Whitehaven Medical Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
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 an announced comprehensive inspection at the Whitehaven Medical Centre on 17 November 2016. Overall, the practice is rated as good.

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

- There was an open and transparent approach to safety and the practice had a system for reporting and recording significant events, and learning from them.
- Risks to patients and staff were assessed and well managed. This included the development of systems and processes to support non-clinical staff to undertake delegated clinical tasks, and audits were being undertaken to ensure these were being carried out safely.
- Effective governance arrangements were in place.
- All staff were actively engaged in monitoring and improving quality and patient outcomes.
- Staff assessed patients' needs and delivered care and treatment in line with current evidence based guidance. They had the skills, knowledge and experience to deliver effective care and treatment.
- The practice worked with other organisations when planning how services were provided, to ensure patients' needs were met.
- Patients said they were treated with dignity and respect and that they were involved in decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Staff were very committed to supporting patients to live healthier lives through a targeted and proactive approach to health promotion.

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- A culture had been created which encouraged and sustained learning and improvement at all levels. Staff felt supported and respected, but it was evident that the new team was still undergoing a period of adjustment, following the recent merger.
- The provider had a clear vision and strategy for the development of the practice and were committed to providing their patients with good quality, safe care.

We saw some areas of outstanding practice:

- The lead GP provider had introduced a system for audio-recording and transcribing patient consultations. This system enabled him to focus on what the patient was saying, rather than on recording what was being said, and he was also able to see more patients during each clinical session. A further benefit of the system was that the clinical records were of a very high quality.
- Data from the NHS National GP Patient Survey of the practice, published in July 2016, showed patient satisfaction with access to appointments, was very good. For example: 100% of patients said the last appointment they got was convenient, compared to the local Clinical Commissioning Group (CCG) average of 94% and the national average of 92%; 96% of patients said they were able to get an appointment to see or speak to someone the last time they tried, compared with the local CCG average of 87% and the national average of 85%; 99% of patients found it easy to get through to the surgery by telephone, compared with the local CCG average of 80% and the national average of 73%.

However, there were also areas where the provider should make improvements. The provider should:

- Carry out more two-cycle clinical audits, to help demonstrate improvements in patient outcomes.
- Prepare a practice development plan which clearly sets out how the provider intends to enact their vision and strategy.
- Review the systems and protocols for preparing referral letters and dealing with incoming patient letters and blood results, to make sure that potential risks are assessed and minimised.
- Review the standard letter issued in response to complaints received to include details of the Parliamentary and Health Service Ombudsman.
- Consider providing a loop system for the use of patients who have a hearing impairment and, making the reception desk more accessible to patients who require the use of a wheelchair.

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.

- There was an effective system for reporting and recording significant events. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned when things went wrong and shared with staff to support improvement.
- There was a system for dealing with safety alerts and sharing these with staff.
- The practice had clearly defined systems and processes that helped keep patients safe. Individual risks to patients had been assessed and were well managed.Effective medicines management systems and processes were in place.
- The premises were clean and hygienic, and effective infection control processes were in place.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Staff were committed to supporting patients to live healthier lives through a targeted and proactive approach to health promotion. This included providing advice and support to patients to help them manage their health and wellbeing.
- The practice used the information collected for the Quality and Outcomes Framework (QOF), and their performance against national screening programmes, to monitor and improve outcomes for patients. The practice's overall achievement, for 2015/16, was broadly in line with the local clinical commissioning group (CCG) and England averages.
- Patients' needs were assessed and care was planned and delivered in line with current evidence based guidance.
- Quality improvement activities, including clinical audit, were carried out to improve patient outcomes. However, there was limited evidence of two-cycle audits having been carried out.
- Staff worked effectively with other health and social care professionals to ensure the range and complexity of patients' needs were met.
- Clinical staff had the skills, knowledge and experience to deliver effective care and treatment.
- The practice's patient clinical record and intranet systems helped to make sure staff had the information they needed to

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plan and deliver care and treatment. However, the delegation of some clinical tasks to non-clinical staff could potentially increase risks to patient safety because significant clinical findings may be missed.

Are services caring?

Good

The practice is rated as good for providing caring services.

- There was a strong, visible, person-centred culture. Staff treated patients with kindness and respect, and maintained patient and information confidentiality. Patients we spoke with, and most of those who had completed a CQC comment card, were very happy with the care and treatment they received.
- Data from the NHS National GP Patient Survey of the practice, published in July 2016, showed levels of patient satisfaction with the quality of GP and nurse consultations, were either better than, or broadly in line with, most of the local CCG and national averages. With regards to how helpful the receptionists were, the levels of patient satisfaction practice were very high.
- Information for patients about the range of services provided by the practice was available and easy to understand.
- Staff had made arrangements to help patients and their carers cope emotionally with their care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice worked with other organisations when planning how services were provided, to ensure they met patients' needs, and provided flexibility, choice and continuity of care.
- Staff were committed to providing proactive, personalised care to meet the needs of older patients. For example, they had participated in a CCG-led pilot to develop a 'Care Co-ordinator' role. (This is a new role where the post holder provides support to patients at risk of an unplanned hospital admission and losing their independence.)
- Data from the NHS National GP Patient Survey of the practice, published in July 2016, showed patient satisfaction with access to appointments, was very good. For example: 100% of patients said the last appointment they got was convenient, compared to the local CCG average of 94% and the national average of 92%; 96% said they were able to get an appointment to see or speak to someone the last time they tried, compared with the

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local CCG average of 87% and the national average of 85%; 99% found it easy to get through to the surgery by telephone, compared with the local CCG average of 80% and the national average of 73%.

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand. Complaints were taken seriously and staff took action to address them. The practice viewed them as opportunities to learn and improve the service they delivered to patients. However, the contact details for the Parliamentary and Health Service Ombudsman (PHSO) had not been included in the complainant response letter.

Are services well-led?

