearest hospital, unnecessary ambulance call outs and accident and emergency attendances.

The practice was responsive to the needs of older people, and offered home visits for health checks and flu vaccinations. GPs had good links to the local care service and regularly visited patients living in the sheltered housing community.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of people with long-term conditions. This is because the practice is rated as outstanding for providing caring and responsive services, and the good practice that led to these ratings apply to everyone using the practice, including this population group.

The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. Patients with long-term conditions such as diabetes and epilepsy were offered regular reviews and an annual check of their health and wellbeing, or more often where this was judged necessary by the GPs.

Nationally reported QOF data (2013/14) showed the practice had achieved good outcomes in relation to the conditions commonly associated with this population group. For example, the practice

Summary of findings

had obtained 100% of the points available to them for providing recommended care and treatment for patients with epilepsy This was 5.5 percentage points above the local CCG average and 10.6 points above the national average.

Families, children and young people

Outstanding

The practice is rated as outstanding for the care of families, children and older people. This is because the practice is rated as outstanding for providing caring and responsive services, and the good practice that led to these ratings apply to everyone using the practice, including this population group.

Systems were in place to identify and follow-up children who were considered to be at risk of harm or neglect. For example, the needs of all at-risk children were regularly reviewed at practice multidisciplinary meetings, which involved child care professionals such as school nurses and health visitors.

Appointments were available outside of school hours and reception staff had been trained to take note of any urgent problems and notify the doctor about an unwell child or parental concern. The premises were suitable for children and babies. Arrangements had been made for new babies to receive the immunisations they needed. Vaccination rates for 12 month and 24 month old babies and five year old children appeared to be below the local CCG area. The GPs told us this was due to an error made when collating the data and related to the fact that there were a small number of patients so any variance would appear to be higher. They were aware which children had not received immunisations and plans were in place to rectify this.

Staff regularly liaised with the local primary and secondary schools and were first on call for any health concerns.

Pregnant women were able to access an antenatal clinic provided by healthcare staff who were attached to the practice. The practice had obtained 100% of the QOF points available for providing recommended maternity services. Nationally reported QOF data (2013/14) showed that antenatal care and screening were offered in line with current local guidelines.

Working age people (including those recently retired and students)

Outstanding

The practice is rated as outstanding for the care of working age people (including those recently retired and students). This is because the practice is rated as outstanding for providing caring and responsive services, and the good practice that led to these ratings apply to everyone using the practice, including this population group.

Summary of findings

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group.

Patients could order repeat prescriptions and book appointments on-line. The surgery was open between 9:00am and 6:00pm Monday, Tuesday and Friday, from 9:00am until 12.30pm on Wednesdays and between 9:00am and 6.30pm on Thursdays. GPs were very flexible and patients could also have early morning appointments on request.

The practice provided additional services such as health checks for the over 40's, smoking cessation advice clinics and travel vaccinations.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. This is because the practice is rated as outstanding for providing caring and responsive services, and the good practice that led to these ratings apply to everyone using the practice, including this population group.

Systems were in place in place to identify patients, families and children who were at risk or vulnerable. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. These patients were offered regular reviews.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding for the care of people experiencing poor mental health. This is because the practice is rated as outstanding for providing caring and responsive services, and the good practice that led to these ratings apply to everyone using the practice, including this population group.

Nationally reported QOF data (2013/14) showed the practice had achieved good outcomes in relation to patients experiencing poor mental health. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with dementia. This was 4.4 percentage

Summary of findings

points above the local CCG average and 6.6 points above the England average. The practice kept a register of patients with mental health needs which was used to ensure they received relevant checks and tests.

The practice worked closely with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had care plans in place for patients with dementia. Patients experiencing poor mental health were sign posted to various support groups and third sector organisations.

Summary of findings

What people who use the service say

We spoke with 10 patients during our inspection, including two members of the patient participation group. We spoke with people from different age groups, who had varying levels of contact and had been registered with the practice for different lengths of time.

We reviewed 21 CQC comment cards which had been completed by patients prior to our inspection.

All of the patients were complimentary about the practice, the staff who worked there and the quality of service and care provided. They told us the staff were very caring and helpful. They also told us that they were treated with respect and dignity at all times and they found the premises to be clean and tidy.

The latest National GP Patient Survey published in January 2015 showed that the large majority of patients were satisfied with the services the practice offered. Many of the results were well above the national average:

- The proportion of patients who were able to get an appointment when they wanted – 98% (national average 73%);
- Percentage of patients rating their ability to get through on the phone as very easy or easy – 90% (national average 71%);
- Percentage of patients rating their experience of making an appointment as good or very good – 91% (national average 73%);
- The proportion of patients who would recommend their GP surgery – 78% (national average 78%).

Outstanding practice

We saw several areas of outstanding practice including:

- The surgery was embedded in and was an essential part of the local community. Staff regularly liaised with the local primary and secondary schools and were first on call for any health concerns. This helped to avoid unnecessary ambulance call outs and A&E attendances.
- Arrangements had been made to carry out joint home visits with district nurses and carers. This provided patients with a more co-ordinated care service.
- Both of the GPs lived above the practice and often treated people outside of normal opening hours, this prevented many patients from having to travel to access hospital services, which were a considerable distance away.
- The practice offered a range of compassionate services to address social isolation amongst its patient population.

