# Dr Winter-Barker, Roberts, Stonehouse, O'Sullivan & Mr Eddy

**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 Dr Winter-Barker, Roberts, Stonehouse, O'Sullivan and Mr Eddy on 16 November 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses.
- All staff were actively engaged in activities to monitor and improve quality and outcomes for patients.
- Risks to patients and staff were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and responsibilities.
- The practice had satisfactory facilities and was equipped to treat patients and meet their needs at both sites. Plans had been made to improve access arrangements at the main practice site.
- Staff were consistent and proactive in supporting patients to live healthier lives through a targeted approach to health promotion. Information was provided to patients to help them understand the care and treatment available to them.
- There was a clear leadership structure and staff felt supported by the management team. Good governance arrangements were in place.
- Staff had a clear vision for the development of the practice and were committed to providing their patients with good quality care.
- Feedback from patients was positive about the way staff treated them. Patients said they were treated with compassion, dignity and respect. Arrangements had

# Summary of findings

been made which promoted and supported patients to become active partners in their care. However, the arrangements for preventing unauthorised access to patient related information could be improved.

- Information about how to complain was available and easy to understand.

We also saw areas of outstanding practice:

- The NHS GP Patient Survey results showed the practice had performed very well in all areas, especially in relation to patient satisfaction with the quality of GP and nurse consultations, staff's commitment to providing patients with good continuity of care and access to appointments.
- Following feedback from the local NHS Trust, the practice improved how it delivered services to patients with dermatological conditions. In 2014, a GP partner completed a diploma in Dermatology. They saw the practice's own patients who had dermatological needs as well as patients from other practices. There was evidence that this had had a very positive impact on the way in which the needs of these patients were managed. For example, the referral rate to secondary specialist services had reduced from 198 patients, in 2014, to 80 for the same period in 2015, which meant more patients benefitted from receiving care and treatment closer to home.
- A named GP provided a fortnightly 'ward round' at a local care home for patients with complex healthcare needs. This helped to pre-empt any potential health problems. These patients were also able to access same-day urgent care, from the same GP.
- The practice participated in the 'Unplanned Admissions' enhanced service and had identified 2% of patients who were at greater risk of hospitalisation. Arrangements had been made to carry out reviews of the needs of these patients and provide feedback to the clinical team each month. Staff also reviewed the needs of patients who had been admitted into hospital to identify whether this could have been prevented. Recent local Clinical Commissioning Group data showed that unplanned admissions into hospital had reduced by 12.7% and that the practice had the second lowest level of unplanned admissions for the most recent month.

In addition, the provider should:

- Consider using a second thermometer to check the accuracy of the temperature readings displayed on the thermometer installed in the dispensary refrigerator. The provider should also arrange for annual calibration checks to be carried out of the thermometer installed in the dispensary refrigerator.
- Provide the member of staff designated as the practice's infection control lead with advanced infection control training.
- Make sure that patient related information is kept secure at all times and can only be accessed by authorised persons.

**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.

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, but a centralised log of the safety alerts received at the practice, and of any subsequent actions taken had not been maintained. Individual risks to patients had been assessed and were well managed. Medicines management systems and processes were safe. Appropriate arrangements were in place for recruiting and vetting staff. The premises were clean and hygienic and there were good infection control processes in place. However, the member of staff who was the designated infection control lead had not completed advanced training to support them to carry out their role.

### Are services effective?

Good

The practice is rated as good for providing effective services.

The Quality and Outcomes Framework (QOF) data, for 2014/15, showed the practice had performed well in obtaining 96.8% of the total points available to them, for providing recommended care and treatment to their patients. (This was in line with the local clinical commissioning group (CCG) average and 3.3% above the England average.) The QOF data also showed the practice had performed well in obtaining 99.2% of the total points available to them, for delivering care and treatment aimed at improving public health. For example, the QOF data showed the practice had obtained 100% of the points available to them in the area of cardiovascular disease (primary prevention). (This was 9.3% above the local CCG average and 12.1% above the England average.)

Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included promoting good health, and providing advice and support to patients to help them manage their health and wellbeing. Staff worked well with other health and social care professionals to help ensure patients' needs were met. All staff were actively engaged in activities to monitor and improve quality and outcomes for patients. Staff supported patients to live healthier lives through a targeted and proactive approach to health promotion. Clinical audits carried out by the team had led to improvements in patient care.

# Summary of findings

**Are services caring?**

Good

The practice is rated as good for providing caring services.

Patients were complimentary about the practice, the staff who worked there, the quality of service and, the care and treatment they received. They told us staff provided a good service which met their needs, and said they were treated with respect and dignity. The NHS GP Patient Survey results for the practice showed they had performed very well, and that their performance was above both the local CCG and national averages, in relation to patient satisfaction with the quality of GP and nurse consultations. The survey results also showed patients responded very positively to questions about their involvement in planning and making decisions about their care and treatment. These results were also significantly above the local CCG and national averages. During the inspection we saw staff treating patients with kindness and respect. Staff were courteous and very helpful to patients. Patients attending at the reception desk and contacting the practice by telephone were treated with dignity and respect. However, the provider had failed to ensure that patient related information was kept secure at all times. This increased the potential risk that such information might be accessed by unauthorised persons.

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services.

Services were planned and delivered to take into account the needs of different patient groups and to provide flexibility, choice and continuity of care. In addition, staff helped to coordinate patients' care and treatment through partnership working with other services and providers. The practice engaged in local CCG initiatives and worked with them to improve and develop patient care in the locality within which they were based. Results from the most recent NHS GP Patient Survey of the practice showed that patient satisfaction with access to appointments and their preferred GP, and appointment waiting times, was significantly higher than most of the local CCG and national averages. Patients we spoke with on the day of the inspection, and most of those who completed Care Quality Commission (CQC) comment cards, were satisfied with access to appointments. The main practice and their branch surgery had good facilities and were well equipped to treat patients and meet their needs. Information about how to complain was available in the practice's patient information leaflet and on their website. Complaints received by the practice in the last 12 months had been handled in line with their complaints procedure.