Good

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. However, there was no documented business plan setting out how the lead GP provider intended to enact their strategy and vision.
- A culture had been created which encouraged and sustained learning and improvement at all levels. Staff felt supported and respected.
- The practice had a governance framework which supported the delivery of their strategy, and the provision of good quality care. Quality improvement activity was undertaken, to help improve patient outcomes. There were systems and processes in place which helped to ensure non-clinical staff undertaking delegated clinical tasks were supported to do this safely.
- The lead GP and practice manager had complied with the Duty of Candour regulation. They encouraged a culture of openness and honesty, and ensured that lessons were learned following significant events.
- Following the recent merger with another GP surgery, the practice was actively planning how they could effectively engage with their new patient participation group.

Summary of findings

The six population groups and what we found

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

Older people

Good

- Nationally reported Quality and Outcomes Framework (QOF) data, for 2015/16, showed the practice had performed above, or broadly in line with, most of the local clinical commissioning group (CCG) and national averages, in relation to providing care and treatment for the clinical conditions commonly associated with this population group.
- Staff were committed to providing proactive, personalised care to meet the needs of older patients. For example, they were participating in a CCG-led pilot to set up a 'Care Co-ordinator.' (This is a new role where the post holder provides support to patients at risk of an unplanned hospital admission and losing their independence.) Staff told us that this had helped to monitor the health and wellbeing of older patients who had little or no contact with the practice. All patients over 75 years of age had a named GP who was responsible for their care.
- Staff worked in partnership with other health care professionals to ensure that older patients received the care and treatment they needed.
- The practice had recently introduced nurse-led home visits to monitor the health of housebound patients with the long-term conditions (LTCs). Older patients had access to influenza, shingles and pneumococcal vaccinations, either at the practice or in their own homes.

People with long term conditions

Good

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

- The QOF data, 2015/16, showed the practice had performed above, or broadly in line with, most of the local CCG and national averages, in relation to providing care and treatment for the clinical conditions commonly associated with this population group.
- Patients with long-term conditions were offered regular reviews to check their health needs were being met and that they were receiving the right medication. Longer appointments and home visits were available when needed.
- A member of the nursing team carried out reviews in patients' own homes for those who were housebound.

Summary of findings

Families, children and young people

Good

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

- There were systems in place to protect children who were at risk and living in disadvantaged circumstances. For example, regular multi-disciplinary safeguarding meetings were held where the needs of vulnerable children and families were discussed. All clinical staff had completed appropriate safeguarding training. Appointments were available outside of school hours and the practice's premises were suitable for children and babies.
- The practice offered contraceptive and sexual health advice, and information was available, about how patients could access specialist sexual health services.
- The practice had a comprehensive screening programme. Publicly available information showed the practice had performed well in relation to the national breast screening average, and broadly in line with the cervical screening national average. The uptake of cervical screening for females aged between 25 and 64, attending during the target period, was, at 76%, slightly below the national average of 81.8%. However, publicly available data showed that less patients had accessed the national bowel cancer screening programme.
- The practice offered a full range of immunisations for children. Publicly available information showed they had performed better than the local CCG averages in relation to delivering immunisations to five year olds. For five year olds, the rates ranged from 92.3% to 100% (the local CCG averages ranged from 81.4% to 95.1%). The immunisation rates for children aged 12 months old were 85.7%. (These were broadly in line with the local CCG averages which ranged from 73.3% to 93.1%).

Working age people (including those recently retired and students)

Good

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

- The needs of the working population had been identified, and the practice adjusted the services it provided to ensure there were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services, as well as a full range of health promotion and screening that reflected the needs of this group of patients.

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- The QOF data showed the practice had performed either above, or broadly in line with, most of the local CCG and England averages, in providing recommended care and treatment to this group of patients.
- Working age patients had very good access to appointments. Extended hours appointments were routinely provided between 6:30pm and 7pm each weekday.
- Information on the practice's website, and on display in their patient waiting areas, informed them how to access the out-of-hours service.

People whose circumstances may make them vulnerable

Good

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

- The practice held registers of patients living in vulnerable circumstances. For example, staff maintained a register of patients with learning disabilities which they used to ensure they received an annual healthcare review.
- Information about the practice's most vulnerable patients was shared with the local out-of-hours service, to help promote continuity of care for these people.
- Systems were in place to protect vulnerable children from harm. Staff understood their responsibilities regarding information sharing and the documentation of safeguarding concerns, and they regularly worked with multi-disciplinary teams to help protect vulnerable patients. Staff were aware of how to contact relevant agencies in normal working hours and out-of-hours.
- Appropriate arrangements had been made to meet the needs of patients who were also carers.

People experiencing poor mental health (including people with dementia)

Good

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

- The QOF data, for 2015/16, showed the practice had performed above the local CCG and national averages, in relation to providing care and treatment to this group of patients.
- The practice's clinical IT system clearly identified patients with dementia and mental health needs, to ensure staff were aware of their specific needs. The QOF data, for 2015/16, indicated

that the percentage of patients with specified mental health conditions, who had a care plan documented in their medical record during the previous 12 months, was much better than the national average, (96.7% compared to 88.5%.)

- Patients experiencing poor mental health had access to information about how to contact various support groups and voluntary organisations.
- Clinical staff actively carried out opportunistic dementia screening, to help ensure their patients were receiving the care and support they needed to stay healthy and safe.
- Staff had completed Dementia training, which helps to raise awareness of dementia related issues.

Summary of findings

What people who use the service say

As part of our inspection we asked practice staff to invite patients to complete Care Quality Commission (CQC) comment cards. We received 34 completed comment cards and these were mostly very positive about the standard of care and treatment provided. Words used to describe the service included: absolutely fabulous; very professional; first class practice; very professional treatment; excellent care; facilities first class; very helpful; exceptional. The majority of cards contained positive feedback. However, there were five negative comments. These related to: a refusal to undertake a home visit to a patient living in a care home; the lack of privacy in the reception area; a changed atmosphere since the recent merger; long appointment waiting times, and difficulties experienced by a patient using a wheelchair trying to negotiate the dropped kerb outside of the practice.