Coniston Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector and included a GP.

Background to Coniston Medical Practice

Coniston Medical Practice is registered with the Care Quality Commission to provide primary care services. It is located in the village of Coniston in Cumbria.

The practice provides services to around 950 patients from one location; Wraysdale House, Coniston Cumbria, LA21 8ER. We visited this address as part of the inspection. The practice has two GP partners (one male and one female), and three staff who carry out reception, administrative and dispensing duties.

The practice is part of Cumbria clinical commissioning group (CCG). The practice is situated in an area of relatively low levels of deprivation. The practice population is made up of a significantly higher than average proportion of patients over the age 65 (27.1% compared to the national average of 16.7%).

The practice is located in a converted two storey building. All patient facilities are on the ground floor. It also offers on-site parking. Access to the building is via a number of steps, alternative arrangements are made to ensure those patients using wheelchairs or pushing prams can access services.

Surgery opening times at the practice are between 9:00am and 6:00pm Monday, Tuesday and Friday, from 9:00am until 12.30pm on Wednesdays and between 9:00am and 6.30pm on Thursdays. Patients can book appointments in person, on-line or by telephone. Due to the rural location, the practice has an on-site dispensary.

The practice provides services to patients of all ages based on a General Medical Services (GMS) contract agreement for general practice.

The service for patients requiring urgent medical attention out of hours is provided by the 111 service and Cumbria Health On Call (CHOC).

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

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

Detailed findings

- Is it well-led?

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

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

As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. This included the local clinical commissioning group (CCG).

We carried out an announced visit on 19 May 2015. We spoke with 10 patients and four members of staff from the practice. We spoke with and interviewed two GPs and two staff carrying out reception, administrative and dispensing duties. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 21 CQC comment cards on which patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Safe track record

The practice had a good track record for maintaining patient safety.

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how the practice operated. Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards reflected this. We (CQC) had not received any safeguarding or whistle-blowing concerns regarding patients who used the practice. We met with the local clinical commissioning group (CCG) before we inspected the practice and they did not raise any concerns with us.

As part of our planning we looked at a range of information available about the practice. This included information from the General Practice Outcome Standards (GPOS) and the Quality and Outcomes Framework (QOF). The latest information available to us indicated there were no areas of concern in relation to patient safety.

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 responsibility to raise concerns, and how to report incidents and near misses. Staff said there was an individual and collective responsibility to report and record matters of safety.

We saw that records were kept of significant events and incidents. We reviewed a sample of the reports completed by practice staff during the previous 12 months, and the minutes of meetings where these were discussed. The records looked at showed the practice had managed such events consistently and appropriately during the period concerned and this provided evidence of a safe track record for the practice.

Learning and improvement from safety incidents

The practice was open and transparent when there were near misses or when things went wrong. There was a system in place for reporting, recording and monitoring significant events. We spoke with the GPs about the arrangements in place. They told us that all staff had responsibility for reporting significant or critical events. Staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Records of those incidents were kept on the practice computer system and made available to us. We found details of the event, steps taken, specific action required and learning outcomes and action points were noted. There was evidence that significant events were discussed at staff meetings to ensure learning was disseminated and implemented.

We saw there had been a significant event in relation to a request to dispense medicines to patients in hospital. We saw evidence that a thorough investigation had taken place. This had identified some key learning points, which had been shared with the relevant staff. The event had been discussed within the practice and protocols were revised to ensure the practice could direct the requests to the relevant organisation. The changes were implemented and the practice told us they would be reviewed at a later date to confirm they remained effective.

We discussed the process for dealing with safety alerts with the GPs. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. The practice had a documented procedure in place for staff to follow. Any alerts were discussed at clinical meetings to ensure staff were aware of any necessary action. We saw minutes confirming these discussions had taken place.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. Safeguarding policies and procedures were in place. These provided staff with information about safeguarding legislation and how to identify, report and deal with suspected abuse. Information about how to report safeguarding concerns and contact the relevant agencies was easily accessible.

There was an identified member of staff with a clear role to oversee safeguarding within the practice. Staff we spoke with said they knew which of the GP partners was the safeguarding lead. This GP was responsible for ensuring staff were aware of any safeguarding cases or concerns.

Good

Are services safe?

There was a system on the practice's electronic records to highlight vulnerable patients. Children and vulnerable adults who were assessed as being at risk were identified using READ codes. These codes alerted clinicians to their potential vulnerability (clinicians use READ codes to record patient findings and any procedures carried out).

The clinicians discussed ongoing and new safeguarding issues at their weekly meetings, and also held regular meetings with health visitors. The staff we spoke with had a good knowledge and understanding of the safeguarding procedures and what action should be taken if abuse was witnessed or suspected.

We saw records which confirmed all relevant staff had attended training on safeguarding children. Both of the GPs had completed child protection training to Level 3. This is the recommended level of training for GPs who may be involved in treating children or young people where there are safeguarding concerns. The administrative staff had attended Level 1 training sessions. This was confirmed by the staff we spoke with.