**Are services well-led?**

Good

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

# Summary of findings

Staff had a clear vision about how they wanted the practice to grow and develop, and were taking steps to deliver this. The practice had good governance processes, and these were underpinned by a range of policies and procedures that were accessible to all staff. There were good systems and effective processes in place to identify and monitor risks to patients and staff, and to monitor the quality of services provided. Regular practice and multi-disciplinary team meetings took place, which helped to ensure patients received effective and safe clinical care. The practice proactively sought feedback from patients, who were encouraged and supported to comment on how services were delivered. There was a strong focus on continuous learning and improvement at all levels within the practice. The practice was forward thinking and committed to providing patient focussed services delivered by staff who had the skills and competencies needed to do this.

# 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.

Nationally reported Quality and Outcomes Framework (QOF) data, for 2014/15, showed the practice had, overall, performed well in relation to providing care and treatment for the clinical conditions commonly associated with this population group. For example, QOF data showed the practice had achieved 100% of the total points available to them for providing the recommended care and treatment to patients with cancer. (This was 0.2% above the local CCG average and 2.1% above the England average.)

Staff were committed to providing proactive, personalised care to meet the needs of these patients. For example, staff were working in collaboration with other health and social care professionals to develop the new 'Care Navigator' and 'Case Manager' roles. (These new roles will be used to support patients at risk of an unplanned hospital admission and losing their independence, and those who require help to access extra help and assistance.) The GP team carried out fortnightly visits to patients living in a local care home, so they could receive proactive, planned care. The practice offered home visits and longer appointment times where this was needed by their older patients. Staff had completed care plans for the 2% of vulnerable patients who had been assessed as being most at-risk. These covered, where appropriate, patients' end of life needs.

### People with long term conditions

Good

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

Nationally reported Quality and Outcomes Framework (QOF) data, for 2014/15, showed the practice had performed very well in relation to providing care and treatment for the clinical conditions commonly associated with this population group. For example, QOF data showed the practice had achieved 100% of the total points available to them for providing the recommended care and treatment to patients with chronic obstructive pulmonary disease (COPD.) (This was 2.4% above the local CCG average and 4% above the England average.)

Staff offered proactive, personalised care to meet the needs of patients with long-term conditions. In addition to the practice's work supporting the development of the new 'Care Navigator' and 'Case

# Summary of findings

Manager' roles referred to above, nursing staff provided a range of clinics and services aimed at educating patients about their long-term conditions, and helping them to better manage their health and wellbeing.

**Families, children and young people**

Good

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

The GPs offered maternity care in collaboration with the midwife attached to the practice. Child development clinics were also provided, and patients were able to access health visitor staff at both the main practice and the branch surgery. All the GPs helped to provide a family planning service which included access to a five day emergency coil service and contraceptive implants. Arrangements had been made to support and encourage women to access cervical screening services. The QOF data, for 2014/15, showed the practice had obtained 100% of the overall points available to them for providing cervical screening services. (This was 0.6% above the local CCG average and 2.4% above the England average.) Nationally reported data showed that the majority of childhood immunisation rates were above average, when compared to the overall percentages for children receiving the same immunisations within the local CCG area. Most of the immunisation rates were above 90%. Younger patients were able to access contraceptive and sexual health services, and appointments were available outside of school hours. Regular multi-disciplinary meetings were held to help ensure important information about vulnerable patients was shared. There were systems in place to identify and follow up children who were at risk.

**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 practice was proactive in offering on-line services. For example, patients were able to book appointments and order repeat prescriptions on-line. Extended hours appointments were offered to make it easier for families and working-age patients to obtain convenient appointments. Staff provided a full range of health promotion and screening that reflected the needs of 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 maintained a register of patients living in vulnerable circumstances, including homeless people and those with a learning disability. Clinical staff had carried out annual health checks for patients with a learning disability and they offered longer appointments to these patients. The practice regularly worked with multi-disciplinary teams, involved in the case management of vulnerable people. Staff gave vulnerable patients information and advice about how to access relevant support groups and voluntary organisations. They knew how to recognise signs of abuse in vulnerable adults and children. Staff understood their responsibilities regarding information sharing and documenting safeguarding concerns, and knew 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).

The practice regularly worked with multi-disciplinary teams, involved in the case management of people experiencing poor mental health, including those with dementia. Staff had carried out advance care planning for patients with dementia to help them document their preferences and wishes about how they wanted to be cared for should they be unable to make decisions for themselves. Staff gave patients experiencing poor mental health information and assistance about how to access relevant support groups and voluntary organisations. The practice had a system in place to follow up patients who had attended accident and emergency (A&E), where they may have been experiencing poor mental health. Staff had received training on how to care for patients with mental health needs and dementia.

# Summary of findings

## What people who use the service say

We spoke with nine patients during our inspection, and these included a member of the practice's patient participation group (PPG). All of the patients were complimentary about the practice, the staff who worked there and the quality of service and care provided. They told us they were usually able to get an appointment when they needed one, and were able to see their preferred GP. They told us staff provided a good service which met their needs, and said they were treated with respect and dignity. Patients said the premises were always clean and tidy, and eight of the nine patients said they had never had to make a complaint.

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 32 respondents were positive about the standard of care and treatment provided by the practice. Words used to describe the service included: pleasant; very caring; wonderful, helpful and diligent; would highly recommend; excellent; fabulous service; very efficient; exceptional. None of the patients who completed comment cards raised any concerns about the care and treatment they received at the practice.

The results of the NHS GP Patient Survey of the practice, published in July 2015, showed they had performed very well in most areas. The practice's performance was above both the local Clinical Commissioning Group and national averages, in all but one area of the survey. For example, of patients who responded to the survey:

- 94% said they found it easy to get through to this surgery by phone, compared with the local CCG average of 80% and the national average of 73%.
- 97% found the receptionists at this surgery helpful, compared with the local CCG average of 90% and the national average of 87%.
- 81% with a preferred GP said they usually got to see or speak to that GP, compared with the local CCG average of 62% and the national average of 60%.
- 92% were able to get an appointment to see or speak to someone the last time they tried, compared with the local CCG average of 88% and the national average of 85%.
- 97% had confidence and trust in the last GP they saw, compared with the local CCG average of 96% and the national average of 95%.
- 100% said they had confidence and trust in the last nurse they saw or spoke to, compared with the local CCG average of 98% and the national average of 97%.

(There were 135 responses and a response rate of 53%. This equates to 2.2% of the total practice population.)