We spoke with five patients during the inspection. Feedback was varied. Most reported staff treated them well, respected their dignity and privacy, and gave them enough time during consultations. However, there was also less positive feedback. Two patients expressed concern about unhelpful and unfriendly staff attitudes. Most patients reported they were unaware they were being recorded during consultations with the GP, and also said they did not know how to complain. One patient expressed concern about the lack of privacy in the waiting area. Two patients mentioned that appointments did not always run on time and one said that there were not enough medical staff.

Data from the NHS National GP Patient Survey of the practice, published in July 2016, showed patient satisfaction with the quality of GP and nurse consultations and the reception team, was mostly better than, or in line with, the local clinical commissioning group (CCG) and national averages. In relation to appointment convenience and the helpfulness of receptionists, the practice had performed very well. For example, of the patients who responded to the survey:

- 95% had confidence and trust in the last GP they saw. This was the same as the national average, but just below the local CCG average of 97%.
- 85% said the last GP they saw treated them with care and concern. This was the same as the national average, but below the local CCG average of 90%.
- 91% said the last GP they saw was good at listening to them, compared to the local CCG average of 94% and the national average of 89%.
- 92% said the last GP they saw was good at giving them enough time, compared to the local CCG of 91% and the national average of 87%.
- 98% had confidence and trust in the last nurse they saw or spoke to. This was the same as the local CCG average, but above the national average of 97%.
- 95% said the last nurse they saw was good at listening to them, compared to the local CCG of 94% and the national average of 91%.
- 94% said the last nurse they saw treated them with care and concern. This was the same as the local CCG average, but above the national average of 91%.
- 96% said the last nurse they saw was good at giving them enough time, compared to the local CCG of 95% and the national average of 92%.
- 100% said the last appointment they got was convenient, compared with the local CCG average of 94% and the national average of 92%.
- 96% were able to get an appointment to see or speak to someone the last time they tried, compared with the local CCG average of 87% and the national average of 85%.
- 99% found it easy to get through to the surgery by telephone, compared with the local CCG average of 80% and the national average of 73%.
- 78% said they usually waited 15 minutes or less after their appointment time, compared to the local CCG average of 67% and the national average of 65%.

(273 surveys were sent out. There were 110 responses which was a response rate of 40.3%. This equated to 2.5% of the practice population.)

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- Carry out more two-cycle clinical audits, to help demonstrate improvements in patient outcomes.
- Prepare a practice development plan which clearly sets out how the provider intends to enact their vision and strategy.
- Review the systems and protocols for preparing referral letters and dealing with incoming patient letters and blood results, to make sure that potential risks are assessed and minimised.
- Review the standard letter issued in response to complaints received to include details of the Parliamentary and Health Service Ombudsman.
- Consider providing a loop system for the use of patients who have a hearing impairment and, making the reception desk more accessible to patients who require the use of a wheelchair.

Outstanding practice

- The lead GP provider had introduced a system for audio-recording and transcribing patient consultations. This system enabled him to focus on what the patient was saying, rather than on recording what was being said, and he was also able to see more patients during each clinical session. A further benefit of the system was that the clinical records were of a very high quality.
- Data from the NHS National GP Patient Survey of the practice, published in July 2016, showed patient satisfaction with access to appointments, was very good. For example: 100% of patients said the last appointment they got was convenient, compared to the local Clinical Commissioning Group (CCG) average of 94% and the national average of 92%; 96% of patients said they were able to get an appointment to see or speak to someone the last time they tried, compared with the local CCG average of 87% and the national average of 85%; 99% of patients found it easy to get through to the surgery by telephone, compared with the local CCG average of 80% and the national average of 73%.

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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 advisor, and a second CQC inspector. There was also an Expert by Experience. An expert by experience is somebody who has personal experience of using or caring for someone who uses a health, mental health and/or social care service.

Background to Whitehaven Medical Centre

Whitehaven Medical Centre provides care and treatment to 4396 patients of all ages, based on a General Medical Services (GMS) contract. The practice is part of the NHS Cumbria clinical commissioning group (CCG). We visited the following location as part of inspection: Catherine Street, Whitehaven, Cumbria, CA28 7PA. The practice had merged with a local GP surgery in August 2016, with staff and patients transferring across to the Whitehaven Medical Group.

The practice is a dispensing surgery which means they can, if they meet certain criteria, supply eligible patients with medicines directly.

The practice serves an area where deprivation is higher than the England average. In general, people living in more deprived areas tend to have a greater need for health services. The percentage of people with a long-standing health condition is higher than the national average, 61.3% compared to 54%. Life expectancy for men is lower than the national average, 77 years compared to 79 years. The life expectancy for women is also lower than the national average, 81 years to 83 years.

The practice relocated to its current site in November 2014 and now occupies a building that has been adapted to meet patients' needs. All treatment and consultation rooms are located on the ground floor. The practice has a lead GP (male) who is one of the providers. The other provider is the practice/medicines manager (female). The practice also employs a regular, experienced long-term GP (male). There is a nurse practitioner (NP) and three practice nurses (female), as well as a healthcare assistant (female), and a team of administrative and reception staff. There were no arrangements for patients to be able to see a female GP if they wanted to. However, the NP held their own daily clinical sessions, and we were told the other practice nurses would be available if patients were not comfortable with seeing a male GP.

It states we have no arrangements for female patient to see a female GP. They can access the Nurse Practitioner clinics as she sees all patients.

The practice is open:

Monday to Friday: 8am to 6:30pm.

Extended hours are provided between 6:30pm and 7pm Monday to Friday.

Staff are available to answer the telephone from 8am and 6:30pm.

GP appointment times are:

Monday to Friday: 8:10am to 12 noon, and then 2pm to 6pm.

The practice is closed at the weekend.

When the practice is closed patients can access out-of-hours care via Cumbria Health On Call, and the NHS 111 service.

Detailed findings

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 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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 17 November 2016. During our visit we:

- Spoke with a range of staff, including the GP provider, the practice manager, a dispenser, two nurses and some of the administrative staff. We also spoke with five patients, including a member of the practice's patient participation group.
- Observed how staff interacted with patients in the reception and waiting area.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients shared their views and experiences of the service.