The practice had a chaperone policy. We saw posters on display in the consultation rooms to inform patients of their right to request a chaperone. Staff told us that the GPs undertook this role.

A whistleblowing policy was in place. Staff we spoke with were all able to explain how, and to who, they would report any such concerns. They were all confident that concerns would be acted upon.

Medicines management

There were clear systems in place to manage medicines. We checked medicines stored in the treatment rooms and medicine refrigerator and found they were stored securely and were only accessible to authorised staff. We saw medicines were in date and good systems to check expiry dates were implemented. There were procedures to ensure expired and unwanted medicines were disposed of in line with waste regulations.

There was a clear policy for ensuring medicines were kept at the required temperatures (for example, some vaccines needed to be stored in a refrigerator). The policy described the action to take in the event of a potential failure of the refrigerator. Staff confirmed the procedure was to check the refrigerator temperature every day to ensure the vaccines were stored at the correct temperature. We saw records of the daily temperature recordings, which showed the correct temperatures for storage were maintained.

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 designated safe, access to them was restricted and the key was held securely.

Due to the rural location and the lack of pharmacy in the village, there was a dispensary within the practice. Patients were therefore able to obtain their medicines either straight after their consultation, or within a day if stocks were not held on site. Staff had access to written procedures to support the safe dispensing of medicines and these were up to date.

There were systems in place to ensure GPs regularly monitored patients medicines and re issuing of medicines was closely monitored, with patients invited to book a 'medication review', where required.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We saw records of blank prescription form serial numbers were made on receipt into the practice and when the forms were issued to GPs. Blank prescriptions were securely stored at all times.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol covered, for example, how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

Cleanliness and infection control

We looked around the practice and saw it was clean, tidy and well maintained. Patients we spoke with told us they were happy with the cleanliness of the facilities. Comments from patients who completed CQC comment cards reflected this.

One of the GPs was the nominated infection control lead. We saw there was an up to date infection control strategy and detailed guidance for staff about specific issues. For example, hand hygiene and use of protective clothing. All

of the staff we spoke with about infection control said they knew how to access the practice's infection control procedures. Staff attended annual training courses on infection control.

The risk of the spread of infection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment (PPE) such as aprons and gloves were available for staff to use. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels. The consultation room had flooring that was impermeable, and easy to clean. The privacy curtains in the consultation rooms were changed every six months or more frequently if necessary. We saw records were maintained so staff knew when they were due to be changed.

The GPs carried out cleaning duties. We looked at records and saw the domestic staff completed cleaning schedules, on a daily, weekly, monthly and annual basis.

We saw there were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We looked at the practice's clinical waste bins located in the consultation room. All of the clinical waste bins we saw had the appropriately coloured bin liners in place. We saw there was a spillage kit (these are specialist kits to clear any spillages of blood or other bodily fluid) available.

Staff were protected against the risk of health related infections during their work. We asked the reception staff about the procedures for accepting specimens of urine from patients. They showed us there were bags for patients to put their own specimens in. The GPs then wore PPE when transferring the specimens for testing.

A legionella risk assessment had been completed (legionella is a type of bacteria found in the environment which can contaminate water systems in buildings and can be potentially fatal).

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. We saw evidence of calibration of relevant equipment; for example, weighing scales and blood pressure monitoring equipment. Fire extinguishers were serviced regularly. The practice maintained records showing when the next service was due.

Staffing and recruitment

The practice had an up to date recruitment policy in place that outlined the process for appointing staff.

We looked at one of the personnel files. We saw that pre-employment checks, such as obtaining a full work history, evidence of identity and references had been carried out, prior to staff starting work.

Both of the GPs had undergone DBS checks as part of their application to be included on the National Medical Performers' List. All performers are required to register for the online DBS update service which enables NHS England to can carry out status checks on their certificate. The practice had carried out a risk assessment which had determined that none of the administrative staff required a DBS check.

We saw there was a rota system in place to ensure there were enough staff on duty. There was also an arrangement in place for members of staff to cover each other's annual leave.

Staff we spoke with were flexible in the tasks they carried out. This demonstrated they were able to respond to areas in the practice that were particularly busy. For example, by working on the front reception desk receiving patients or by answering the telephones. Staff told us there was always enough staff on duty to maintain the smooth running of the practice and ensure patients were kept safe.

We asked the GPs how they assured themselves that GPs employed by the practice continued to be registered to practice with the relevant professional bodies (For GPs this is the General Medical Council (GMC)). They told us they routinely checked with the GMC to assure themselves of the continuing registration of staff. We saw records of these checks were maintained.

Monitoring safety and 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 regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

Good

Are services safe?

One of the GPs showed us a number of risk assessments which had been developed and undertaken; including a fire and a health and safety risk assessment. Risk assessments of this type helped to ensure the practice was aware of any potential risks to patients, staff and visitors and planned mitigating action to reduce the probability of harm.

There were clear lines of accountability for all aspects of patient care and treatment. The GPs each had lead roles such as safeguarding and infection control. Each clinical lead had systems for monitoring their areas of responsibility.