## Areas for improvement

**Action the service SHOULD take to improve**

- Consider using a second thermometer to check the accuracy of the temperature readings displayed on the thermometer installed in the dispensary refrigerator. The provider should also arrange for annual calibration checks to be carried out of the thermometer installed in the dispensary refrigerator.
- Provide the member of staff designated as the practice's infection control lead with advanced infection control training.
- Make sure that patient related information is kept secure at all times and can only be accessed by authorised persons.

# Summary of findings

## Outstanding practice

- The NHS GP Patient Survey results showed the practice had performed very well in all areas, especially in relation to patient satisfaction with the quality of GP and nurse consultations, staff's commitment to providing patients with good continuity of care and access to appointments.
- Following feedback from the local NHS Trust, the practice improved how it delivered services to patients with dermatological conditions. In 2014, a GP partner completed a diploma in Dermatology. They saw the practice's own patients who had dermatological needs as well as patients from other practices. There was evidence that this had had a very positive impact on the way in which the needs of these patients were managed. For example, the referral rate to secondary specialist services had reduced from 198 patients, in 2014, to 80 for the same period in 2015, which meant more patients benefitted from receiving care and treatment closer to home.
- A named GP provided a fortnightly 'ward round' at a local care home for patients with complex healthcare needs. This helped to pre-empt any potential health problems. These patients were also able to access same-day urgent care, from the same GP.
- The practice participated in the 'Unplanned Admissions' enhanced service and had identified 2% of patients who were at greater risk of hospitalisation. Arrangements had been made to carry out reviews of the needs of these patients and provide feedback to the clinical team each month. Staff also reviewed the needs of patients who had been admitted into hospital to identify whether this could have been prevented. Recent local Clinical Commissioning Group data showed that unplanned admissions into hospital had reduced by 12.7% and that the practice had the second lowest level of unplanned admissions for the most recent month.

# Dr Winter-Barker, Roberts, Stonehouse, O'Sullivan & Mr Eddy

**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 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 Dr Winter-Barker, Roberts, Stonehouse, O'Sullivan & Mr Eddy

The location Dr Winter-Barker, Roberts, Stonehouse, O'Sullivan and Mr Eddy is registered with the Care Quality Commission to provide primary care services. The practice provides services to approximately 6,050 patients at two locations, both of which were visited as part of this inspection:

- St Mary's Surgery, Applethwaite, Windermere, Cumbria, LA23 1BA.
- Staveley Surgery, Crook Road, Staveley, Kendal, LA8 9NG.

Dr Winter-Barker, Roberts, Stonehouse, O'Sullivan and Mr Eddy provides care and treatment to patients of all ages, based on a General Medical Services (GMS) contract. The main practice is situated in the town of Windermere and is part of the NHS Cumbria clinical commissioning group (CCG.) Dispensing services are provided at both the main practice and the branch surgery. This service was provided for patients who lived more than a mile away from a pharmacy, The health of people who live in Cumbria is varied when compared to the England average. Deprivation is lower than average, however, about 12,000 (14.7%) of children live in poverty. The practice has less patients (15.6%) aged under 18 years of age than the England average, but more patients (26.8%) aged 65 years or over. A significant number of the patient population (61.9%) have a long-standing health condition. The practice had a very low proportion of patients who were from ethnic minorities.

The main practice is located in an adapted building, the old vicarage. There are some treatment and consultation rooms on the ground floor, and there are additional rooms on the first floor which can be accessed by patients who are independently mobile. The Staveley branch surgery is a purpose built building and provides patients with fully accessible services. The main practice and the branch surgery provide a range of services and clinics including, for example, services for patients with asthma, heart disease and diabetes. There are four GP partners (two male and two female) and two GP associates (salaried and female), a nurse practitioner, a practice nurse, two healthcare assistants and a team of reception and administrative staff.

# Detailed findings

The main practice is open Monday to Friday between 8am and 6:30pm. The Staveley branch surgery is open Monday, Tuesday, Thursday and Friday between 9am and 5:30pm, and on Wednesday between 9am and 1pm. A GP also provides a three-hour extended surgery at the main practice every Monday from 6:30pm to 9:30pm.

Appointment times were:

The main practice at Windermere:

Monday to Friday: morning surgeries take place between 9am and 12 noon and afternoon surgery start times range from 2.30pm to 3.30pm and finish at approximately 6pm, apart from a Monday evening when an extended surgery was provided.

The Staveley branch surgery:

Monday to Friday: morning surgeries take place between 9am and 12 noon and afternoon surgery start times range from 2.30pm to 3pm and finish at 5.30pm. The branch surgery is closed on a Wednesday afternoon.

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

## Why we carried out this inspection

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

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

## How we carried out this inspection

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

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

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

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

The inspection team:

- Reviewed information available to us from other organisations, for example, NHS England.
- Reviewed information from CQC intelligent monitoring systems.
- Carried out an announced inspection visit on 16 November 2015.
- Spoke to staff and patients.
- Looked at documents and information about how the practice was managed.
- Reviewed patient survey information, including the NHS GP Patient Survey.
- Reviewed a sample of the practice's policies and procedures.

Good

# Are services safe?

## Our findings

**Safe track record and learning**

There was an open and transparent approach to reporting and recording significant events, and lessons were learned when something went wrong. Staff had recorded that seven significant events had taken place in the previous 12 months, and they had maintained a comprehensive significant event log.

We looked at a sample of the records of significant events in more detail. Following a recent incident at the practice, we saw that staff had reflected on, and learnt from what took place, and had then used this learning to improve their arrangements for providing patients with safe care. We saw the incident had been discussed at the daily clinical meeting, and recorded as a significant event. The significant event form contained a good level of detail and demonstrated staff's responsiveness to the incident that occurred. We also saw that, in light of the incident, action had been taken to provide staff with additional training, during the practice's next planned learning event. As part of the learning process, documentation was used by staff to, for example, record patient consent. This had been reviewed to identify whether any improvements were required. Following another significant event, we saw staff had responded promptly and comprehensively. This included providing affected patients with an apology and appropriate aftercare. However, we did identify that a recent incident involving a member of staff had not been treated as a significant event. We discussed this with the provider during the feedback meeting. They told us that, although they had not treated the incident as a significant event at the time, they had, as a team, considered whether any subsequent action could be taken to prevent this from happening again. A member of the nursing team we spoke with told us the incident had been handled well and comprehensively discussed within the team to reduce the risk of the incident happening again.