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

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

We also looked at how well services were provided for specific groups of people and what good care looked 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).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff had identified and reported on five significant events during the previous 12 months. Copies of significant event reports could be accessed by all staff on the practice intranet system. The sample of records we looked at, and evidence obtained from interviews with staff, showed the practice had managed such events consistently and appropriately. Following a significant event where a home visit had been missed, we saw action had been taken to prevent a reoccurrence. For example, clinicians had been reminded of the need to check the home visit computer screen after their morning clinical session and the home visit slot colour was changed from green to red to make them stand out more.
- The practice's approach to the handling and reporting of significant events ensured that the provider complied with their responsibilities under the Duty of Candour regulation. (The Duty of Candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.)
- The practice had systems for responding to safety alerts and sharing these with staff, and for recording, investigating and learning from incidents. Staff we spoke with were clear about how they would raise concerns or report on any incident that occurred. The practice manager told us they were unable to access the local clinical commissioning group's (CCG) Safeguard Incident and Risk Management System (SIRMS). They said this had been raised with the local CCG. (This system enables GPs to flag up any issues via their surgery computer, to a central monitoring system, so that the local CCG can identify any trends and areas for improvement.)

Overview of safety systems and processes

The practice had a range of clearly defined and embedded systems and processes in place which helped to keep patients and staff safe and free from harm. These included:

- Arrangements to safeguard children and vulnerable adults. Policies and procedures for safeguarding children and vulnerable adults were in place. Staff told us they were able to easily access these. The lead GP acted as the children and vulnerable adults safeguarding lead, providing advice and guidance to team members when required. Staff demonstrated they understood their safeguarding responsibilities and said they knew what to do if they were concerned about a patient's wellbeing. Although multi-disciplinary meetings (MDT) were held fortnightly to discuss the needs of patients with complex needs, 'bespoke' safeguarding meetings did not take place. The lead GP told us that the local health visitor team was always invited to attend these meetings, but said attendance was rare. They also told us any concerns they had would be shared immediately with the local health visitor. Children at risk were clearly identified on the practice's clinical IT system via relevant codes, so clinical staff took this into account during consultations. The majority of staff had received safeguarding training relevant to their role. For example, the lead GP had completed level three child protection training.
- Chaperone arrangements to protect patients from harm. All the staff who acted as chaperones were trained for the role and had undergone a Disclosure and Barring Service (DBS) check. (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.) The chaperone service was advertised on posters displayed in the waiting area, as well as above the examination couches in each consultation room.
- Appropriate standards of cleanliness and hygiene. The practice employed their own cleaning staff who worked to an agreed schedule. There was an identified infection control lead and infection control protocols in place. These could be easily accessed by staff on the practice's IT system shared drive. Most staff had completed infection control training appropriate to roles and responsibilities. Quarterly infection control audits had been completed. Sharps bin receptacles were available in the consultation rooms. Those looked at had been signed and dated by the assembler. Clinical waste was appropriately handled.
- Appropriate arrangements for managing medicines, including emergency drugs and vaccines. The practice had a range of dispensing standard operating

procedures, which had recently been audited to ensure they were being followed by staff. The practice had a system for managing high-risk medicines. Although we identified that staff had sometimes failed to update their high-risk medicines paper records system, patients' electronic medical records were up-to-date. Although a log was kept of the serial numbers of prescription forms placed in the printers, staff did not maintain a similar log when prescription forms were distributed to the clinical staff.

- All prescription forms were securely stored. Prescriptions were signed by the lead GP before being dispensed and a suitable system was in place to ensure that dispensed medicines were collected by the right patient. Dispensed medicines were checked each month to identify any that had not been collected. Dispensers had completed appropriate training and underwent an in-house competency assessment, to help ensure they were dispensing safely.
- Suitable arrangements had been made to store and monitor vaccines. These included carrying out daily temperature checks of the vaccine refrigerators and keeping appropriate records. Patient Group Directions (PGD) had been adopted by the practice, to enable nurses to administer medicines in line with legislation. These were up-to-date and had been signed. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.)
- The carrying out of a range of employment checks to make sure staff were safe to work with vulnerable patients. We looked at a sample of staff recruitment files. Appropriate indemnity cover was in place for all clinical staff. The provider had obtained information about staff's previous employment and, where relevant, copies of their qualifications, as well as written references. The provider had also carried out DBS checks on each person and obtained proof of their identity.

Monitoring risks to patients

Overall, risks to patients were assessed and well managed.

- There were procedures for monitoring and managing risks to patient and staff safety. For example, the practice had arranged for all clinical equipment to be serviced and, where appropriate, calibrated, to ensure they were safe and being maintained in good working order. A range of other routine safety checks had also been carried out. These included checks of electrical and fire safety equipment, and the completion of a fire risk assessment. All staff had completed fire safety training and fire drills had previously taken place during 2015. A fire drill was also planned for the week following this inspection. The practice manager had carried out a review of health and safety arrangements in February 2016. A more comprehensive health and safety risk assessment was also carried out in April 2016, to help keep the building safe and free from hazards. The practice had a legionella protocol, underpinned by a risk assessment that had been reviewed during the previous 12 months. Staff carried out regular checks of the temperature of the water supply to prevent the spread of legionella, and a contractor was employed to carry out tests for the presence of the bacteria. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal.)
- There were suitable arrangements in place for planning and monitoring the number and mix of staff required to meet patients' needs. The lead GP and practice manager had reviewed capacity and demand levels, and had taken action to help make sure there were sufficient numbers of staff. This included re-designing systems and processes to help maximise the amount of time the lead GP could spend with patients. An experienced nurse practitioner had recently been appointed, to help increase the number of available appointments, reduce waiting times for appointments and enable the lead GP to have time to deal with more complex cases. The practice had also appointed a GP locum to work one day a week to help smooth the transition of patients from the surgery that had merged with the Whitehaven Medical Group and offer continuity of care. (The GP locum had previously worked at the practice that had merged.) There were sufficient numbers of nursing and non-clinical staff, to meet current patient demand. Rotas were in place which helped to make sure sufficient numbers of staff were always on duty to meet patients' needs.

Arrangements to deal with emergencies and major incidents

Good

Are services safe?

