St Pauls 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?	Outstanding
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 inspected the practice on 14 November 2014. We did not visit the branch surgery as part of this inspection. We inspected this service as part of our new comprehensive inspection programme. Overall, we rated the practice as good. Our key findings were as follows:

- Patients reported they were treated with kindness and respect, and received safe care and treatment which met their needs;
- Patient outcomes were either in line with, or better than average, when compared to other practices in the local Clinical Commissioning Group (CCG) area;
- Practice staff provided care and treatment in line with guidance produced by the National Institute for Health and Care Excellence (NICE);
- The practice was clean and hygienic, and good infection control arrangements were in place;
- The practice learned from significant events and incidents and took action to prevent their recurrence;
- The practice was well-led and had good governance arrangements. Staff felt well supported.

We saw areas of outstanding practice:

- The practice was involved in supporting the implementation of an internet delivered self-care service that enables patients to set their own goals and, with the support of their GP, monitor their own health and wellbeing;
- The practice was involved in developing and supporting the implementation of a Telehealth Scheme to monitor patients who are at higher risk of having health problems. The Scheme also provides patients with opportunities to learn more about their condition and what they can do to manage it.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good 

The practice is rated as good for providing safe services.

The practice had demonstrated it was safe over time. Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The management team took action to ensure lessons were learned from any incidents or concerns, and shared these with staff to support improvement. Safe staff recruitment practices were followed and there were enough staff to keep patients safe. Good infection control arrangements were in place and the practice was clean and hygienic. Risks to patients were assessed and well managed. There was evidence of good medicines management. Action had been taken to address the compliance action we set following our last inspection. This ensured information about changes to patients' medicines, following their discharge from hospital, was checked by a GP and, where necessary, appropriate action taken.

Are services effective?

Outstanding 

The practice is rated as outstanding for providing effective services.

Nationally reported data showed patient outcomes for effective were either in line with, or better than average, when compared to other practices in the local CCG area. Patients' needs were assessed and care was planned and delivered in line with current legislation and best practice guidance produced by the National Institute for Health and Care Excellence (NICE.) Staff had received training appropriate to their roles and responsibilities. Arrangements had been made to support clinical staff with their continuing professional development. There were effective systems in place to support multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the information and equipment they needed to deliver effective care and treatment.

Are services caring?

Good 

The practice is rated as good for providing caring services.

Nationally reported data showed patient outcomes for caring were either in line with, or better than average, when compared to other practices in the local CCG area. Patients said they were treated well and were involved in making decisions about their care and treatment. Arrangements had been made to ensure their privacy and dignity was respected. Patients had access to information and

Summary of findings

advice on health promotion, and they received support to manage their own health and wellbeing. Staff demonstrated they understood the support patients needed to cope with their care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Nationally reported data showed patient outcomes were either in line with, or better than average, when compared to other practices in the local CCG area. Services had been planned so they met the needs of the key population groups registered with the practice. Patient feedback regarding access to appointments and waiting times was generally good. The practice was in the process of changing its appointment system in response to some dissatisfaction expressed by patients. We found the practice had been responsive to this feedback and was taking steps to improve its appointment system to provide patients with better access. The practice had taken steps to reduce emergency admissions for patients with complex healthcare conditions, and older patients had been allocated a named GP to help promote continuity of care. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system, with evidence demonstrating the practice responded quickly to any issues raised.

Are services well-led?

Good

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

The leadership, management and governance of the practice assured the delivery of person-centred care which met patients' needs. The practice had a clear vision for improving the service and promoting good patient outcomes. This included a strategic plan to improve access to appointments and upgrading the practice's IT system. An effective governance framework was in place. Staff were clear about their roles and understood what they were accountable for. They also felt well supported. The practice had a range of policies and procedures covering its activities. Systems were in place to monitor and, where relevant, improve the quality of the services provided to patients. The practice actively sought feedback from patients and used this to improve the services they provided.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as outstanding for the care of older patients.