Staff demonstrated a good understanding of their responsibilities regarding the reporting of concerns, and said they would feel comfortable doing so. Significant events were added to the weekly clinical practice meeting agenda to enable a full discussion and face-to-face shared learning to take place. Learning was also shared via minutes from this meeting which were made available to all clinical staff. Appropriate arrangements had also been made to share learning from significant events with non-clinical staff.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance and national safety alerts. A good system was in place for handling safety alerts. The practice manager told us that any received were forwarded to the relevant member of the team, so that appropriate action could be taken. However, staff did not keep a centralised log providing an overview of the actions taken in relation to alerts received. We shared this with the practice manager who agreed to consider this following the inspection.

**Overview of safety systems and processes**

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe.

Arrangements had been made to safeguard adults and children from abuse that reflected relevant legislation, and local requirements and policies. Safeguarding policies were available to staff and were easily accessible via the practice's intranet system. Although there was a designated safeguarding lead for the practice, a member of the nursing team was unsure as to who held this role. They told us they would clarify this following the inspection, as the GP who had previously held this role had recently left. Staff demonstrated they understood their responsibilities and acted to protect vulnerable patients. All had received training relevant to their role. For example, the nurse practitioner had completed Level 3 training in child protection, as had all of the GPs.

A notice in the waiting room advised patients that staff would act as chaperones, if required. We were told that all chaperone duties were carried out by the practice's two healthcare assistants. Both staff had received training to carry out this 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.)

There were suitable arrangements for managing medicines, including emergency drugs stored in the practice, which helped keep patients safe. Leadership and oversight of the dispensing service was provided by a lead

Good

# Are services safe?

GP and the practice manager. The practice manager was a trained dispenser and had completed extra training in the management of controlled drugs, to enable them to carry out this role. They told us they felt well supported by the clinical team. All staff involved in the dispensing of medicines had completed, or were completing, training that was relevant to their roles and responsibilities. The competency of these staff was checked on an annual basis.

Regular medication audits were carried out with the support of the local clinical commissioning group pharmacy staff, to ensure the practice was prescribing in line with best practice guidelines for safe and cost effective prescribing. We were provided with evidence demonstrating that these audits had resulted in more effective prescribing for patients taking certain types of medicines relating to, for example, broad spectrum antibiotic usage. We also noted that there was a low level of antidepressant use.

The practice had systems in place which helped ensure the safe management of the repeat prescribing of medicines. The staff we spoke with were able to clearly describe the processes they followed when they received acute or repeat prescription requests. This included, for example, forwarding prescription requests to a GP for checking when the authorised number of repeat prescription requests, or medicine review dates, had been exceeded. Staff told us the GPs were responsible for carrying out medicine reviews and were readily available to answer any queries they had. The practice had a system for, and a clear audit trail of, the management of information about changes to patients' medicines received from other services.

Dispensing staff told us they reviewed all incoming patient medicine related information, and electronically tasked the relevant GPs, so they could check any discrepancies against the current prescription record. Staff were clear that no medicines would be dispensed until any discrepancies had been rectified. We saw recorded evidence confirming this.

Arrangements had been made which helped ensure the security of blank prescription pads and paper. Dispensing staff were responsible for releasing prescription pads to clinical staff and logged serial numbers and quantities in a register. We saw evidence confirming this. All prescription pads were securely stored at all times.

Controlled drugs (CDs) were safely managed. All CDs were securely stored and only designated staff had access to the area in which these were kept. Suitable records had been maintained which provided evidence of good medicines management.

Overall, the arrangements for monitoring the safety of vaccines at the main practice were appropriate. Staff had taken steps to ensure that the 'cold-chain' was maintained for all three refrigerators used to store medicines requiring cold storage. Staff had carried out daily temperature checks on all three refrigerators. We looked at a sample of the records of daily temperature checks for the refrigerators and for two identified no concerns. With regard to the other refrigerator we were told there had been one occasion recently when the temperature had not been monitored appropriately. We discussed this with the practice manager, and were able to confirm that they had taken prompt and appropriate action to address this and the vaccines it contained at the time were discarded. When we looked at the records of daily temperature checks for this refrigerator we observed that on a small number of occasions, vaccines had been stored outside of the recommended temperature range for very short periods of time. Staff told us they had, at the time, taken appropriate and immediate action to address this matter. However, we noted that there were no arrangements in place for staff to use a second thermometer to check the accuracy of the temperature readings displayed on the thermometers installed in any of the refrigerators. Also, there were no arrangements for carrying out annual calibration checks of these thermometers. All three refrigerators were clean and hygienic, and were located in rooms that could be locked when they were not occupied by staff.

The practice manager told us they carried out an annual quality assurance review of the dispensary and the Standard Operating Procedures staff used, in conjunction with dispensing team members. However, the outcome of this process had not been documented. The practice manager told us they would take action to address this.

The arrangements for carrying out required staff recruitment checks were satisfactory. The recruitment files we sampled showed that appropriate checks had been undertaken prior to staff's employment. These included: checks that staff were registered with the appropriate

professional body; obtaining references from previous employers; carrying out a DBS check to make sure, where appropriate, new staff were safe to care for vulnerable adults and children.

Appropriate standards of cleanliness and hygiene were maintained. The main practice and the branch surgery were clean and tidy throughout. We saw evidence of a structured and managed approach to maintaining cleanliness at both sites. The practice had a member of staff who was the designated infection control lead and who provided staff with guidance and advice when appropriate. However, this person had not completed the more advanced training needed to enable them to carry out this lead role. There were infection control protocols in place and all staff had received basic infection control training. An infection control audit had been completed to help ensure that good infection control practice was being followed. The practice manager told us that the flooring in one of the examination rooms was carpeted, but that steps were being taken to replace part of the area with a more suitable covering.

A legionella risk assessment had been completed in 2013, and regular water temperature checks were undertaken to help prevent the risk of Legionella developing in the practice's water systems. Regular monitoring of water temperature checks were carried out at the main site and the branch surgery. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal.)

**Monitoring risks to patients:**

There were procedures for monitoring and managing risks to patient and staff safety. For example, a detailed assessment of the potential risks to both patients and staff had been completed. Fire prevention checks had been carried out at both sites, and a fire drill had recently been carried out in the main practice. The practice's fire risk assessment had recently been reviewed for both sites. All electrical and clinical equipment had been regularly checked to ensure it was safe to use and working properly.

Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs. Staff told us there were enough staff to meet patients' needs and to ensure the smooth running of the practice. There was minimal use of locum GP staff and the lead nurse told us the practice had sufficient nursing hours to meet the needs of patients with long-term conditions.

**Arrangements to deal with emergencies and major incidents**

The practice had a business continuity plan in place for major incidents, such as a power failure or building damage. There was an instant messaging system on the computers in all the consultation and treatment rooms, which alerted staff to any emergency at the main practice and branch surgery.

The practice had a system which ensured staff carried out regular checks of the practice's emergency drugs. We found recorded checks had been carried out during the last six months. Checks of the practice's resuscitation equipment, including the defibrillator and oxygen supply, had also been carried out regularly, and a record kept of these checks except for October 2015. We were told this was an oversight. 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 fit for use. All staff received annual basic life support training, to help them respond effectively in the event of an emergency.

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 practice had systems in place to ensure all clinical staff were kept up to date with any changes in guidance. They had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet patients' needs. The nurse practitioner told us they had access to a range of long-term condition templates, which helped them to obtain the information they need to provide appropriate care, treatment and advice.

**Management, monitoring and improving outcomes for people**

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF, and performance against national screening programmes, to monitor outcomes for patients. Overall, the practice had performed well in obtaining 96.8% of the total points available to them, for providing recommended care and treatment to their patients. (This level of performance was in line with the local Clinical Commissioning Group (CCG) average and 3.3% above the England average.) The data also showed the practice had obtained 99.2% of the total points available to them for delivering care and treatment aimed at improving public health. This achievement was 2% above the local CCG average and 3.5% above the England average. This practice was not an outlier for any QOF (or other national) clinical targets. Examples of good QOF performance included the practice obtaining:

- 100% of the total points available to them for providing recommended clinical care for patients with cancer. This was 0.2% above the local CCG average and 2.1% above the England average.
- 100% of the total points available to them for providing recommended clinical care for patients with chronic obstructive pulmonary disease. This was 2.4% above the local CCG average and 4% above the England average.
- 100% of the total points available to them for providing recommended clinical care for patients with heart failure. This was 0.4% above the local CCG average and 2.1% above the England average.

The practice's clinical exception reporting rate was 7.4% for 2014/15. This was 2.7% below the CCG average and 1.8% below 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).

Staff were proactive in carrying out clinical audits to help improve patient outcomes. The practice had prepared a plan identifying the clinical audits that would be carried out in 2015/16. These included, for example, clinical audits covering death in a preferred place of care, reviews of patients prescribed regular anti-depressants and the use of secondary care dermatology. We saw that where the first part of planned two-cycle clinical audits had been undertaken, a date for re-audit had been set, and included on the practice's clinical audit plan.

Complete two-cycle audits had also been carried out. A member of the GP team had recently completed a two-cycle audit to evaluate the effectiveness of the care and treatment staff provided to mothers with postnatal depression. The outcome of the audit showed that patients who met the criteria for inclusion, had experienced improved outcomes in two of the three standards against which clinical practice had been evaluated. For example, staff had ensured that all mothers with postnatal depression had received follow-up clinical care. Areas for further improvement had also been identified, including the need to develop a maternal postnatal template to remind clinicians to enquire about the baby's feeding history, mood and previous antenatal and postnatal history. A two-cycle audit had also been completed to review how well clinicians complied with the good practice guidance, issued by the Royal College of General Practitioners, regarding the information they included on prescriptions. Although the outcome of the audit showed improvements had been made in how prescriptions were written, we saw the team had agreed that more could still be done. We saw that actions had been agreed to achieve

improved performance in writing prescriptions, including ensuring that any GP Registrars on placement would be supported to comply with the same prescribing practice standards.

**Effective staffing**

There were good arrangements for making sure that staff had the skills, knowledge and experience to deliver effective care and treatment. This included providing new staff with an appropriate induction. For example, there was an induction pack for locum GPs, to help make sure they understood the practice's systems, policies and procedures. Staff had received the training they needed to carry out their roles and responsibilities, including for example, training on safeguarding vulnerable patients, basic life support and infection control. Staff had access to, and made use of, e-learning training modules and in-house training. The nurse practitioner told us they had completed a diploma in the care of patients with diabetes, and the practice nurse had completed a diploma in primary care heart disease prevention in the community. We were told nursing staff had completed training updates on administering vaccines and carrying out cervical screening. Both of the healthcare assistants had obtained a relevant National Vocational Qualification at Level 3. Dispensing staff had completed training which enabled them to carry out their role. The nurse prescriber told us they undertook an annual prescribing update and were shortly due to attend a national conference on nurse prescribing. The practice nurse told us the management team was very supportive of their need to carry out training and ensured they were made aware of any training available. There were arrangements in place for staff to have an annual appraisal, and GP staff were supported to work towards their re-validation.

**Coordinating patient care and information sharing**

The practice's patient clinical record and intranet systems helped make sure staff had the information they needed to plan and deliver care and treatment. The information included, for example, patients' care plans, medical records and test results. All documents relating to patients were scanned onto the practice's clinical record system and then any tasks that required completion were assigned to a GP. Clinical staff had access to NHS patient information leaflets which they were able to share with patients in line with their needs. Systems were in place which enabled staff to receive information from out-of-hours emergency services, and to share important information about vulnerable patients with end of life and/or complex needs. Staff worked well together, and with other health and social care services, to understand and meet the range and complexity of patents' needs and to assess and plan ongoing 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). The patient clinical system provided staff with prompts to consider when carrying out a consultation with, for example, any patient aged under 16. The nurse we interviewed demonstrated an understanding of consent issues, especially in relation to treating patients with learning disabilities. All staff had completed training in the use of the MCA.

**Health promotion and prevention**

Staff were consistent and proactive in supporting patients to live healthier lives. There was a focus on early identification and prevention, and on supporting patients to improve their health and wellbeing.

Patients had access to appropriate health assessments and checks, including national screening programmes. Over the past three years, the practice had offered NHS patient health checks to 1,715 patients, of which 942 had attended. Evidence was made available to us which showed that some of the patients who attended for these checks were found to have a range of health conditions which needed treatment. For example, since 2013, as a result of having attended for their NHS health check, nine patients had been identified as having diabetes and they now receive appropriate care and treatment.

