Care Quality Commission

Windermere and Bowness Medical Practice

Quality Report

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

Ratings

Overall rating for this service	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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Windermere and Bowness Medical Practice on 28th February 2017. 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 an effective system in place for reporting and recording significant events.
- Risks to patients were generally assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by the management team.
- The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the Duty of Candour.

We saw some areas of outstanding practice:

- The practice used non-traditional staff roles to meet the needs of their patients, such as a home visiting nurse practitioner. A physiotherapist was also employed as a musculoskeletal practitioner, and since

Summary of findings

this was implemented in 2013/14, referrals to orthopaedics had dropped from 188 a year to 114 in 2015/16. In the same period, the number of injections performed at the practice had risen from 88 to 322, reducing the need for patients to travel to hospital and increasing the capacity of secondary care. Patients we spoke to on the day of inspection valued these services highly. One Medicial Group were due to introduce these roles in their other practices.

- Chronic disease management at the practice was extended to include patients with rheumatoid arthritis. Patients were reviewed annually, and the care plans created in conjunction with them encouraged patients to write their aims and objectives to improve their wellbeing, and to identify any areas they wish to explore with the GP or nurse practitioner.
- The practice had developed strong working relationships with the wider healthcare team in their community. This had led to the implementation of joint clinics between the GPs and the health visitor, which allowed them to have closer contact with vulnerable families, as well as being able to offer immediate advice or treatment that might otherwise have required an appointment. The practice also held bi-monthly meetings with the community psychiatric nurse, which ensured that the practice was able to offer support and collaborative treatment to some of the most vulnerable patients.

There was an area of practice where the provider should make improvements:

- All staff members should complete the cleaning checklists provided for their areas of work.

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?
The practice is rated as good for providing safe services.

Good

- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were generally assessed and well managed.

Are services effective?
The practice is rated as good for providing effective services.

Good

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were above the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- The practice employed a musculoskeletal practitioner. Since beginning the role in 2013/14, the annual number of referrals to orthopaedics had dropped from 188 to 114 in 2015/16, while in the same time the number of injections performed at the practice had risen from 88 to 322, reducing the need for patients to travel to hospital and increasing the capacity of secondary care.

Are services caring?
The practice is rated as good for providing caring services.

Good

Summary of findings

- Data from the National GP Patient Survey, published in July 2016, showed patients rated the practice higher than others for all aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice took a proactive approach to identifying carers. There was a carers' lead who offered support, and the practice had identified 2.4% of their list as carers.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning group to secure improvements to services where these were identified.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- 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 and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

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. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.

Summary of findings

- The provider was aware of and complied with the requirements of the Duty of Candour. The managers encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff.
- The practice proactively sought feedback from staff and patients, which they acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels. This included at provider level, where a number of the improvements made at the practice had been implemented at other practices in the corporate 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

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

- The practice offered proactive, personalised care to meet the needs of the older people in their population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Staff at the practice worked with a national charity to deliver an open evening where patients came into the practice to be guided through the use of the online medical record. We saw that the practice had a high-uptake of online services and access to online records.
- Performance for conditions associated with older patients, such as chronic obstructive pulmonary disorder (COPD), was better than the national average. The practice achieved 100% of the total Quality and Outcomes Framework points available for this condition, compared to the national average of 95.9%.

People with long term conditions

Good

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

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was better than the national average. The practice achieved 94% of the total QOF points available, compared to the national average of 89.8%. The exception reporting rate was also lower than the national average (9.1% compared to 11.6%).
- Patients with rheumatoid arthritis were reviewed annually, and the care plans encouraged patients to write their aims and objectives to improve their wellbeing, and to identify any areas they wish to explore with the GP or nurse practitioner.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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 identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 80%, which was in line with the local and national average of 81%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice offered level two sexual health screening. This benefitted patients as the local sexual health clinic had recently ceased operation.
- We saw positive examples of joint working with midwives, health visitors and school nurses. For example, the GPs and health visitors offered a joint monthly clinic to families with children under five years old.
- The practice had a good working relationship with the neighbouring school. We were told that, on occasion, the nurse practitioner had gone to the school to see children who were feeling unwell.