Appropriate staffing levels and skill-mix were provided by the practice during the hours the service was open.

The practice had systems in place to manage and monitor health and safety. The fire alarms and emergency lights were regularly tested. We saw records confirming these checks had been carried out.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including a defibrillator (used to attempt to restart a person's heart in an emergency). All staff we spoke with regarding emergency procedures knew the location of this equipment. The practice did not carry supplies of oxygen. A comprehensive risk assessment had been carried out; this had determined that it was not necessary to keep oxygen at the practice. Suitable, alternative arrangements had been made, so the GPs could quickly access oxygen from the local first response team when needed.

Staff attended annual fire safety training and a member of the team was a designated fire warden. Emergency medicines were available in a secure area of the practice and all staff knew of their location. The defibrillator was accessible and staff carried out regular checks on the battery and the associated equipment.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. GPs demonstrated an up-to-date knowledge of clinical guidelines for caring for patients. There was a strong emphasis on keeping up-to-date with clinical guidelines, including guidance published by professional and expert bodies. The practice undertook regular reviews of their referrals to ensure current guidance was being followed.

Both clinicians we interviewed were able to describe and demonstrate how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners. New guidelines and the implications for the practice's performance and patients were discussed at weekly clinical meetings.

We found from our discussions with the GPs that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, the practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. We spoke with staff about how the practice helped people with long term conditions manage their health. They told us that there were regular clinics where patients were booked in for recall appointments. This ensured patients had routine tests, such as blood or spirometry (lung function) checks to monitor their condition.

Nationally reported data taken from the Quality and Outcomes Framework (QOF) for 2013/14 showed the practice had achieved maximum points (with an overall score of 91.9%) for most of the 20 clinical conditions covered. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions such as diabetes and implementing preventative measures. The results are published annually.) The scores for some conditions were below average, however, this was due to the small number of patients, if one person for example did not attend a review then this would have a large impact on the scores.

We were told patient safety alerts and guidelines from NICE were discussed at relevant team meetings to enable shared learning. We saw minutes of practice meetings where new guidelines were shared with staff, the implications for the practice's performance were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed these actions were designed to ensure each patient received support to achieve the best health outcome for them.

Patients we spoke with said they felt well supported by the GPs with regards to decision making and choices about their treatment. This was reflected in the comments left by patients who filled in CQC comment cards.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs and nurses showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of a patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in managing, monitoring and improving outcomes for patients. For example, GPs held clinical lead roles in a range of areas, including cancer and safeguarding. Non-clinical staff had been given responsibilities for carrying out a range of designated roles including, for example, making sure emergency drugs were up-to-date and fit for use.

The practice had a system in place for completing clinical audit cycles, which led to improvements in clinical care. We saw a number of clinical audits had recently been carried out. The results and any necessary actions were discussed at the clinical team meetings. This included an audit of patients taking a type of medicine which had been reclassified. A check was undertaken of all patients who had been prescribed the medication. Patients were identified and had an appointment with a GP to discuss alternative options. A second cycle was carried out after a period of time; this showed that all patients had been prescribed the correct medicines.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also ensured that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

Good

Are services effective?

(for example, treatment is effective)

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of these patients and their families.

Effective staffing

Practice staffing included medical and dispensing/ administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support. Every member of staff in the practice had an individual training plan which set out which training had been completed and when it was next due. Once a month the practice closed during the afternoon for protected learning time (Time In, Time Out sessions).

Both GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation (every GP is appraised annually and 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 NHS England).

GPs received feedback from their colleagues every year as part of the appraisal process. They told us this was a good way to improve their performance and welcomed this approach as promoting an open and honest culture in which learning took place.

All other staff had received an appraisal, at least annually, or more frequently if necessary. During the appraisals, training needs were identified and future career development plans were discussed. The GPs spent some time in the dispensary and reception areas carrying out observations and providing support for staff. Staff told us they felt supported and the GPs found this helped them to identify areas for further training.

We saw the practice had an induction programme to be used when staff joined the practice. This covered individual areas of responsibility and general logistical information about how the practice operated. A comprehensive pack had also been developed to support locum GPs with their work.

The administrative and support staff had clearly defined roles, however they were also able to cover tasks for their colleagues. This helped to ensure the team were able to maintain levels of support services at all times, including in the event of staff absence and annual leave.

The patients we spoke with were very complimentary about the staff. Staff we spoke with and observed were knowledgeable about the role they undertook.

Working with colleagues and other services

The practice had positive working relationships and had forged close links with other health and social care providers, to co-ordinate care and meet patients' needs.

We saw various multi-disciplinary meetings were held. For example, regular palliative care meetings were held, which involved practice staff and the district and palliative care nurses. The practice safeguarding lead had good relationships with social services, health visitors and school nurse services. Staff commented they worked well with the local CCG and felt supported.

There were no care homes in the area but the practice worked very closely with the local care at home scheme; GPs had daily contact with the patients and the care organisation. Information about patients was shared on a timely basis to help meet their needs. Well established arrangements were in place with the local district nurses, the GPs often carried out joint home visits.