Arrangements had been made to support and encourage women to access cervical screening services. The QOF data, for 2014/15, showed the practice had obtained 100% of the overall points available to them for providing cervical screening services. (This was 0.6% above the local CCG average and 2.4% above the England average.) The data also showed the practice had protocols that were in line with national guidance. This included protocols for the management of cervical screening, and for informing women of the results of these tests.

Good

# Are services effective?

## (for example, treatment is effective)

Nationally reported QOF data, for 2013/14, showed the practice had obtained 100% of the overall points available to them for providing recommended care and treatment to patients who smoked. (This was 3.1% above the local CCG average and 4.9% above the England average.) The data also confirmed the practice had supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy.

The practice had obtained 100% of the QOF points available to them for providing recommended care and treatment to patients with learning disabilities. (This was the same as the local CCG average and 0.2% above the England average.)

The practice offered a full range of immunisations for children at their child health and immunisation clinic. On the basis of the nationally reported data available to the Care Quality Commission (CQC), we saw that, where comparisons allowed, the delivery rates for the majority of childhood immunisations were either above or just below, when compared to the overall percentages for children receiving the same immunisations within the local CCG area. Most of the immunisation rates were above 90%+. Influenza vaccination rates for patients over 65 years of age, and patients in at risk groups, were comparable to other practices in the local CCG.

Good

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

We observed throughout the inspection that members of staff were courteous and very helpful to patients. Patients attending at the reception desk and calling by telephone were treated with dignity and respect. Curtains/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 kept closed during consultations so that conversations taking place in these rooms could not be overheard. Reception staff told us they knew when patients wanted to discuss sensitive issues or appeared distressed and said they would offer them a private room to discuss any matters they wanted to talk about. However, on a number of occasions, we saw that staff had left their computer terminals unattended. In addition, we also found that patient referral and hospital correspondence had been left unsecured in a room to which patients potentially had access. This increased the potential risk that such information might be accessed by unauthorised persons.

We spoke with nine patients during our inspection, one of whom was a member of the practice's patient participation group (PPG). All of the patients were complimentary about the practice, the staff who worked there and the quality of service and care provided. They told us they were usually able to get an appointment when they needed one and see their preferred GP. They told us staff provided a good service which met their needs, and said they were treated with respect and dignity. Patients said the premises were always clean and tidy.

The NHS GP Patient Survey results, published in July 2015, showed the practice had performed very well. The practice's performance was above both the local Clinical Commissioning Group (CCG) and national averages, in all but one area of the survey. In addition, the results also demonstrated staff's commitment to providing their patients with good continuity of care. For example, of the patients who responded to the survey:

- 100% said they had confidence and trust in the last nurse they saw, compared to the local CCG average of 98% and the national average 97%.
- 97% said they had confidence and trust in the last GP they saw, compared to the local CCG average of 96% and the national average 95%.
- 80% said they usually got to speak to their preferred GP, compared with the local CCG average of 62% and the national average of 59%.

**Care planning and involvement in decisions about care and treatment**

Patients we spoke with, and those who completed CQC comment cards and had commented on this, told us clinical staff involved them in making decisions about their care and treatment. Also, where patients had commented, those that were taking medication confirmed they had received appropriate information about the medicines they had been prescribed.

Results from the NHS GP Patient Survey we reviewed showed patients were very positive about the way in which clinical staff involved them in making decisions about their care and treatment. The results were consistently above the local and national averages. For example, of the patients who responded to the survey:

- 96% said the last GP they saw was good at explaining tests and treatments; compared to the local CCG average of 89% and national average of 86%.
- 93% said the last GP they saw was good at involving them in decisions about their care, compared to the local CCG average of 85% and the national average of 81%.

**Patient and carer support to cope emotionally with care and treatment**

Patients were provided with access to information to help them cope emotionally with their care and treatment. Staff had access to a range of health related information leaflets which they were able to print off and give to patients during consultations. There was a younger person's sexual health information noticeboard in the entrance area of the main practice, as well as various information leaflets about common health conditions and current health promotion initiatives. However, we did not see any information about how to access bereavement or mental health services.

The practice had identified the needs of carers and maintained a carers' register to help them target support. Patients were asked if they were carers when registering

Good

# Are services caring?

and the practice's computer system alerted GPs if a patient was also a carer. To help improve the care and support the practice provided to these patients, staff were working with a local carers' support group. Evidence submitted to us as part of this inspection confirmed that 49 carers had been referred to, and had undergone an assessment and received subsequent support from this local carers group. However, neither the practice's website, nor their patient leaflet, contained any information about the support staff provided to carers.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

Staff worked well with the local clinical commissioning group (CCG), and other local practices, to plan services and to improve outcomes for their patients. For example, the practice manager acted as the local CCG lead for training and education, and had led on the development of a local, sustainable model of development and education to meet the needs of GPs, nurses and healthcare assistants.

Services were planned and delivered to take into account the needs of different patient groups and to help ensure flexibility, choice and continuity of care. For example, good arrangements had been made to meet the needs of older patients and patients with long-term conditions. The practice had performed well in obtaining 96.1% of the total points available to them for providing recommended care and treatment to older patients and those with the long-term conditions covered by QOF. This performance was 1.6% above the England average.

The nursing team provided patients with access to a range of appointments and clinics to help ensure they received the care and treatment they needed in relation to any long-term conditions they had. A good administrative system ensured patients received an invitation to attend an annual review, or more frequently where clinical staff judged this to be necessary. A system was also in place to follow up patients who failed to attend for their healthcare review.

A named GP provided a fortnightly 'ward round' at a local care home for patients with complex healthcare needs. The needs of each patient were reviewed to pre-empt any potential health problems. These patients were also able to access same-day urgent care, provided by the same GP. Clinical staff also provided support to two other local care homes.

The practice had recently developed a clinical strategy for 2015/16 aimed at improving their arrangements for meeting the needs of patients with long-term conditions. We were told this strategy would be subject to a full audit programme after 12 months. Staff had developed a comprehensive, point of care anticoagulation monitoring service, which had also recently been extended to cover housebound patients. This service provided patients with more choice and greater flexibility about how their needs were met. Following a review of hypertension diagnosis rates, the practice had made a decision to offer in-house ambulatory blood pressure monitoring service, to help clinicians improve diagnosis rates.

Clinical staff had taken steps to improve their dementia diagnosis rates. (Early diagnosis means these patients can benefit from planned, managed care.) Clinical staff had used a recognised tool to screen at risk patients and, as a result, had increased the number of patients with a diagnosis of dementia by 20%.