The practice had made satisfactory arrangements to deal with emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms, which alerted staff to any emergency.
- The majority of staff had completed basic life support training, to help them respond effectively in the event of an emergency. Arrangements were being made to provide refresher training for a member of the administrative team who was on leave when this was last provided. However, they had last received such training in 2015.
- Emergency medicines were available in the practice, and these were kept in a secure area. All of the emergency medicines we checked were within their expiry dates.
- Staff had access to a defibrillator and a supply of oxygen for use in an emergency. Regular checks were carried out to make sure they were in good working order.
- The practice had a business continuity plan for major incidents. This was accessible to all staff via the practice's intranet system. Key staff were able to access the plan remotely out-of-hours. We identified that some of the key emergency contact numbers had not been completed. The practice manager agreed to address this matter following the inspection.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The lead GP received NICE updates, and ensured these were discussed with the nurse practitioner.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF), and their performance against national screening programmes, to monitor and improve outcomes for patients. The QOF data, for 2015/16, showed the practice had obtained 92.9% of the total points available to them for providing recommended care and treatment. This was similar to the local CCG average of 94.9%, and the England average of 97.7%.

- Performance for the diabetes related indicators was either better than, or broadly in line with, the England averages, For example, the percentage of patients with diabetes, for whom the last blood pressure reading, in the period from 1 April 2014 to 31 March 2015, was 140/80 mmHg or less, was higher than the England average (92.6% compared to 78%). The data also showed the percentage of patients with diabetes, with a record of a foot examination and risk classification, during the same period of time, was broadly in line with, the England average (87.4% compared to 88.3%).
- Performance for the mental health related indicators was better than most of the England averages. For example, the percentage of patients with the specified mental health conditions, who had had a comprehensive, agreed care plan documented in their medical record, during the period from 1 April 2014 to 31 March 2015, was higher than the England average (96.7% compared to 88.5%). The data also showed that the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses, whose alcohol consumption had been recorded, during the same period of time, was higher than when compared to the England average (95.2% compared to 89.5%).

The practice's exception reporting rate, at 13.8%, was 3.6% above the local CCG average and 4.6% above the England average. (The QOF scheme includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect.) We discussed this exception reporting rate with the lead GP. They told us the practice's QOF performance was regularly reviewed by the practice manager and that an effective patient recall system was in place. Patients who failed to respond to an invitation to attend for their healthcare review were personally contacted by telephone, email or, when they next time came into the practice.

There was evidence of quality improvement activity, which included clinical and non-clinical audits. However, there was limited evidence of two-cycle audits having been completed. The provider told us they would consider how they could strengthen their audit arrangements. Shortly following the inspection, the provider sent us a programme of the improvement audits they intended to carry out over the next 18 months.

The audits we looked at were relevant, showed learning points and evidence of changes to practice. The audits were clearly linked to areas where staff had identified potential risks to their patients. Plans were in place to repeat the appointment, dispensing and transcribing audits during the next 12 months. We looked at some of those that had been carried out during the previous 12 months. These included:

- A two-cycle clinical audit that focussed on ensuring cost-effective prescribing of food supplements. Improvements included the development of an enteral feeding protocol and the referral of patients assessed as needing food supplements to a dietician.
- An audit to check whether medicines that had been dispensed had received a final accuracy check to ensure prescription items had been correctly dispensed.
- An audit of appointment availability, to ensure there was sufficient capacity to meet patients' needs, following the merger with another practice.
- A transcription audit to help ensure that patient consultation audio-recordings were being correctly transcribed.

Good

Are services effective?

(for example, treatment is effective)

We received positive feedback about staff's approach to prescribing from the local CCG pharmacist supporting the practice. For example, they told us that, prior to the merger of another local surgery with the Whitehaven Medical Group, staff had been effective in reducing their Benzodiazepine prescribing rate. The pharmacist told us that, after the merger, local data showed the practice once again had a high Benzodiazepine prescribing rate, but staff were already working hard to reduce this. They also said the practice manager closely monitored prescribing rates and that staff were easy to work with, open to advice and actively sought support, to help improve their performance.

Effective staffing

Overall, staff had the skills, knowledge and experience needed to deliver effective care and treatment.

- The practice had an induction programme for newly appointed staff. A member of staff told us they had received an induction on transferring to the practice following the recent merger.
- The practice could demonstrate how they ensured staff received role specific training. For example, the nursing staff had completed additional post qualification training, to help them meet patients' needs. All of the nurses had recently updated their cervical screening training, and had just completed an update to help them effectively monitor patients prescribed Warfarin. (Warfarin is a medication which requires patients to have regular blood tests to determine their dose). Dispensing staff and the practice manager had completed vocational training in how to safely dispense medicines. All the staff whose files we sampled had completed training in fire safety, child protection, basic life support and information governance. Most had completed training in infection control and safeguarding vulnerable adults. There were small gaps in some staff's training which the practice manager agreed to address following the inspection.
- Staff had received an annual appraisal of their performance during the previous 12 months. Appropriate arrangements were in place to support the lead GP to undergo revalidation with the General Medical Council.

Coordinating patient care and information sharing

The practice's patient clinical record and intranet systems helped to make sure staff had the information they needed to plan and deliver care and treatment.

- The information included patients' medical records and test results. Staff shared NHS patient information leaflets, and other forms of guidance, with patients to help them manage their long-term conditions.
- All patient consultations carried out by the lead GP were audio-recorded, and then transcribed by a designated member of the administration team, who had received specific training to enable them to do this. These transcriptions were completed immediately following each consultation and uploaded onto each patient's medical records. The lead GP told us these arrangements enabled them to focus on what the patient was saying, rather than on recording what was being said. They also said it enabled them to see more patients during each clinical session and that the audio-recordings were deleted, usually within 20 minutes of each consultation. They said these arrangements complied with the guidance issued by the General Medical Council as well as the Data Protection Act. Patients were encouraged to record the consultation themselves, so that they could refer to this following their appointment. The Nurse Practitioner currently typed up notes from their own consultations, but plans were being made to support them to use the same audio-recording and transcription system.
- A comprehensive transcription protocol was in place and information about the audio-recording of patient consultations was clearly displayed on a poster in the patient waiting area, as well as on the television screen in same area. This information was also included in the information pack for new patients. In addition, at the time that the audio-recording of consultations was introduced, all patients were sent information about these arrangements, as well as a permission slip for them to complete. We were told patients were able to opt-out of this process, and that this would be highlighted in their medical records. However, some of the patients we spoke to said they were not aware their consultations were being recorded. To help reduce any potential risks related to this process of transcription, the lead GP had prepared a standard template for carrying out consultations. We looked at a sample of patient consultation records and saw that they were of a

very high quality. Potential risks associated with this approach were being managed via regular weekly checks. There had also been one in depth audit of this process. Plans were under consideration to extend this process to include consultations carried out by the nurse practitioner.