We found appropriate end of life care arrangements were in place. There were procedures in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out-of-hours provider and the ambulance service.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff had been fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice used electronic systems to communicate with other providers. For example, making referrals to hospital services using the Choose and Book system (the Choose and Book system enables patients to choose which hospital they will be seen in and allows them to book their own outpatient appointments). Staff reported this system was easy to use.

Good

Are services effective?

(for example, treatment is effective)

Regular meetings were held throughout the practice. Information about risks and significant events were shared openly at meetings. Information about risks and significant events were shared openly at meetings. Patient specific issues were also discussed to enable continuity of care.

Correspondence from other services such as blood results and letters from the local hospital including discharge summaries, was received both electronically and by post. Staff we spoke with were clear about their responsibilities for reading and taking action to address any issues arising from communications from other care providers. They understood their roles and how the practice's systems worked.

Consent to care and treatment

Before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. There was a practice policy on consent, this provided guidance for staff on when to document consent.

The GPs were both able to give examples of how they obtained verbal or implied consent. GPs we spoke with showed they were knowledgeable about how and when to carry out Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

We found that staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. Some staff had recently received specific training on consent and the MCA. Decisions about or on behalf of patients who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the MCA. The GPs described the procedures they had followed where people lacked capacity to make an informed decision about their treatment.

Health promotion and prevention

The practice identified people who needed ongoing support and were proactive in offering this. This included carers, those receiving end of life care and those at risk of developing a long term condition. For example, there was a register of all patients with rheumatoid arthritis. Nationally reported QOF data (2013/14) showed that the practice had obtained 100% of the points available to them for providing recommended clinical care and treatment to rheumatoid arthritis patients. The data indicated that 100% of patients on the register had a face-to-face annual review in the preceding 12 months. This was 9.3 percentage points above the local CCG average and 10.3 points above the England average.

The QOF data showed the practice obtained 96.9% of the points available to them for providing cervical screening to women. This was 2.8 percentage points below the local CCG average and 0.6 points below the England average. The practice had procedures in place for the management of cervical screening. However, the proportion of patients eligible for screening who had been tested was 77.8%, this was slightly below the local average of 82.5% and the national average of 81.9%. However, this was due to the very small number of patients served by the practice which meant one person not attending could have a big impact on the result.

Patients with long term conditions were reviewed each year, or more frequently as necessary. Arrangements were in place to contact patients who did not attend to ensure they received a review. The GPs carried out home visits to carry out reviews for patients who were housebound.

New patients were offered a 'new patient check', to ascertain details of their past medical histories, social factors including occupation and lifestyle, medications and measurements of risk factors (e.g. smoking, alcohol intake, blood pressure, height and weight).

Information on a range of topics and health promotion literature was available to patients in the waiting area of the practice. This included information about screening services, smoking cessation and child health. Patients were encouraged to take an interest in their health and to take action to improve and maintain it.

The practice offered a full range of immunisations for babies and children, as well as travel and flu vaccinations, in line with current national guidance. Vaccination rates for 12 month and 24 month old babies and five year old children appeared to be below the local CCG area. The GPs told us this was due to an error made when collating the data and related to the fact that there were a small number of patients so any variance would appear to be higher. They were aware which children had not received immunisations and plans were in place to rectify this.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

There was a strong patient-centred culture. We spoke with ten patients during our inspection. All were happy with the care they received from the practice and said their dignity and privacy was respected. Patients commented that the practice provided a very good and high quality service.

We reviewed 21 CQC comment cards which had been completed by patients prior to the inspection. Comments were overwhelmingly positive. Words used to describe the approach of staff included supportive, caring, polite, sensitive and helpful. Many patients commented on the high quality care they and their families had received.

The GPs provided a compassionate service for their population. The practice was located in the centre of the small village. Both of the GPs lived above the practice and often treated people outside of normal opening hours. They told us they were a traditional family practice and knew their patients well. They said they would rather see patients themselves than send them to hospital. The nearest accident and emergency department was 25 miles away across the Lake District country park.

Staff were familiar with the steps they needed to take to protect people's dignity. Consultations took place in a purposely designed consultation room with an appropriate couch for examinations and curtains to maintain privacy and dignity. We noted that consultation room door was closed during consultations and conversations taking place in the room could not be overheard.

We saw the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. Staff spoke quietly so their conversations could not be overhead. Staff were aware of how to protect patients' confidential information. There was a room available if patients wanted to speak to the receptionist privately.

Staff were aware of the need to keep records secure. We saw patient records were mainly computerised and systems were in place to keep them safe in line with data protection legislation. Information regarding patient confidentiality was contained within the practice information leaflet.

The practice had policies in place to ensure patients and other people were protected from disrespectful, discriminatory or abusive behaviour. The staff we spoke with were able to describe how they put this into practice.

Care planning and involvement in decisions about care and treatment

Patients were satisfied with the level of information they had been given. We reviewed the 21 completed CQC comment cards, patients felt they were involved in their care and treatment.