Staff had performed well in reducing unplanned admissions into hospital. The practice participated in the 'Unplanned Admissions' enhanced service and had identified a register of 2% of patients who they had judged to be at greater risk of hospitalisation. Arrangements had been made to carry out reviews of the needs of patients on this register and to provide feedback to the clinical team on a monthly basis. In addition, staff also reviewed the needs of patients who had been admitted into hospital to identify whether this could have been prevented. Recent local CCG data showed that unplanned admissions into hospital had reduced by 12.7%. The data indicated that the practice had the second lowest level of unplanned admissions in the most recent complete month.

Staff were working in collaboration with other local practices, and health and social care providers, to develop 'case manager' and 'Care Navigator' roles, within their primary care community area. (The role of these staff is to provide extra support to patients with complex needs and multi-morbidity (more than one long-term condition) and those judged to be at risk of crisis and losing their independence.)

Staff had performed well in meeting the needs of palliative care patients. They maintained a register of palliative care patients in line with the Gold Standards Framework guidelines. Patients on the register were discussed each month during the full practice clinical team meetings, which also included district and palliative care nurses. Over half of the patients on the register had a documented 'place of care' and resuscitation choice recorded on their medical record. Work was underway to ensure this information was available for all patients. A GP at the practice had recently completed a diploma in palliative care, which the practice manager hoped would help them to further improve the services they provided to patients with palliative care needs.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

Staff had taken steps to provide services which met the needs of working age patients. The practice offered appointments every Monday evening, at the main practice site at Windermere, for working patients who could not attend during normal opening hours. Telephone consultations with a GP or nurse were also available each lunch time. Staff told us they often arranged to see patients before normal clinic times, to fit in with patients' work or other commitments. Patients were able to book appointments and request repeat prescriptions on-line.

Staff had been proactive in meeting the needs of patients with dermatological conditions. Following feedback from the local NHS Trust, the practice took steps to improve the services they offered to patients with dermatological conditions. In 2014, a member of the GP team completed a diploma in Dermatology. As well as seeing practice patients with dermatological needs in-house, this GP also worked as a GPwSI (General Practitioner with Special Interest) in the South Lakes area, providing care and treatment to patients from other practices. We were provided with evidence which showed that in taking on the role of a GPwSI, the GP had had a positive impact on the way in which the needs of this group of patients were managed. For example, between January and October 2014, clinical staff at the practice had referred 198 patients to specialist services based at the local hospital. In the same period during 2015, the referral rate had dropped to 80, indicating that a greater number of patients had been able to benefit from receiving care and treatment closer to home.

All GPs provided maternity care in collaboration with the midwife attached to the practice. Child development clinics were also provided, and patients were able to access health visitor staff at both the main practice and the branch surgery. A family planning service was provided by all the GPs. Following recent staff changes within the GP clinical team, the practice had made changes to how staff delivered family planning services. This included providing patients with access to a five day emergency coil service and contraceptive implants, making it easier for working age patients to access this service. Fast access appointments were available for teenagers, and we were told ill-children under the age the five would be given a same-day urgent appointment where required. The practice offered a walk-in minor surgery service that was often used by children as an alternative to visiting the Accident and Emergency department. The practice told us they had treated 47 children over the past 12 months.

Services had been put in place to meet the needs of patients with mental health needs. The practice had obtained 100% of the QOF points available to them for providing recommended care and treatment to patients with mental health needs. (This was 4.6% above the local CCG average and 7.2% above the England average.) The QOF data showed that 91.7% of patients with the mental health conditions covered by QOF had a comprehensive care plan in place, which had been agreed with them and their carers. (This was 1.5% above the local CCG average and 3.4% above the England average.) The surgery hosted a range of counselling services provided by the local foundation trust and patients were able to access a wide range of literature regarding these services, including how to self- refer into the service.

Reasonable adjustments had been made which helped patients with disabilities, and those whose first language was not English, to use the main practice and branch surgery. For example, at the branch surgery consultation and treatment rooms were located on the ground floor. However, at the main practice, some of the consultation and treatment rooms were on the first floor. We were told that, although this was not ideal, arrangements had been made which ensured that patients with mobility issues were always able to see a GP in one of the ground floor rooms. Disabled toilet facilities were available at both the main practice and the branch surgery. However, a patient call system had not been installed for use in an emergency in the disabled toilet in the main practice. A loop system was available to help improve access for hearing impaired patients. However, this system was not in use at the time of our visit. The waiting area in the main surgery was spacious making it easier for patients in wheelchairs to manoeuvre. Staff had access to a telephone translation service and interpreters should they be needed. However, we were told these services were rarely required. We did identify that there was no information available in other languages in the patient waiting areas or on the practice's website.

**Access to the service**

The main practice at Windermere was open Monday to Friday between 8am and 6:30pm. The Staveley branch surgery was open Monday, Tuesday, Thursday and Friday between 9am and 5:30pm, and on Wednesday between 9am and 1pm. An extended hours surgery was also provided at the main practice site with a GP every Monday.

Appointment times were:

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

The main practice site: (Windermere)

Monday to Friday:morning surgeries took place between 9am and 12 noon and afternoon surgery start times range from 2.30pm to 3.30pm and finished at approximately 6pm, with the exception of Monday evenings when an extended hours surgery was provided.

The Staveley branch surgery:

Monday to Friday:morning surgeries took place between 9am and 12 noon and afternoon surgery start times ranged from 2.30pm to 3pm and finished at 5.30pm. The branch surgery was closed on a Wednesday afternoon.

Patients were able to book routine appointments up to six weeks in advance, and same-day and urgent appointments were available for patients who had been assessed as having urgent needs. Patients were usually able to obtain an appointment with a GP or nurse practitioner within 48 hours. Appointments could also be booked online by patients who registered for that service. Home visits were available for those patients who were too ill to attend one of the surgeries. Daily telephone consultations were offered so that patients could obtain advice without having to attend the practice. All of the patients we spoke with said they were able to obtain an appointment when they needed one. Good arrangements had been made to monitor the capacity of the appointment system to handle patient demand, and to take action when extra resources were considered necessary.