- The READ coding of incoming post relating to patients was carried out by a non-clinical member of staff.(READ codes are the standard clinical terminology system used in general practice).This member of staff 'filtered' the mail so that letters with 'no action required by GP' were filed, and letters with 'action required by GP' were sent to the lead GP. It was evident the practice had a very thorough approach to READ coding. There was a clear process and written protocol which described how incoming post should be handled. Staff we spoke with were clear about the process, and a recent audit had been carried out to determine whether it was being appropriately implemented. Where the audit had identified concerns, an action plan had been drawn up to address these. For example, the plan included sourcing a specific coding course, for the non-clinical member of staff who dealt with the post, as well as providing them with relevant support and on-going supervision. The practice manager told us further audits would be carried out every three months to identify and address any other potential risks to patient safety.In addition to these audits, the practice manager also checked each day whether patient information had been coded correctly.
- Routine blood results were screened and filed by a designated non-clinical member of staff, rather than a member of the clinical team. (The practice told us that this person had previously been a registered nurse and therefore had recent experience of checking blood results.)This task was supported by an appropriate protocol, which included guidance on referring potentially complex blood results to the lead GP for review. The practice had recently started auditing a sample of the routine blood results to check whether they were being processed correctly. The provider said they intended to carry out such an audit every three months.
- All referral letters were prepared by a non-clinical member of staff. The lead GP read and checked all of these letters to ensure they were correct. They told us that because they no longer prepared the referral letters, they had more time for patient consultations. They also said that the turnaround time for making a referral had improved as a consequence, with some being actioned on the same-day and all being actioned within 48 working hours.
- Although the inspection team understood the reasons why the lead GP had decided to use non-clinical staff to deal with some of the tasks referred to above, this could potentially increase risks to patient safety, because significant clinical findings may be missed. The practice had already identified these potential risks and had recently commenced a programme of audits to mitigate them.
- Referrals for pathology and X-rays were handled in a similar manner, and included a review by the lead GP. We noted that the system for handling pathology results had not yet been formally audited. We shared this with the lead GP and they agreed to introduce regular audits of this process.
- All relevant information was shared with other services, such as hospitals, in a timely way. Important information about the needs of vulnerable patients was shared with the out-of-hours and emergency services.
- Staff worked together with other health and social care professionals, to meet the range and complexity of patients' needs and to assess and plan on-going care and treatment.

Consent to care and treatment

Patients' consent to care and treatment was sought in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of the legislation and guidance, including the Mental Capacity Act (MCA, 2005). When staff provided care and treatment to young people, or adult patients whose mental capacity to consent was unclear, they carried out appropriate assessments of their capacity and recorded the outcome. Relevant staff had completed training in the use of the MCA.

Supporting patients to live healthier lives

Good

Are services effective?

(for example, treatment is effective)

Staff were committed to supporting patients to live healthier lives through a targeted and proactive approach to health promotion.

- Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged between 40 and 74 years.
- There were suitable arrangements for making sure any abnormalities or risks identified during these checks were followed up by the lead GP or the nurse practitioner.

The practice had a comprehensive screening programme. Publicly reported information showed the practice had performed well when compared to the national breast screening average, and was broadly in line with the national average cervical screening. However, they had performed less well with regards to bowel cancer screening.

- The uptake of breast screening by females aged between 50 and 70, during the previous 36 months, was above the national average, 75.3% compared to 72.2%.
- The uptake of bowel cancer screening by patients aged between 60 and 69, during the previous 30 months, was below the national average, 49.4% compared to 57.9%.
- The uptake of cervical screening for females aged between 25 and 64, attending during the target period, was at 76%, slightly below the national average of 81.8%. The practice had protocols for the management of cervical screening, and for informing women of the results of these tests. These protocols were in line with national guidance.
- The practice offered a full range of immunisations for children. Publicly available information showed they had performed better than the local CCG averages in relation to delivering immunisations to five year olds. The rates ranged from 92.3% to 100% (the local CCG averages ranged from 81.4% to 95.1%). The immunisation rates for children aged 12 months old were 85.7%. (These were broadly in line with the local CCG averages which ranged from 73.3% to 93.1%).

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff were highly motivated to offer care that was kind, promoted patients' dignity and respected cultural differences. Throughout the inspection staff were courteous and helpful to patients who attended the practice or contacted it by telephone. We saw that patients were treated with dignity and respect. Privacy screens were provided in consulting rooms so that patients' privacy and dignity could be maintained during examinations and treatments. Consultation and treatment room doors were closed during consultations, so that conversations could not be overheard. Although the seats in the waiting area were located close to the reception desk, staff spoke clearly about how they managed patient confidentiality. This included the offer of a private space if patients needed to discuss a confidential matter. Plans had been made to increase the size of the waiting area, however, the practice had been unsuccessful in securing the funds necessary to achieve this.

We spoke with five patients during the inspection. Feedback was varied. Most reported staff treated them well, respected their dignity and privacy, and gave them enough time during consultations. However, two patients expressed less positive comments about a staff member's attitude towards them.

As part of our inspection we asked practice staff to invite patients to complete Care Quality Commission (CQC) comment cards. We received 34 completed comment cards and these were mostly very positive about the standard of care and treatment provided. Words used to describe the service included: absolutely fabulous; very professional; first class practice; very professional treatment; excellent care; facilities first class; very helpful; exceptional. However, there were five less positive comments. These related to: a refusal to undertake a home visit to a patient living in a care home; the lack of privacy in the reception area; a 'changed atmosphere' since the recent merger.