Working age people (including those recently retired and students)

Good

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

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

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.

Summary of findings

- The practice held a register of patients living in vulnerable circumstances.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- 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 normal working hours and out of hours.

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).

- Performance for mental health related indicators was better than the national average. The practice achieved 97.2% of the total QOF points available, compared to the national average of 92.8%. Exception reporting for this indicator was lower than the national average (8.5% to 11.3%).
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. They held bi-monthly meetings with the community psychiatric nurse, with whom they managed patients collaboratively.
- The practice carried out advance care planning for patients with dementia. They had also produced a booklet called 'This is Me' which was given to patients so that they could keep a written record of their personal needs and preferences in the event of the patient being admitted to hospital.
- 73% of patients diagnosed with dementia had had their care reviewed in a face-to-face meeting in the last 12 months. This was lower than the national average of 84%.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The National GP Patient Survey results, published in July 2016, showed the practice was performing above local and national averages. 218 survey forms were distributed and 101 were returned. This represented a 46% response rate and approximately 1.7% of the practice's patient list.

- 95% of patients found it easy to get through to this practice by telephone compared to the national average of 73%.
- 97% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 85%.
- 94% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 91% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received nine comment cards which were all positive about the standard of care received. Commonly used words included 'excellent', 'kind', helpful', 'caring' and 'considerate'.

We spoke with 10 patients during the inspection. All of these patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. The practice carried out a Friends and Family Survey to ask patients how likely they would be to recommend the service to their relatives or friends. An average of 87% of patients said they would be 'extremely likely' to recommend the practice between November 2016 and January 2017.

Areas for improvement

Action the service SHOULD take to improve

- All staff members should complete the cleaning checklists provided for their areas of work.

Outstanding practice

- The practice used non-traditional staff roles to meet the needs of their patients, such as a home visiting nurse practitioner. A physiotherapist was also employed as a musculoskeletal practitioner, and since this was implemented in 2013/14, referrals to orthopaedics had dropped from 188 a year to 114 in 2015/16. In the same period, the number of injections performed at the practice had risen from 88 to 322, reducing the need for patients to travel to hospital and increasing the capacity of secondary care. Patients we spoke to on the day of inspection valued these services highly. One Medicial Group were due to introduce these roles in their other practices.
- Chronic disease management at the practice was extended to include patients with rheumatoid arthritis. Patients were reviewed annually, and the care plans created in conjunction with them encouraged patients to write their aims and objectives to improve their wellbeing, and to identify any areas they wish to explore with the GP or nurse practitioner.
- The practice had developed strong working relationships with the wider healthcare team in their community. This had led to the implementation of joint clinics between the GPs and the health visitor, which allowed them to have closer contact with vulnerable families, as well as being able to offer immediate advice or treatment that might otherwise have required an appointment. The practice also held bi-monthly meetings with the community psychiatric nurse, which ensured that the practice was able to offer support and collaborative treatment to some of the most vulnerable patients.

Care Quality Commission

Windermere and Bowness Medical Practice

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 practice manager specialist advisor.

Background to Windermere and Bowness Medical Practice

Windermere and Medical Practice is registered with the Care Quality Commission to provide primary care services.

The practice provides services to approximately 5,800 patients from one location at Health Centre, Goodly Dale, Windermere, Cumbria, LA23 2EG. We visited this location on this inspection.

The practice is based in a purpose-built surgery building which is owned by One Medicare and one of the former practice partners. It has level access and all patient services for the surgery are available on the ground floor.

The practice comprises 28 members of staff, including five salaried GPs (there are no GP partners as this is a corporate provider), two nurse practitioners, a musculoskeletal practitioner, three practice nurses, a healthcare assistant, two phelbotomists, a practice manager, a clinical interface manager, a medicines manager, an IT administrator, a senior receptionist, six receptionists and three secretaries. The practice is governed by a parent provider, One Medicare, and is one of nine locations operated by this same provider in different parts of England.

The practice is part of Cumbria clinical commissioning group (CCG). Information taken from Public Health England placed the area in which the practice was located in the fifth least deprived decile. In general, people living in more deprived areas tend to have greater need for health services. The practice population profile broadly reflects the national average, with no one age group particularly over- and under-represented. We saw that the population of the practice altered during the spring/summer months, due to the increase of tourists or people working in the tourism industry who come to the area.