Results from the NHS GP Patient Survey of the practice, published in July 2015, showed that patient satisfaction levels with access to the practice and appointments, were either significantly above, or broadly in line with, the local CCG and the national averages. Of the patients who responded to the survey:

- 77% were satisfied with the practice's opening hours, compared to the local CCG average of 78% and the national average of 75%.
- 80% said they were usually able to get to see or speak to their preferred GP, compared to the local CCG average of 62% and the national average of 59%.
- 94% said they could get through easily to the surgery by telephone, compared to the local CCG average of 81% and the national average of 73%.

**Listening and learning from concerns and complaints**

There was a system for handling complaints and concerns and staff told us they made every effort to address concerns raised by patients. However, information shared with us shortly after the inspection indicated that staff may have, on one occasion, failed to follow the practice's complaints procedure. The practice manager told us they would review the way the complaint was handled to identify whether there were any lessons to be learned from this.

There was a person responsible for handling all complaints received by the practice. The GP partners undertook this role in the absence of the practice manager. Arrangements had been made to carry out an annual review of complaints received, to see whether there were any trends or themes that would enable the practice to make improvements to the service.

Information was available to help patients understand the complaints system. For example, information about complaints was available in the practice's information leaflet and on their website. The practice also had a complaints procedure which provided an overview of how any complaints received would be responded to. Although the procedure contained useful information, it could have included more detail to help patients better understand what would happen when they made a complaint. For example, the procedure did not include any reference to how practice staff would support patients to access an advocate or interpreter services.

The practice had received two complaints during the previous 12 months. The practice manager confirmed that both of these had been handled in line with their complaints procedure, and we were provided with evidence which confirmed that both had been treated seriously, lessons had been learnt as a result and apologies had been made to the patients concerned.

# 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 about how to deliver high quality care and promote good outcomes for patients. This was clearly demonstrated to us in the presentation they made to the inspection team and in the interviews we held with staff. The practice's vision included: achieving improved continuity of care and use of resources between the main site and the branch surgery; improving facilities at the main practice site; ensuring the smooth continuation of services and clinics in response to planned staff departures; and implementing the agreed clinical lead system. We saw evidence that staff were taking action to enact their strategy. The practice had recently developed a clinical strategy for 2015/16 aimed at improving their arrangements for meeting the needs of patients with long-term conditions. We were told this strategy would be subject to a full audit programme after 12 months.

The practice had a stable staff team and a low turnover of staff. Succession planning had taken place to ensure continuity of clinical care. Plans were being formulated to obtain funding to make improvements at the main practice site, including increasing the number of ground floor consulting rooms.

The interviews we carried out with staff provided evidence of a culture which was patient focussed and underpinned by effective teamwork. Our interviews with GP staff and the practice manager showed they understood the challenges they faced and the impact of these on their day-to-day practice.

**Governance arrangements**

We saw evidence of good governance arrangements. The practice had policies and procedures to govern their activities and there were systems to monitor and improve quality and identify areas of risk and how to minimise these. A clinical lead system had recently been introduced to help promote good leadership, and provide staff with access to expertise. Other staff had also been designated key lead roles to help promote their involvement in the day-to-day running of the practice. Regular practice and multi-disciplinary team meetings took place, which helped to ensure patients received effective and safe clinical care. For example, weekly practice clinical meetings took place. The GP partners, the practice manager and senior administrative lead also met monthly. The practice manager ensured that relevant information from these meetings was shared with all staff.

Arrangements had been made which supported staff to learn lessons when things went wrong, and to support the identification, promotion and sharing of good practice. The practice proactively sought feedback from patients and had a patient participation group (PPG). There were good arrangements for making sure the premises, and the equipment used by staff, were maintained in a safe condition and worked satisfactorily. There was a clear staffing structure and staff understood their own roles and responsibilities. Clinical audits were carried out and staff were able to demonstrate how these led to improvements in patient outcomes.

**Leadership, openness and transparency**

The GP partners and practice manager had the experience, capacity and capabilities needed to run the practice and ensure high quality care. The management team had created a culture which encouraged and sustained learning at all levels in the practice. Through their partnership working with other agencies, they had promoted quality and continuing improvement for the patients who used their service. Staff we interviewed told us the practice was well led and they said they would feel comfortable raising any issues of concern. There was a clear leadership structure in place and staff felt supported by management. Staff told us regular meetings were held and their involvement was encouraged. They also said they felt respected, valued and supported.

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

The practice encouraged and valued feedback from patients, the public and staff. Staff proactively sought patients' feedback and engaged them in the delivery of the service, for example, through their patient participation group (PPG) and the surveys they had carried out. The most recent set of PPG minutes demonstrated that PPG members had taken part in discussions with staff about potential areas for improvement and how these might be implemented. The minutes we looked at showed the practice had made a decision to run a trial with one of the GPs offering extended 15 minute appointment times, to see whether this might help address feedback from the

# Are services well-led?

Good

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

national GP Patient Survey regarding appointment waiting times. However, we noted that the practice's website did not include any feedback on the work being undertaken by the PPG. Nor was such information made available in the practice's patient waiting areas.

The practice also obtained feedback from patients via the Friends and Family Test which had been introduced earlier in 2015. The results for August, September and October 2015, showed that 100% had reported that they would be 'extremely likely' or 'likely' to recommend the practice to families and friends. Feedback had also been gathered from staff through staff meetings and appraisals. Staff told us they would not be concerned about giving feedback or raising concerns or issues with the GP partners or the practice manager. They told us they felt involved and engaged in how the practice was run.

**Continuous improvement**

There was a strong focus on continuous learning and improvement at all levels within the practice.

Staff were forward thinking and committed to providing patient focussed services, delivered by staff who had the skills and competencies needed to do this. The practice manager acted as the chair for the local practice manager's forum, and was involved in leading on work to provide clinical staff across the locality with access to focussed, relevant training to help develop and maintain their skills and competencies. The practice demonstrated their commitment to continuous learning. Following the departure of the senior partner, who had acted as the practice's GP trainer, another GP had taken on this role and was currently undergoing accreditation. In addition to their intention to once again provide placements for GP Registrars, following accreditation, the practice also offered placements to nursing students in collaboration with Health Education England. An education session was provided at the beginning of the weekly clinical meetings twice monthly, and the GP partners had also recently formed a small education group that met monthly, to which their peers also had access. Staff told us these sessions provided time for learning and reflection. Regular practice learning team sessions also took place to help promote staff's knowledge and competencies.