Nationally reported data showed the practice had achieved good outcomes in relation to the conditions commonly associated with older people. The practice offered proactive, personalised care to meet the needs of older people. It provided a range of enhanced services including, for example, a named GP who was responsible for overseeing the care and treatment received by the practice's older patients. Clinical staff had received the training they needed to provide good outcomes for older patients. The practice was involved in supporting the implementation of an internet delivered self-care service that enables patients to set their own goals and, with the support of their GP, monitor their own health and wellbeing.

People with long term conditions

Good

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

Nationally reported data showed the practice had achieved good outcomes in relation to those patients with common long-term conditions. The practice had taken steps to reduce unplanned hospital admissions by improving services for patients with complex healthcare conditions. All patients on the practice's long-term conditions registers received healthcare reviews that reflected the severity and complexity of their needs. Person-centred care plans had been completed for each patient. These included details of the outcome of any assessments patients had undergone, as well as the support and treatment that would be provided by the practice. Practice nurses had received the training they needed to provide good outcomes for patients with long-term conditions.

Families, children and young people

Good

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

Nationally reported data showed the practice had achieved good outcomes in relation to child health surveillance, contraception and maternity services. Systems were in place for identifying and following up children who were considered to be at risk of harm or neglect. The practice's paediatric nurse practitioner reviewed all accident and emergency reports for children under 16. All newly registered children under 16 received an appointment with the

Summary of findings

paediatric nurse practitioner. The practice provided Level 2 sexual health services including the fitting of long-term reversible contraception by a GP who had completed additional training in this area.

Working age people (including those recently retired and students)

Good

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

The needs of this group of patients had been identified and steps taken to provide accessible and flexible care and treatment. The practice was proactive in offering on-line services to patients. Patients could order repeat prescriptions and book appointments on-line. Appointments were available from 08:00am to 6:30pm each weekday and until 8:00pm on some weekdays at the main practice site. Health promotion information was available in the waiting area and on the practice web site. The practice provided additional services such as Well Woman clinics, smoking cessation and weight management, travel vaccinations and minor surgery.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable.

The practice had achieved good outcomes in relation to meeting the needs of patients with learning disabilities. The practice held a register which identified which patients fell into this group. It used this information to ensure they received an annual healthcare review and other relevant checks and tests. Staff worked within multi-disciplinary teams to help meet the needs of vulnerable patients. The practice sign-posted vulnerable patients to various support groups and other relevant organisations. The practice ran a shared care drug clinic in collaboration with the drug & alcohol recovery service provider UNITY. This helped affected patients at the practice, and their families, to access treatment and recovery support for substance misuse.

People experiencing poor mental health (including people with dementia)

Good

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

The practice had achieved good outcomes in relation to meeting the needs of patients with mental health needs. It kept a register of these patients which it used to ensure they received relevant checks and tests. Where appropriate, care plans had been completed for patients who were on the register, in agreement with patients and

their carers. The practice regularly worked within multi-disciplinary team settings to help ensure patients' needs were identified, assessed and monitored. The practice provided extra services to meet the needs of this population group. Some GPs had completed extra training to enable them to act as an approved doctor, so they could ensure that patients with mental health problems were legally admitted into hospital for assessment and treatment. One of the GPs acted as the mental health locality lead which provided opportunities for the practice to feed into the development of local mental health services.

Summary of findings

What people who use the service say

During the inspection we spoke with six patients and reviewed three CQC comment cards completed by patients. The feedback we received indicated most patients were satisfied with the care and treatment they received. Most patients told us they received a good service which met their needs. They said they were treated with dignity and respect and their privacy was protected.

Findings from the 2014 National GP Patient Survey for the practice indicated a high level of satisfaction with most aspects of the care and treatment it provided. For example, of the patients who responded:

- 92% said the last GP they saw, or spoke to, was good at listening to them;
- 90% said the last GP they saw or spoke to was good at giving them enough time, and treating them with care and concern;
- 86% said the last GP they saw or spoke to was good at explaining tests and treatments;
- 98% said they had confidence and trust in the last GP they saw or spoke to;
- 83% said they were satisfied with the practice's opening hours.

All of the above results were higher than the average scores for practices within the regional CCG area. (A Clinical Commissioning Group is a group of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.)

However, of the patients who responded in the same survey:

- 58% said they found it easy to get through the this surgery by phone;
- 44% who had a preferred GP usually got to see or speak to that GP;
- 63% described their experience of making an appointment as good;
- 59% said they usually waited 15 minutes or less after their appointment time.