The results of the National GP Patient Survey from January 2015 showed most patients felt involved in their care and treatment. The scores were slightly below the national average, but the results for these questions were based on a very small number of completed surveys.

- 82% said the last GP they saw or spoke to was good at listening to them (national average 88%)
- 70% said the last GP they saw or spoke to was good at involving them in decisions about their care (national average 74%)

We saw that access to interpreting services was available to patients, should they require it. Staff we spoke with said the practice did not have many patients whose first language was not English. They said when a patient requested the use of an interpreter, a telephone service was available. There was also the facility to request translation of documents should it be necessary to provide written information for patients.

Patient/carer support to cope emotionally with care and treatment

Patients' emotional needs were seen as being as important as their physical needs. Patients we spoke with on the day of our visit were positive about the emotional support provided by the practice. Patients told us staff responded compassionately when they needed help and provided support when required. The CQC comment cards we received were also consistent with this feedback. For example, patients commented that staff were caring and took time to help and support them.

We observed staff during the inspection and saw positive interactions with patients. For example, the dispensary did not stock a particular medicine for a patient. The receptionist told the patient it would be delivered to the practice that afternoon, and they would deliver it to the patient's home on their way home from work, rather than

Are services caring?

the patient having to make a return journey. Several patients told us the staff went out of their way to help them, including dealing with minor injuries which prevented patients having to travel to hospital.

The practice offered a range of compassionate services to address social isolation amongst its patient population. Many people lived outside the village in very rural areas, for example on isolated farms. Some of the patients had been reluctant to engage with health care services in the past. The GPs had overcome this and spent time getting to know these patients. They carried out home visits and provided care and support where necessary.

The practice was a member of the local 'care scheme', as part of this the GPs called in or telephoned on a daily basis to check how patients and their carers were and whether they needed anything. This was confirmed by patients we spoke with. The practice offered an additional service to help support the emotional needs of its patient population.

Those patients receiving palliative care and their families were given the GPs personal mobile telephone numbers and were encouraged to contact them whenever they needed to.

We saw there was a variety of information on display throughout the practice. There were several noticeboards with a range of information regarding common health conditions and local support groups.

Practice staff knew their patients very well but routinely asked if they had caring responsibilities. A carer's register had been set up to help them identify and make sure they were receiving the professional support they needed.

Support was provided to patients during times of bereavement. Staff told us that if families had suffered bereavement, this was followed up by the practice, with either a visit or telephone call depending upon the circumstances. Clinical staff referred patients struggling with loss and bereavement to support groups who provided these types of services.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to the needs of the local population. The majority of patients we spoke with and those who filled out CQC comment cards said they felt the practice was meeting their needs. For example, patients could access appointments face-to-face in the practice, receive a telephone call back from a clinician or be visited at home.

Where patients were known to have additional needs, such as being hard of hearing, were frail, or had a learning disability this was noted on the patient's medical record. This meant the GP would already be aware of this and any additional support could be provided, for example, a longer appointment time.

Staff told us that one the biggest challenge in terms of patient demographics was the rural nature of the practice boundaries and the availability of public transport locally. In addition, a relatively high proportion of patients were elderly and/or housebound. Nationally reported data showed that 42.3% (compared to 26.5% nationally) of patients were over the age of 65.

The practice responded to the specific needs of its community by offering extra support to patients. We saw several examples of how patients had been supported to remain in their own homes, rather than have to move out of the area to the nearest care home. This included working with local carers and carrying out regular visits to a sheltered housing community.

The doctors had access to suitable vehicles to ensure they could visit patients in remote areas during times of severe weather. Steps had been taken to use two different mobile phone networks so staff were able to communicate with each other and with patients where the reception was poor.

Staff regularly liaised with the local primary and secondary schools and were first on call for any health concerns. This helped to avoid unnecessary ambulance call outs and A&E attendances.

Due to the location of the practice there were a large number of tourists and temporary residents throughout the year. Staff had been proactive and had informed the local caravan park of their contact details so patients could get in touch if necessary.

Patients we spoke with told us they felt they had sufficient time during their appointment. Results of the National GP Patient Survey from January 2015 showed that 82% (compared to 86% nationally) of patients thought the doctors gave them enough time.

The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of older patients and those with long-term conditions. The practice offered patients with long-term conditions, such as asthma and diabetes, an annual check of their health and wellbeing, or more often where this was judged necessary by the GPs.

The Quality and Outcomes Framework (QOF) data (2013/14) showed the practice had obtained 100% of the points available to them for providing recommended care and treatment to patients needing palliative care (this was 3.3 percentage points above the national average). The practice kept a register of patients who were in need of palliative care and their IT system alerted clinical staff about those who were receiving this care. QOF data showed that multi-disciplinary team (MDT) meetings took place at least every three months, to discuss and review the needs of each patient on this register. Staff told us these meetings included relevant healthcare professionals involved in supporting patients with palliative care needs, such as community nurses and health visitors.