The surgery is open from 8am to 6.30pm, Monday to Friday, with extended opening hours until 7pm on Wednesday. Telephones at the practice are answered from 8am until 6.30pm, Monday to Friday. Outside of these times a message on the telephone answering system redirects patients to out of hours or emergency services as appropriate. The service for patients requiring urgent medical attention out of hours is provided by the NHS 111 service and Cumbria Health on Call Ltd (CHoC).

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

Why we carried out this inspection

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. The inspection was planned to check whether the provider is meeting the legal

Detailed findings

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 28 February 2017. During our visit we:

- Spoke with a range of staff and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public 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 told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (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).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events. Furthermore, significant events recorded by the practice were logged and reviewed centrally by the provider, who could provide assistance with investigation if required.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a new protocol for ensuring that the correct blood tests had been performed before a patient was administered a particular medication had been put in place following a significant event.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child safeguarding level three.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received 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 practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The lead nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were carried and we saw evidence that action was taken to address any improvements identified as a result. However, we saw that checklists to show that all equipment had been cleaned regularly were not always completed by all staff.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely. There were also arrangements in place for the destruction of controlled drugs.
- We reviewed three personnel files and found appropriate recruitment checks had been undertaken

Good

Are services safe?

prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate DBS checks.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had an up-to-date fire risk assessment and carried out regular fire drills. All electrical equipment was checked to ensure it was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to 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.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed the practice had achieved 98.3% of the total number of points available, compared to the clinical commissioning group (CCG) average of 97.7%, and the national average of 95.3%. The practice exception reporting rate was below local and national averages at 7.4% (CCG average 10.2%, national average 9.8%). (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/16 showed:

- Performance for diabetes related indicators was better than the national average. The practice achieved 100% of the total points available, compared to the national average of 89.8%. The exception reporting rate was lower than the national average (9.1% compared to 11.6%).
- Performance for mental health related indicators was better than the national average. The practice achieved 97.2% of the total points available, compared to the national average of 92.8%. The exception reporting rate was 8.5% compared to the national average of 11.3%.
- Performance for asthma related indicators was better than the national average. The practice achieved 100% of the total points available, compared to the national average of 97.4%. The exception reporting rate was 1.2% compared to the national average of 7%.
- Performance for conditions associated with older patients, such as chronic obstructive pulmonary disorder (COPD), was better than the national average. The practice achieved 100% of the total points available for this condition, compared to the national average of 95.9%. The exception reporting rate was 6.3% compared to the national average of 9.2%.

There was evidence of quality improvement including clinical audit.

- We reviewed eight clinical audits and this was a sample of the 15 audits undertaken by the practice over the past two years. All eight were completed two-cycle audits, where the changes made were implemented and monitored. Some audits had been repeated over six cycles to monitor continuous improvements since 2003.
- The practice participated in local audits, national benchmarking, accreditation, and peer review.
- The practice was a pilot site for trialing new indicators which may be used as part of the Quality and Outcomes Framework in the future. One of the new criteria being trialed was the identification of non-diabetic patients with with raised blood glucose levels, which led the practice to undertake an audit of these patients and to put a plan of action in place to monitor them and provide them with appropriate health promotion advice.
- The practice undertook a wide range of research as an active member of the Clinical Research Network. This is a network of practices nationally who participate in research studies. The topic of the research is chosen by the regional branch, the practice then asked their patients to be a part of the study. The findings were used to make improvements to care nationally.
- The practice is also listed as "research ready" by the Royal College of General Practitioners (RCGP). As such, the practice carried out surveillance work for the RCGP in relation to flu swabbing and flu vaccine surveillance. They also received reports on the quality of their clinical data, which was then compared with other practices in the RCGP network.

Good

Are services effective?