All of the above results were lower than the average scores for practices within the regional CCG area. These results were based on 115 surveys that were returned from a total of 272 sent out. The response rate was 42%.

We received similar feedback from the patients we spoke with during the inspection. Patients were very positive about the care and treatment provided by practice staff. However, most said they were dissatisfied with the previous appointment system and were not sure if the new appointment system would improve things. Some patients also said they were unhappy with the length of time they had to wait to see a GP in the open surgeries. Feedback from the practice's own patient survey indicated that with regards to:

- Telephone access to the practice, 13 patients said it was 'excellent', 65 said it was 'very good', 98 said it was 'good' and 98 said it was 'fair'. However, 59 patients said it was 'poor';
- Seeing a practitioner of choice, 32 patients said it was 'excellent', 58 said it was 'very good', 76 said it was 'good' and 78 said it was 'fair'. However, 87 patients said it was 'poor';
- Appointment satisfaction, 47 patients said it was 'excellent', 97 said it was 'very good', 110 said it was 'good' and 56 said it was 'fair'. However, 21 patients said it was 'poor';
- Appointment waiting times, 21 patients said it was 'excellent', 61 said it was 'very good', 110 said it was 'good' and 96 said it was 'fair'. However, 38 patients said it was 'poor'.

These results were based on 339 returned patient surveys.

Outstanding practice

We saw areas of outstanding practice:

Summary of findings

- The practice was involved in supporting the implementation of an internet delivered self-care service that enables patients to set their own goals and, with the support of their GP, monitor their own health and wellbeing;
- The practice was involved in developing and supporting the implementation of a Telehealth Scheme to monitor patients who are at higher risk of having health problems. The Scheme also provides patients with opportunities to learn more about their condition and what they can do to manage it.

St Pauls Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP. The team also included a Pharmacist Inspector and a practice professional.

Background to St Pauls Practice

St Paul's Practice is a busy city centre practice with 14,900 patients of all ages, based on a General Medical Services (GMS) contract agreement for general practice. The practice is part of NHS Cumbria Clinical Commissioning Group (CCG) and provides care and treatment to patients living in the Carlisle area. It serves an area that has higher levels of deprivation for children and people in the over 65 age group. The practice's population includes more patients aged under 18 years, and less patients aged over 65 years of age, than other practices in the local CCG area.

The practice occupies the ground floor of a block of flats. The premises are fully accessible to patients with mobility needs. St Paul's Practice provides a range of services and clinics, including, for example, clinics for patients with asthma and epilepsy and those needing support with drugs and alcohol misuse. The practice consists of nine GPs, a practice manager, seven nurses (including two nurse prescriber/practitioners), two healthcare assistants, a phlebotomist, a medicines manager and a practice pharmacist, and a large administrative team. St Paul's Medical Centre also operates a branch surgery at the following address.

Arnside House

Sycamore Lane

Carlisle

Cumbria

CA13 SR

When the practice is closed patients can access out-of-hours care via Cumbria Health On-Call and the NHS 111 service. An 'extended hours' service is available on selected days throughout the week with the last available appointment until 19:50pm, for patients who are unable to attend the practice and branch surgery during their usual opening hours.

Why we carried out this inspection

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

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

When we previously inspected the practice in May 2014, we told the provider they were not compliant with Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Assessing and Monitoring the Quality of Service Provision. We said: 'Patients were not protected against the risks associated with the unsafe use

and management of medicines. This was because the arrangements for handling hospital discharge letters and other advisory letters, including the authorisation to supply prescribed medicines, were unsafe.'

Following the inspection, the provider sent us an action plan telling us what action they would take to comply with the compliance action and when this would happen. During this inspection we checked whether the required improvements had been made and found action had been taken to comply with the compliance action we set.

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.

How we carried out this inspection

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

• 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the services it provided. We carried out an announced inspection on 14 November 2014. During this we spoke with a range of staff including: the managing GP partner; the practice manager; a practice nurse; the medicines manager and staff who worked in the reception, medicines and data processing teams. We spoke with six patients who visited the practice on the day of our inspection. We also observed how patients were being cared for in the public areas of the practice and looked at some of the records kept by the practice. Three CQC comment cards had been completed by patients using the practice

Good

Are services safe?