The practice had identified the needs of families, children and young people, and put plans in place to meet them. Pregnant women were able to access an antenatal clinic provided by healthcare staff attached to the practice. The practice had obtained 100% of the QOF points available to them for providing recommended maternity services and carrying out specified child health surveillance interventions. Nationally reported QOF data (2013/14) showed antenatal care and screening were offered in line with current local guidelines. The data also showed that child development checks were offered at intervals consistent with national guidelines.

The practice engaged regularly with the clinical commissioning group (CCG) and other practices across Cumbria to discuss local needs and service improvements that needed to be prioritised.

We found that the practice worked collaboratively with other agencies, regularly updating shared information to ensure good, timely communication of changes in care and

Are services responsive to people's needs?

(for example, to feedback?)

treatment. Regular internal as well as multidisciplinary meetings were held to discuss patients and their families' care and support needs. The practice had taken an innovative approach to providing integrated person-centred pathways of care. Arrangements had been made to carry out joint home visits with district nurses and carers. This provided patients with a more co-ordinated care service.

The practice had established a Patient Participation Group (PPG) to help them to engage with a cross section of the practice population and obtain patient views. A PPG is made up of practice staff and patients that are representative of the practice population. The main aim of a PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice.

We spoke with two members of the PPG; they explained their role and how the group worked with the practice. The representatives told us the PPG had a good working relationship with the practice, and felt that the GPs explained any changes in the health economy to them and listened to any concerns they had.

Tackling inequity and promoting equality

The practice had recognised the needs of the different groups in the planning of its services. For example, the computer system used by the practice alerted GPs if patients were at risk of harm, or if a patient was also a carer. Where patients were identified as carers we saw that information was provided to ensure they understood the various avenues of support available to them should they need it.

Staff at the practice recognised that patients had different needs and wherever possible were flexible to ensure their needs were met. There was a system in place to alert staff to any patients who might be vulnerable or who had special needs, such as patients with poor mental health or a learning disability. Registers were maintained, which identified which patients fell into these groups. The practice used this information to ensure patients received regular healthcare reviews and access to other relevant checks and tests. Some patients had been identified as always needing longer appointments and the system in place ensured that staff were alerted to this need.

Free parking was available directly outside the building. Access to the practice was via some external steps. Arrangements had been made to ensure all patients could gain entry; there was an alternative entrance suitable for wheelchair users or staff would carry out a home visit if the patient preferred. We saw the consulting room was large with easy access for all patients. A hearing loop system was in place for patients who experienced difficulties with their hearing.

Only a small minority of patients did not speak English as their first language. There were arrangements in place to access telephone interpretation services for urgent appointments or book an interpreter to accompany patients where appointments were booked in advance.

The practice accepted any patient who lived within their practice boundary irrespective of ethnicity, culture, religion or sexual preference.

Access to the service

Services were tailored to meet the needs of the local population and were delivered in a way to ensure flexibility and provide choice.

Patients were able to book appointments either by calling into the practice, on the telephone or using the on-line system. Face to face and telephone consultations were available to suit individual needs and preferences. Home visits were also made available every day.

Patients could access appointments in a way and a time that suited them. The practice had undertaken a significant amount of work in relation to accessing the service, including a specific patient survey on access. Each morning, a GP held an open access clinic. Patients were able to see the GP without having to make an appointment. Bookable appointments were available every afternoon. The practice was very flexible and had also made arrangements for those patients who wished to have an appointment before 9:00am. There was a notice on display in the waiting room to advise patients of the 'Early bird' appointments. Patients we spoke with during the inspection commented that this system worked well. Many spoke positively of the daily open access clinics.

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

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The local out of hour's provider was Cumbria Health On Call (CHOC).

In addition to the formal appointments system, the GPs and several patients told us about the informal 'out of hours' service. The GP partners lived above the practice and patients often visited the doctors at lunchtime, on evenings and at weekends if they had a health concern or a minor injury. This extra service meant that patients' received care closer to home and reduced the burden on hospital services. Patients said they felt the doctors were very accessible and went above and beyond their duties. For example, one person told us their elderly relative had had an accident one weekend; they went to the GPs' home and asked for help. The GPs treated the relative and prevented a 999 call and the patient being taken to hospital.

The practice also worked closely with the local primary and secondary schools. The doctors were the first point of contact if anyone had any health concerns. They told us of several examples where they had went to the schools, and in some cases treated patients which had prevented the air ambulance being called to take them to hospital.

Reception staff had been trained to take note of any urgent problems any urgent problems and notify the doctor, of an unwell child or parental concern. This was confirmed when we observed reception staff taking calls from patients; patients were offered appointments on the same day.

The most recent National GP Patient Survey (January 2015) showed 98% (compared to 73% nationally and 77% locally) of respondents were able to get an appointment or speak to someone when necessary. The practice scored very highly on the ease of getting through on the telephone to make an appointment (90% of patients said this was easy or very easy, compared to the national average of 71% and a CCG average of 78%). Patients we spoke with confirmed they were able to get an urgent appointment at short notice.

The practice did not employ any nursing staff. All of the traditional nursing tasks, such as cervical screening tests and monitoring of long term conditions were carried out by the two GP partners.

We found the practice had an up to date booklet which provided information about the services provided, contact details and repeat prescriptions.