(for example, treatment is effective)

Findings were used by the practice to improve services. For example, an audit of the percentage of children who presented with fever led to improvements in their assessment. The audit found that after the second cycle, the number of children who were assessed according to the criteria recommended by NICE guideline had increased, with the number who had their heart rate measured increasing from 21% to 88% between April 2016 and July 2016.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updates for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example, by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a fortnightly basis when care plans were routinely reviewed and updated for patients with complex needs. The close links that the practice had with the wider healthcare team had resulted in a number of joint initiatives whereby patients were cared for collaboratively. The GPs held a joint monthly review clinic for families with babies and infants in conjunction with the health visitor. This allowed them to have closer contact with vulnerable families, as well as being able to offer immediate advice or treatment that might otherwise have required an appointment. The practice also held bi-monthly meetings with the community psychiatric nurse, with whom the practice liaised closely to coordinate care. This again ensured that the practice was able to offer support and collaborative treatment to some of the most vulnerable patients.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Good

Are services effective?

(for example, treatment is effective)

- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- The practice employed a musculoskeletal practitioner. This was a role that had been developed at the practice. They were an advanced physiotherapist who performed assessment, diagnosis and triage of patients with musculoskeletal problems, and were able to prescribe and perform joint injections. Since beginning the role in 2013/14, the annual number of referrals to orthopaedics had dropped from 188 to 114 in 2015/16, while in the same time the number of injections performed at the practice had risen from 88 to 322. This service was reducing the need for patients to be referred to secondary care, freeing up appointments at that service and also benefitting patients at the practice, who did not need to travel as far for treatment. Patients we spoke to on the day of inspection told us this was a service they valued. We were told by a member of the One Medicare management team that this role was due to be extended to other practices in the group.
- A home visiting nurse practitioner could visit patients in their own homes and create care plans. Patients could be followed up for regular monitoring by a health care assistant, who was supported by the nurse practitioner. As well as freeing up time for other clinicians to offer more appointments, this role meant patients who needed this level of support could be seen regularly and by the same clinician each time. Monitoring of patients with long term conditions, or simple routines should as taking blood, could be performed by either the home visiting nurse practitioner or the health care assistant, to remove the need for the patient to attend the surgery. Both practitioners were well-supported by the lead nurse practitioner and the GPs.
- Other services, such as counselling, podiatry and dietetics were available on the premises, and smoking cessation advice was available from a local support group.
- The practice offered level two sexual health screening. This benefitted patients as the local sexual health clinic had recently ceased operation.
- Chronic disease mananagement at the practice was extended to include patients with rheumatoid arthritis. Patients with this condition were reviewed annually, and the care plans created in conjunction with them encouraged patients to write their aims and objectives to improve their wellbeing, and to identify any areas they wish to explore with the GP or nurse practitioner.

The practice's uptake for the cervical screening programme was 80%, which was in line with the CCG and national averages of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available. The practice also encouraged their patients to attend national screening programmes for bowel and breast cancer screening. Data from Public Health England from 2014/15 showed that:

- 76% of females, 50-70, were screened for breast cancer in last 36 months, compared to the national average of 72%.
- 68% of people, 60-69, were screened for bowel cancer within 6 months of invitation, compared to the national average of 58%.

There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were mixed when compared to national averages. For example, the practice scored 8.8 (out of 10) for their vaccination rate in under two year olds (national average 9.1), but was above target for vaccination rates in one year olds (94% received the full course of vaccines compared to a target of 90%).

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

We spoke with 10 patients, including five members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. We also received nine comment cards, which reflected the views expressed by the patients we spoke with.

Results from the National GP Patient Survey, published in July 2016, showed patients felt they were treated with compassion, dignity and respect. The practice was better than average for satisfaction scores on consultations with GPs and nurses and on the attitude of the reception staff. For example:

- 96% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 93% of patients said the GP gave them enough time compared to the CCG average of 91% and the national average of 87%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 96% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 90% and the national average of 85%.
- 96% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 94% and the national average of 91%.
- 99% of patients said they found the receptionists at the practice helpful compared to the CCG average of 90% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the National GP Patient Survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were above local and national averages. For example:

- 92% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 90% and the national average of 86%.
- 93% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 82%.
- 96% say the last nurse they saw or spoke to was good at explaining tests and treatments compared to the CCG average of 92% and the national average of 90%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 142 patients as carers (2.4% of the practice list). The practice had a carers'

Good

Are services caring?

champion who worked with the local carers' organisation to identify and support carers. There was a poster in the waiting area so that patients knew who they were. The practice offered a room for use by the carers' organisation to come to the practice to talk to patients. Written information was available to direct carers to the various avenues of support available to them.