Our findings

Safe Track Record

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how it operated. Also, the information we reviewed as part of our preparation for this inspection did not identify any concerning indicators relating to the safe domain. We had not been informed of any safeguarding or whistle-blowing concerns regarding patients either by the practice or the public. The local CCG did not raise any concerns with us about how this practice operated.

The practice used a range of information to identify potential risks and to improve quality in relation to patient safety. This information included, for example, significant event reports, national patient safety alerts, and comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns and knew how to report incidents and near misses.

The practice kept records of the significant events that had taken place, what lessons had been learnt and what action had been taken to prevent a future reoccurrence. The practice's arrangements for responding to significant events showed they had managed such events consistently and appropriately during the period concerned. This provided evidence of a safe track record for the practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The staff we spoke with were aware of the system in place for raising issues and concerns. Records had been kept of the significant events and untoward incidents that had occurred since our last visit in April 2014. We looked at a sample of these and found they included details about what had happened and why, and what the practice had learned from the events. We also found they included information about the changes that had been introduced to prevent further reoccurrences. We were told that, where significant events or incidents had occurred, these had been placed on the agenda and discussed at practice meetings.

The practice also reported incidents to the local CCG, using the local safeguarding incident reporting and monitoring system (SIRMs). (This system requires practices to grade the degree of risk using a traffic light system, and score the potential impact of the incident on patients using their service.) We were told four incidents had been reported since our last inspection. One of those we looked at showed that once the practice had identified there was a problem with a patient's medicines following their discharge from hospital. We saw they had contacted the hospital concerned to make sure they, and the patient, had both been given accurate information.

Arrangements had been made to make sure the practice responded appropriately to incoming national patient safety alerts (NPSA). The practice manager told us NPSAs were received and disseminated by themselves and the medicines manager, via a 'same-day' email to all members of the team. The practice used a standardised template to record what action had been taken to address a NPSA and by whom.

Reliable safety systems and processes including safeguarding

The practice had systems in place for safeguarding children and vulnerable adults. The practice had completed the Royal College of General Practitioner's Self-assessment Safeguarding Audit Tool. (This Tool helps practices to determine where they are up-to-date with legislative requirements and best practice guidance.) We saw it included details of any actions the practice needed to take to improve how it safeguarded patients.

The practice had policies and procedures which covered the safeguarding of both children and vulnerable adults. These provided staff with clear guidance about what they must do to protect vulnerable patients at risk of potential harm.

Staff we spoke with were aware of which GPs had lead and deputy lead safeguarding responsibilities. Practice training records showed all staff had received relevant, role specific training on safeguarding. For example, all GPs had completed Level 3 child protection training to enable them to fully carry out their safeguarding duties and responsibilities. Practice nursing staff had also completed child protection training to the same level. Non-clinical staff had completed basic safeguarding awareness training. The staff we spoke with were aware of their responsibilities for reporting safeguarding concerns and sharing information

within the practice and with other relevant professionals. Information about how to report safeguarding concerns and contact the relevant agencies was easily accessible within the practice.

A chaperone policy was in place and information about this was displayed in the reception area and was on the practice website. Chaperone training had been undertaken by all staff who carried out chaperone duties. This was confirmed by one of the practice nurses we spoke with.

Patients' records were kept on an electronic system. This system stored all information about patients, including scanned copies of communications from hospitals. A system was in place to highlight vulnerable patients in the practice's electronic records. Children and vulnerable adults who were assessed as being at risk were identified using READ codes. These codes alerted clinicians to their potential vulnerability. (Clinicians use READ codes to record patient findings and any procedures carried out.) Systems were in place which ensured any incoming safeguarding information was scanned to patients' medical records.

The practice had made arrangements to regularly review cases where there were known or suspected safeguarding concerns. The safeguarding lead GP held lists of vulnerable families, children and adults, and work was underway to make this information easily available to other practice staff. GPs attended multi-disciplinary safeguarding and serious case reviews meetings when they judged it was appropriate for them to do so. The practice held quarterly, multi-disciplinary safeguarding meetings to review each patient considered to be at risk and, where appropriate, to share any relevant information they had access to. Attendees included the health visitor and family nurse. The sample of minutes we looked at indicated that where concerns were identified during these meetings, follow up actions and personnel responsible for them were clearly recorded.