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 and there was a designated responsible person who handled all complaints in the practice. The complaints policy was outlined in the practice leaflet.

None of the ten patients we spoke with during the inspection said they had felt the need to complain or raise concerns with the practice. None of the 21 CQC comment cards completed by patients indicated they had felt the need to make a complaint.

Staff we spoke with were aware of the complaints policy. They told us they would deal with minor matters straight away, but would inform one of the GPs of any complaints made to them. Patients could therefore be supported to make a complaint or comment if they wanted to.

The practice had not received any complaints in the 12 months prior to our inspection. However, GPs and staff we spoke with told us that if a complaint was submitted then this would be reviewed in line with the complaints policy. Any lessons to be learned from them would be discussed at staff meetings.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a documented mission statement; this was 'to provide top quality care for our patients in a safe and caring environment. Services have to be effective, tailored to patients' needs and well organised'. The GP partners had a vision for the future of the practice. This included maintaining excellent primary care services for the village of Coniston, continuing to run a dispensary and ensure that the same options for those living in a rural community are available as for those living in cities.

When we spoke with staff it was evident they knew and understood what the practice was committed to providing and what their responsibilities were in relation to these aims. They all told us they put the patients first and aimed to provide person-centred care.

Practice development sessions were held annually. These meetings were used to review any changes that needed to be made to take account of contractual changes in the GP contract, to reaffirm what the practice did well, what its priorities were for the year ahead, and what changes needed to be made to make further improvements to patient outcomes.

Governance arrangements

Arrangements for assessing, monitoring and addressing risks were in place. For example, the practice had a business continuity plan to help ensure the service could be maintained in the event of foreseeable emergencies. The practice had a number of policies and procedures in place to govern activity. These were available to staff via the shared drive on the computer system. The policies and procedures had been reviewed regularly and were up-to-date.

There was a management team in place to oversee the practice. The practice used the Quality and Outcomes Framework (QOF) as an aid to measure their performance. The practice had achieved an overall QOF score of 91.1% of the maximum points available in 2013/2014; this achievement was slightly below both the local clinical commissioning group (CCG) and the national averages (94.9% and 93.5% respectively).

Arrangements were in place which supported the identification, promotion and sharing of good practice. For example, a system was in place which ensured significant events were discussed within the practice team. Staff were encouraged and supported to learn lessons where patient outcomes were not of the standard the practice expected.

We found that staff felt comfortable to challenge existing arrangements and looked to continuously improve the service being offered.

The practice participated in an external peer review with other practices in Cumbria CCG, in order to compare data and identify areas for improvement (peer review enables practices to access feedback from colleagues about how well they are performing against each other and national standards).

Leadership, openness and transparency

There was a well-established management team with clear allocation of responsibilities. For example, one of the GP partners was the lead for diabetes, and another was the safeguarding lead. We spoke with staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. The GP partners told us they considered the culture of the practice to be one of openness and team work. They had an open door policy and said they encouraged all staff to ask questions.

Staff told us that the practice was well led and the GPs were very supportive. We saw that there was strong leadership within the practice and the GPs were visible and accessible. Records showed that regular staff meetings took place. We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings and through individual appraisals.

We found the practice learned from incidents and near misses. Significant events meetings were held where such issues were discussed. Lessons learned from these discussions were shared with the relevant team members.

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

The practice had made arrangements to seek and act on feedback from patients and staff. The GP partners told us they had been proactive in seeking feedback.

There were suggestion boxes in the waiting rooms and there was an active PPG open to all patients. The PPG contained representatives from some of the key population groups. Regular meetings were held; the practice manager

Are services well-led?

Good

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

and a GP from the practice always attended to support the group. We spoke with two members of the PPG and they felt the practice supported them fully with their work and took on board and acted on any concerns they raised.

NHS England guidance stated that from 1 December 2014, all GP practices must implement the NHS Friends and Family Test (FFT), (the FFT is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience that can be used to improve services. It is a continuous feedback loop between patients and practices).

We saw the practice had introduced the FFT, there were questionnaires available in the waiting rooms and instructions for patients on how to give feedback. The GPs were in the process of reviewing the first set of results.

The practice gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff we spoke with told us their regular meetings provided them with an opportunity to share information, changes or action points. They confirmed they felt involved and engaged in the running of the practice.

The practice had whistleblowing procedures and a detailed policy in place. Staff we spoke with were all able to explain how they would report any such concerns. They were all confident that concerns would be acted upon.

Management lead through learning and improvement

The practice had management systems in place which enabled learning and improved performance.

Staff told us that the practice was very supportive of training. They said they had received the training they needed, both to carry out their roles and responsibilities and to maintain their clinical and professional development. We saw that regular appraisals took place. Staff from the practice also attended the monthly CCG protected learning time (PLT) initiative. This provided the team with dedicated time for learning and development.

The GPs met monthly to discuss any significant incidents that had occurred. Reviews of significant events and other incidents had been completed and shared with staff. Staff meeting minutes showed these events and any actions taken to reduce the risk of them happening again were discussed.

GPs met with colleagues at CCG meetings. They also attended learning events and shared information from these with each other.