The practice had worked with One Medicare to produce a booklet called 'This is Me' which was given to all patients in the practice diagnosed with dementia, or where appropriate, to their family and/or carers. Patients were encouraged to complete the booklet with their personal needs and preferences, so that these could be made known to clinicians in the event of the patient being admitted to hospital.

Patients on the practice fraility register who were discharged from hospital were given a follow-up call by the phlebotomy team, to discuss the patient's ongoing needs and to offer support. These calls were often followed by a call or an appointment with a GP or nurse practitioner, if required.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified.

- The practice offered extended hours on a Wednesday evening until 7pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients who needed them, including those with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice had worked with One Medicare to produce a booklet called 'This is Me' which was given to all patients in the practice diagnosed with dementia, or where appropriate, to their family and/or carers. Patients were encouraged to complete the booklet with their personal needs and preferences, so that these could be made known to clinicians in the event of the patient being admitted to hospital.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice had a good working relationship with the neighbouring school. We were told that, on occasion, the nurse practitioner had gone to the school to see children who were feeling unwell.
- Joint injections and other minor orthopaedic procedures were provided by the musculoskeletal practitioner, reducing the need for patients to attend appointments at the hospital. Patients we spoke to on the day of inspection told us this was a service they valued.
- Patients were able to receive travel vaccinations available on the NHS, and some that were only available privately.
- The practice took on a number of temporary residents during the summer months, due to the increase in tourists or people working in the tourist industry in the local area.
- Staff at the practice worked with a national charity to deliver an open evening where patients came into the practice to be guided through the use of the online medical record. We saw that the practice had a high-uptake of online services and access to online records.
- A third-party counselling service offered one session a week from the practice.
- The GPs and health visitors offered a joint monthly clinic to families with children under five years old.
- There were disabled facilities, a hearing loop and translation services available.
- The practice offered level two sexual health screening. This benefitted patients as the local sexual health clinic had recently ceased operation.The surgery offered an International Normalised Ratio (INR) clinic for patients prescribed warfarin. (The INR is a blood test which needs to be performed regularly on patients who are taking warfarin to determine their required dose).
- Patients could order repeat prescriptions and book GP appointments online.
- The practice allowed other services to use rooms at the surgery to offer services that would benefit their patientssuch as an acupuncture service offered by a former practice GP Other services offered from the surgery included podiatry, dietetics, physiotherapy, diabetes specialist nurse, retinal screening, hearing aid clinic, the community psychiatric nurse and the community nursing team

Access to the service

The surgery was open from 8am to 6.30pm, Monday to Friday, with extended opening hours until 7pm on Wednesdays. Telephones at the practice were answered from 8am until 6.30pm, Monday to Friday. Outside of these times a message on the telephone answering system redirected patients to out of hours or emergency services as appropriate. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

Results from the National GP Patient Survey, published in July 2016, showed that patients' satisfaction with how they could access care and treatment was above the local CCG and national averages.

- 95% of patients said they could get through easily to the practice by telephone compared to the national average of 73%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 87% of patients were satisfied with the practice's opening hours compared to the national average of 76%.
- 97% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 85%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system, such as a summary leaflet.
- The practice responded to compliments and concerns raised by patients on the NHS Choices websites, and took action to address concerns where relevant. For example, staff had received additional triage training as a result of feedback from NHS Choices.

We looked at a sample of the nine complaints logged during the past 12 months, and found these were dealt with in a timely way, with openness and transparency when dealing with the complaint. Lessons were learnt from individual concerns and complaints, and also from analysis of trends, and action was taken as a result to improve the quality of care. For example, the practice had made improvements to the forms patients completed when they registered with the practice, to allow them to give a fuller picture of their medical history and medication needs.