Medicines Management

During this inspection, we checked the controlled drugs, and other medicines kept at the practice, and found they were within their expiry date and stored securely. There were clearly written procedures for handling controlled medicines, which were being followed by staff. Medicines that might be needed in an emergency were easily accessible and regularly checked by a member of the practice nursing team. There were appropriate systems for ensuring that vaccines were kept at the required temperature and therefore safe to use.

Staff used practice meetings to regularly discuss medicines management and prescribing issues. Following discussion at one of these meetings, the practice pharmacist had prepared written guidance for the GPs on prescribing for patients with swallowing difficulties following an increase in the number of prescription requests for liquid medicines.

There were systems in place for monitoring patients on high risk medicines. For example, the practice carried out three monthly reviews of patients who were prescribed a medicine that can cause blood disorders amongst other side effects. The practice pharmacist, who was an independent prescriber, closely monitored patients prescribed anti-coagulant medication, including warfarin. The pharmacist held a weekly anticoagulant clinic. Patients could have their blood tested at the clinic, and the pharmacist monitored their health and made any necessary changes to their prescription. Training records provided evidence of the pharmacist's continuing professional development in the specific clinical area for which they prescribed.

Protocols for prescribing medicines, including the issuing of repeat prescriptions, were in line with national guidance. The practice had a small prescribing team, led by the medicines manager and we found that the team was competent and followed the protocols. The practice participated in the Electronic Prescription Service scheme which meant the majority of prescriptions were signed electronically by the doctor and transmitted directly to the community pharmacy the patient had chosen. Other prescriptions were signed by hand before collection by patients. GPs signed the repeat prescriptions for their own patients when this was possible. Blank prescription forms were stored securely and tracked through the practice.

Following an inspection we carried out in April 2014 a compliance action was set in which we told the provider: 'Patients were not protected against the risks associated with the unsafe use and management of medicines. During this inspection, we found the arrangements for checking prescriptions against hospital discharge and advisory letters, were safe.

Cleanliness & Infection Control

Good

Are services safe?

The practice was clean and hygienic throughout. Suitable arrangements had been made which ensured the practice was cleaned to a satisfactory standard. For example, cleaning staff signed an accountability sheet to confirm required cleaning tasks had been carried out. A member of the nursing team, who acted as the practice's infection control lead, told us they regularly checked the premises and ensured any shortfalls in the quality of cleaning identified were immediately addressed with cleaning staff. Patients told us the practice was always clean and hygienic.

A range of infection control policies and procedures were in place. These provided staff with guidance about the standards of hygiene they were expected to follow. Training records confirmed staff had received infection control training. Regular infection control audits were carried out and we were told these were used to make sure good hygiene standards were maintained.

The infection control lead confirmed staff had access to personal protective equipment, such as disposable gloves and aprons, they needed to provide safe care and prevent the spread of infection. Hand hygiene signage, hand washing sinks, antiseptic gel and hand towel dispensers, were available in staff and patient toilets. Sharps bins (used needles are placed in these) were available in clinical areas and we saw these had been signed and dated. The clinical rooms we visited contained paper covers and privacy screens for the examination couches. Arrangements had been made for the privacy screens to be changed every six months. Reception staff knew how to handle specimens and a member of the reception team said they had received training in how to do this. Easily accessible spillage kits (used to clean up bodily fluids) were available and staff knew where these were stored. The clinical rooms we visited were suitably equipped and the surfaces, including the floor covering, were easy to clean. The practice nurse we spoke with confirmed staff had access to all of the cleaning materials they needed to maintain their working space in a hygienic condition.

Equipment

Staff had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. This included, for example, medicines refrigerators, sharps boxes and an electrocardiogram machine (used to monitor a patient's heart). Staff told us the equipment they used was regularly checked and serviced, and we saw records confirming this. For example, all of the portable electrical equipment had been tested within the last 12 months. Fire safety checks were carried out. Other checks included the inspection and calibration of medical equipment.