Data from the NHS National GP Patient Survey of the practice, published in July 2016, showed patient satisfaction with the quality of GP and nurse consultations were in line with the local clinical commissioning group (CCG) and national averages. In relation to the helpfulness of receptionists, the practice had performed very well. For example, of the patients who responded to the survey:

- 95% had confidence and trust in the last GP they saw. This was the same as the national average, but just below the local CCG average of 97%.
- 85% said the last GP they saw treated them with care and concern. This was the same as the national average, but below the local CCG average of 90%.
- 91% said the last GP they saw was good at listening to them, compared to the local CCG average of 94% and the national average of 89%.
- 92% said the last GP they saw was good at giving them enough time, compared to the local CCG of 91% and the national average of 87%.
- 98% had confidence and trust in the last nurse they saw or spoke to. This was the same as the local CCG average, but above the national average of 97%.
- 95% said the last nurse they saw was good at listening to them, compared to the local CCG of 94% and the national average of 91%.
- 94% said the last nurse they saw treated them with care and concern. This was the same as the local CCG average, but above the national average of 91%.
- 96% said the last nurse they saw was good at giving them enough time, compared to the local CCG of 95% and the national average of 92%.
- 100% found receptionists at the practice helpful, compared with the local CCG average of 90% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with, and those who commented on this in their CQC comment cards, told us clinical staff involved them in decisions about their care and treatment. Results from the NHS GP Patient Survey of the practice showed patient satisfaction levels regarding involvement in decision-making was either above, or broadly in line with, the local CCG and national averages. Of the patients who responded to the survey:

Good

Are services caring?

- 85% said the last GP they saw was good at explaining tests and treatments, compared to the local CCG average of 90% and the national average of 86%.
- 85% said the last GP they saw was good at involving them in decisions about their care, compared to the local CCG average of 86% and the national average of 82%.
- 94% said the last nurse they saw was good at explaining tests and treatments, compared with the local CCG average of 92% and the national average of 90%.
- 94% said the last nurse they saw was good at involving them in decisions about their care, compared to the local CCG average of 89% and the national average of 85%.

Patient and carer support to cope emotionally with care and treatment

Staff were good at helping patients and their carers to cope emotionally with their care and treatment.

- Staff understood patients' social needs, supported them to manage their own health and care, and helped them maintain their independence.
- Notices in the patient waiting room told patients how to access a range of support groups and organisations.
- Where patients had experienced bereavement, staff would contact them to offer condolences and support.

The practice was committed to supporting patients who were also carers.

- Staff maintained a register of these patients, to help make sure they received appropriate support, such as an annual influenza vaccination and the offer of a carers health check. There were 117 patients on this register, which equated to 3% of the practice's population.
- A member of the nursing team acted as the carers' lead and, where appropriate, provided support, including referring patients to the local carers' association, to help them access help and advice.
- Two members of staff currently shared the role of 'Care Navigator', to help provide extra, targeted support to patients at risk of an unplanned hospital admission and losing their independence.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Services were planned and delivered to take into account the needs of different patient groups and to provide flexibility and choice. Examples of the practice being responsive to, and meeting patients' needs included:

- Providing all patients over 75 years of age with a named GP who was responsible for their care, and access to a regular health review and check-up, with a member of the nursing team. The practice had recently introduced nurse-led home visits, to monitor the health of housebound patients with the long-term conditions (LTCs). Staff were committed to providing proactive, personalised care to meet the needs of older patients. For example, two members of staff acted as 'Care Co-ordinators,' providing extra support to patients at risk of an unplanned hospital admission and losing their independence. Older patients had access to influenza, shingles and pneumococcal vaccinations, either at the practice or in their own homes.
- Providing nurse-led LTCs clinics, to help ensure patients received the care, treatment and support they needed to manage their illnesses. A member of the nursing team carried out reviews in patients' own homes for those who were housebound. The practice had developed a system which helped to alert staff about patients with specific LTCs required ongoing blood monitoring.
- Appointments were available outside of school hours and ill children had access to same day care. The practice premises were suitable for children and babies. The practice offered contraceptive services, and sexual health information was available in the waiting area. Patients were able to access weekly midwife-led ante-natal care clinics, and clinicians undertook six week post-natal checks.
- Clearly identifying patients on the Care plans had been put in place to meet the needs of patients with specified mental health conditions, including those with dementia. Patients experiencing poor mental health had access to information about relevant support groups and voluntary organisations. Staff told us that, where appropriate, they referred patients to local mental health services, to help ensure they could access appropriate care and treatment.
- The nursing team offering a range of health promotion clinics, including smoking cessation appointments and new patient checks. The practice provided a very responsive appointment system, with extended hours appointments available Monday to Friday between 6:30pm and 7pm. Patients were able to book appointments and request prescriptions online.
- Making reasonable adjustments to help patients with disabilities, and those whose first language was not English, to access the practice. disabled toilet which had appropriate aids and adaptations.
- Making arrangements to meet the needs of vulnerable patients. For example, staff maintained a register of patients with learning disabilities which they used to ensure they received an annual healthcare review. Information about the practice's most vulnerable patients was shared with the local out-of-hours service, to help promote continuity of care for these people. Systems were in place to protect vulnerable children from harm. Staff understood their responsibilities regarding information sharing and the documentation of safeguarding concerns, and they regularly worked with multi-disciplinary teams to help protect vulnerable patients. Staff were able to provide examples of how they went the 'extra mile' for their patients. For example, staff routinely issued prescriptions on a monthly basis, for those patients who were unable to remember to re-order them. Daily prescriptions were provided for those patients at risk of an overdose. Staff had contacted probation officers and social workers, to help ensure a patient of no fixed abode received appropriate care and support. The provider told us they had also purchased food for this patient.

Access to the service

The practice was open Monday to Friday between 8am to 6:30pm. Extended hours were available Monday to Friday between 6:30pm and 7pm.