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 practice had a mission statement, which was developed with practice staff. All staff knew and understood the values.
- The practice had a strategy and supporting business plans which reflected the vision and values and these were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. There was good use of different staff roles in order to maximise the benefit to patients. For example, the practice employed a home visiting nurse practitioner to visit patients in their own homes and create care plans. Patients could be followed up for regular monitoring by a health care assistant , who was supported by the nurse practitioner. The practice also had a musculoskeletal (MSK) practitioner who was able to offer treatments which would normally require the patient to attend hospital.
- Practice specific policies were implemented and were available to all staff. These policies were One Medicare policies which had been tailored to the needs of the practice.
- A comprehensive understanding of the performance of the practice was maintained. There was a regular programme of meetings for staff at all levels to ensure that safety and quality could be discussed and learning could be shared. The GPs, nurse practitioners, MSK practitioner and practice manager met daily to discuss any clinical matters from morning surgery, as well as to plan the on-the-day surgery for the afternoon and home visits. They also met weekly (the practice manager attended monthly) to discuss alerts, safeguarding issues, complaints, clinical developments, clinical updates, audits and quality indicators. Other staff groups, such as receptionists and phlebotomists, also held their own regular team meetings.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. The practice was actively involved in research.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- The practice told us they had good support from the management team at One Medicare, who managed certain parts of the practice business, such as premises and human resources. The Chief Medical Officer and Director of Nursing visited the surgery at regular intervals to help the practice to look for quality improvements. There was also a Clinical Effectiveness Network which met every two months, and was attended by clinical leads from the practice. These meetings were used to discuss (amongst other topics) audits, significant events and complaints from across the group, to look for learning.

Leadership and culture

On the day of inspection, the management in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the managers were approachable and always took the time to listen to all members of staff.

The practice was part of One Medicare, whose management team formed the overall management of the practice, while the day-to-day running of the practice was performed by the practice manager, lead nurse and lead GP. We saw evidence to show that there had been a culture of innovation and sharing good practice with other services over a number of years, and this culture had continued since joining the corporate provider in 2015. For example, the role of the musculoskeletal practitioner, which was developed at Windermere, was due to be replicated in other practices in the group.

As well as sharing within the provider organisation, staff were proactive in sharing good practice more widely. For example, the practice had hosted visits from physiotherapists from the UK and overseas who were interested to learn more about the role of the MSK practitioner. This practitioner had also published articles promoting the role and its benefits for patients in a number of journals. Other staff at the practice published learning in

Are services well-led?

Good

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

journals also, such as an article describing a case of warfarin-induced tissue necrosis. We saw evidence that this article had influence the practice of other clinicians as far afield as New Zealand.

The provider was aware of and had systems in place to ensure compliance with the requirements of the Duty of Candour. (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).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. They were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- There were clear lines of communication with the corporate team.
- Salaried GPs at the practice were given protected time to allow them to carry out administrative work and training, as well as to contribute to audits and research.
- Whilst there had been a number of changes at the practice following the move to join a corporate provider, staff told us that they felt supported throughout. The practice had made a concerted effort to ensure staff were kept aware of the chances as they were happening, and we were told by staff on the day of inspection that this was appreciated.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

· The practice had gathered feedback from patients through their patient participation group (PPG), the surveys they carried out and complaints received. There was a group of 10 members who met quarterly, who completed surveys and submitted proposals for improvements to the practice management team. Examples of improvements included a photograph board in the waiting area to identify staff, and patients being informed when there was likely to be a longer wait than usual for their appointment to start.

- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and participated in local pilot schemes to improve outcomes for patients in the area. For example:

- The practice was heavily involved in a number of research projects, such as the pilot for new indicators for the Quality and Outcomes Framework, and being a member of the Clinical Research Network.
- The practice was keen to develop new roles and new ways of working, such as the home visiting nurse practitioner role and the musculoskeletal practitioner.
- Staff were keen to promote learning to outside organisations, and had published in journals as well as inviting other clinicians/groups to the practice to observe their ways of working.

- A trial of offering appointments via videoconference had recently been run by the provider, and this service was due to be operational soon. This meant that patients at the practice would have the option of having a teleconference appointment with a doctor at the One Medicare offices in Leeds rather than a telephone

Are services well-led?

Good

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

appointment with a practice doctor. It was hoped this would increase the number of appointments that doctors at the practice could offer by reducing the demand on them.