Staffing & Recruitment

The practice had a recruitment policy which provided clear guidance about the pre-employment checks that should be carried out on staff. The practice had not appointed any doctors or nurses since our last visit in April 2014. In our previous inspection we found thorough checks had been undertaken to make sure clinical staff were registered with their professional body and were fit to practice. For example, we found these had included Disclosure and Barring Service (DBS) checks and requesting staff references from applicants' previous employers. All the staff carried NHS Smart cards which contained a recent identification photograph. We were told staff's identities had been verified under the NHS Employment Check Standards process. We checked the General Medical and Nursing and Midwifery Councils registers and confirmed all clinical staff were licensed to practice.

Staff employed to work at the practice were qualified and competent staff. They had the skills and experience needed to carry out their roles safely and effectively. The staff team and partnership were stable with many staff having worked at the practice for over ten years. The practice manager told us staffing levels were subject to constant review to ensure they remained relevant and appropriate, and were being monitored daily following the introduction of the new appointment system.

Monitoring Safety & Responding to Risk

The practice had systems and policies in place to manage and monitor risks to patients, staff and visitors. This included carrying out regular checks of the premises and equipment. The practice had a health and safety policy which provided staff with guidance about their role and responsibilities, and what steps they should take to keep patients safe. The premises were safe and free from hazards. Staff told us the practice was a safe place to work. None of the patients we spoke to raised any concerns about health and safety. Risk assessments had been completed identifying a range of potential hazards and the action taken to minimise or manage them.

Good

Are services safe?

Staff knew how to identify and respond to changing risks to patients. For example, the needs of neonates, babies and children considered to be at risk of potential harm or abuse, were regularly reviewed in multi-disciplinary meetings held by the practice.

Arrangements to deal with emergencies and major incidents

Systems were in place to identify and manage foreseeable risks. The provider's business continuity plan set out the alternative arrangements that would be put in place if, for example, the practice IT system failed. The plan had been reviewed to make sure it was up-to-date and relevant. An 'Emergency Situations Protocol' had been devised to help staff be clear how about how they should respond in the event of an emergency.

The practice had equipment for managing emergencies including access to a supply of oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The staff we spoke to knew the location of this equipment and records we saw confirmed these were checked regularly to make sure they were in good working order. The drugs available for emergencies were within their expiry dates, which meant they were safe to use. Staff told us regular checks of medicine expiry dates were carried out to make sure these had not been exceeded. Staff we spoke with knew where to access the practice's resuscitation equipment and regular checks were carried out to make sure it was kept in good working order. Relevant staff had completed Cardio Pulmonary Resuscitation (CPR) training which we were told was updated every three months. Each consultation room had a 'panic button' call system which could alert colleagues in the event of an emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice staff we spoke with were able to clearly explain why they adopted particular treatment approaches. They were familiar with current best practice guidance, and were able to access NICE guidelines via the practice IT system. From our discussions with these staff we were able to confirm they completed thorough assessments of patients' needs. These were in line with NICE guidelines and were reviewed as and when appropriate. A recent clinical meeting at the practice included an item where one of the GPs had presented an update on NICE Cholesterol management guidelines. (NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment.)

Clinical responsibilities were shared between the GPs and the practice nursing team. For example, one GP partner acted as the lead for drugs and alcohol misuse. Some GPs held lead roles which related to the work they carried out as GPs with Special Interests (GPswSI.) Other GPs acted as the safeguarding and IT development leads and represented the practice at CCG meetings. All of the clinical staff we spoke with felt well supported and said they would feel comfortable about seeking any help or guidance they needed to carry out their role and responsibilities.

Nationally reported data taken from the Quality Outcomes Framework (QOF) for 2013/14 showed the practice had achieved maximum points (with an overall score of 98.2%) for all but one of the 20 clinical conditions covered. The practice had obtained 97.9% of the points available for the Diabetes Mellitus clinical condition. However, this was still above both the local CCG and England averages. (The QOF is a voluntary incentive scheme for GP practices which rewards them for how well they care for patients.)