All consultations were by appointment only and could be booked by telephone, in person or on-line. Patients who called before 2pm were able to access same day appointments. Patients who requested same day appointments after 2pm would still be included on the lead GP's clinic list for that day. If patients wanted to book appointments in advance, they were also able to do this. The receptionist we spoke with said the lead GP would

Good

Are services responsive to people's needs?

(for example, to feedback?)

always fit in any patient who said they needed to see a doctor urgently. A real-time check of the appointment system indicated that the next routine appointments for a GP or nurse were available within two days of the inspection.

The practice had a system in place to assess whether a home visit was clinically necessary; and the urgency of the need for medical attention. All patients requesting a home visit were called back and triaged using a standardised template designed by the lead GP. Records of triaged telephone calls were saved onto the patient's medical record and then discussed by staff at the daily clinical meeting. This process enabled visits to be prioritised and carried out where appropriate. We were told that telephone consultations were also offered if this was appropriate. The lead GP provider had recently made a decision that the nurse practitioner would carry out home visits from 10am onwards, to help ensure patients' needs were met more promptly.

The majority of patients who provided feedback on CQC comment cards raised no concerns about telephone access to the practice, or appointment availability. Results from the NHS GP Patient Survey of the practice, published in July 2016, showed that they had performed very well in relation to telephone access and appointment availability. Patient satisfaction levels were above the local clinical Commissioning group (CCG) and national averages. Of the patients who responded to the survey:

- 100% said the last appointment they got was convenient, compared with the local CCG average of 94% and the national average of 92%.
- 96% were able to get an appointment to see or speak to someone the last time they tried, compared with the local CCG average of 87% and the national average of 85%.
- 99% found it easy to get through to the surgery by telephone, compared with the local CCG average of 80% and the national average of 73%.
- 78% said they usually waited 15 minutes or less after their appointment time, compared to the local CCG average of 67% and the national average of 65%.

Listening and learning from concerns and complaints

The practice had a system in place for managing complaints.

- This included having a designated senior member of staff who was responsible for handling any complaints and there was a complaints policy which provided staff with guidance about how to handle them. Information about how to complain was available on the practice's website and was also on display in the patient waiting areas.
- The practice had received four complaints during the previous 12 months. In the complaint we sampled, we saw staff had offered an apology as well as an open invitation to speak with a GP about the complaint findings. It was clear staff had responded promptly to the patient's concerns and treated the issues they raised with seriously. However, the contact details for the Parliamentary and Health Service Ombudsman (PHSO) had not been included in the complainant response letter.

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 clear vision to deliver high quality care and promote good outcomes for patients.

- The lead GP and practice manager were highly motivated and committed to improving the quality of care and treatment provided to patients. This was clearly demonstrated in the presentation they made to us at the beginning of the inspection. Staff we spoke with understood what the management team was trying to achieve in terms of the quality of service provided to patients, and they had a clear understanding of their roles and responsibilities.
- Staff engaged with the local clinical commissioning group's (CCG) Quality Incentive Scheme, and used this to drive improvements. However, there was no documented business plan which set out how the lead GP intended to enact their vision and strategy.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the lead GP's strategy for delivering good quality care. This ensured that:

- There was a clear staffing structure and staff understood their roles and responsibilities. The practice manager told us staff roles and responsibilities were still being adjusted following the recent merger with a local practice.
- Staff had access to a range of policies and procedures, which they were expected to follow.
- Staff had lead roles, to help ensure key tasks were carried out safely and effectively. For example, the nurse practitioner (NP) ran their own clinics providing GP style consultations, in addition to dealing with minor injuries and ailments.
- Quality improvement activity was undertaken, to help improve patient outcomes. Staff were supported to learn lessons when things went wrong, and there was a culture which supported the identification, promotion and sharing of good practice.
- Regular planned meetings were held to share information and manage patient risk. These included daily clinical meetings, involving the lead GP, the NP and the practice manager, to discuss emerging clinical issues and any practice management related concerns. Multi-disciplinary meetings took place every other week, involving key clinical staff, the palliative care nurse and members of the community nursing team. This helped to ensure the needs of vulnerable patients were regularly reviewed. Full team meetings were held approximately every quarter. However, plans were being made to hold these on a more regular basis once everything had settled down following the merger.

Leadership, openness and transparency

On the day of the inspection, the lead GP and practice manager demonstrated they had the experience, capacity and capability to run the practice and ensure high quality, compassionate care. They told us they prioritised safe, high quality care which placed the patient at the forefront of everything the practice did.

The provider had complied with the requirements of the Duty of Candour regulation. (The Duty of Candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

- The lead GP and practice manager encouraged a culture of openness and honesty. There were effective systems which ensured that when things went wrong, patients received an apology and action was taken to prevent the same thing from happening again.
- A culture had been created which encouraged and sustained learning at all levels. Staff we spoke with told us they felt supported, valued and respected by the lead GP and practice manager. They said they would feel comfortable about raising any concerns.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients and staff. Staff had gathered feedback from patients through their Friends and Family Test survey. A suggestions box in the waiting area also provided an opportunity for patients to leave feedback. Prior to the merger, the practice had tried to set up a patient participation group (PPG), but this had not been successful. However, following the merger, the practice inherited the other surgery's PPG, and plans were being made to actively engage with this group. We saw that a letter had been sent

Are services well-led?

Good

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

to PPG members providing an update on recent changes at the practice and asking for comment. Patients had also been invited to comment on the practice in the lead up to this inspection.

A system for staff appraisal was in place. Steps were being taken to ensure all newly transferred staff received an appraisal. Staff told us they would not hesitate to give feedback or discuss any concerns and issues with the practice management team.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. The lead GP and practice manager were forward thinking and actively encouraged and supported staff to access relevant training. The team demonstrated their commitment to continuous improvement through:

- Carrying out quality improvement activities, including clinical audits, to help improve patient outcomes.
- Their willingness to consider alternative ways of working designed to improve patient access and the quality of clinical consultations.
- Encouraging and supporting staff to access relevant training including, for example, training sessions run by the local CCG.
- Learning from any significant events that had occurred, to help prevent them from happening again.