The practice had taken steps to ensure its staff had the knowledge, skills and competence to respond to the needs of older people and patients with long-term conditions. For example, two nurses were trained in Asthma and COPD management and care. The nurse who ran the weekly Leg Ulcer and Dressing clinic had been fully trained in this area. Two qualified nurse practitioners had completed additional training to enable them to assess, diagnose, treat and manage patients' health. A Well Woman clinic, held twice a week was run by a GP who had completed additional training to enable them to deliver this service. One of the practice nurses we spoke with said they received regular updates to their training, and confirmed they had all of the training they currently needed to carry out their role.

The practice made use of information technology to help them with their 'call and recall' system. This ensured patients were invited for their healthcare check at regular intervals agreed by a practice nurse. Arrangements were in place to follow up any non-attenders.

Clinical staff used care plan templates to record details of the assessments they had carried out and the advice they had given to patients. They had access to other assessment tools which they used according to the needs of the patient. The practice manager told us the GPs used a standardised dementia screening tool to help identify and treat patients with potential cognitive impairments.

Interviews with practice staff demonstrated the culture in the practice was that patients were referred to relevant services on the basis of need. Patients' age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice had participated in the development and implementation of innovative approaches to providing integrated person-centred care and treatment that involved working with other providers and fellow GP practices in the Carlisle area. The practice had supported the implementation of an internet delivered self-care service that enables patients to set their own goals and, with the support of their GP, monitor their own health and wellbeing. They were also involved in developing and supporting the implementation of a Telehealth Scheme to monitor patients who are at higher risk of having health problems. The Scheme went live shortly before our inspection took place. (This Scheme uses remote monitoring to enable patients in Carlisle care homes to monitor and manage their health.) We were told both approaches are mainly likely to benefit older patients and patients with long-term conditions.

Staff across the practice had key roles in monitoring and improving outcomes for patients. For example, the practice pharmacist and medicines manager monitored the

Good

Are services effective?

(for example, treatment is effective)

effectiveness of medicines management. The practice manager monitored how well the practice performed against key indicators, such as those contained within the QOF.

The practice had completed clinical audits covering osteoporosis and the use of Disease-Modifying Anti-Rheumatic Drugs (DMARDS). At the time of our visit, a clinical audit focussing on patients with Atrial Fibrillation who took Aspirin was underway. We were told original audit findings had been re-audited, and there was evidence of improved health outcomes for patients. The lead GP we spoke with experienced some difficulty accessing completed full cycle audits for us to look at. They agreed to look at how this information could be made more accessible in the future. (Clinical audit is an assessment of clinical practice against best practice, e.g. clinical guidance; to measure whether agreed standards are being achieved, and to make recommendations and take action where standards are not being met.)

The lead GP for governance had developed a clinical audit process for the practice, with input from the wider clinical team. They said clinical audits were usually carried out because a member of the clinical team had a specific interest in a particular area or, there had been a significant event where a patient had potentially been placed at risk of harm.

The practice was an accredited GP training practice. (Training practices are required to carry out regular clinical audits in areas other than the clinical conditions covered by QOF.) The body responsible for overseeing GP education would have ensured this expectation was met. GPs are also expected to complete at least one full cycle audit during each five-yearly revalidation cycle. (Confirming that this requirement has been completed is the responsibility of a designated Responsible Officer.)

The practice also used the information they collected for the QOF, and information about their performance against national screening programmes, to monitor outcomes for patients. For example: 95.6% of patients with cancer, diagnosed within the previous 15 months, had had a review recorded within three months of the practice receiving confirmation of the test results; 80.8% of patients with chronic obstructive airways disease had a review in the preceding 12 months, which included an assessment of breathlessness using a recognised tool. We confirmed the practice had met all the applicable QOF clinical indicators, in relation to, for example, epilepsy, asthma and heart failure. The information we looked at before we carried out the inspection did not identify this practice as an outlier for any QOF (or other national) clinical targets.

Effective staffing

There was a good skill mix within the clinical team. For example, three clinicians had taken on the role of GPs with Special Interest (GPswSI.) One GP acted as an Ears, Nose and Throat GPswSI, and provided two clinics a week for patients registered with the practice. Patients registered with other practices were also able to access these clinics. The other two GPs acted as GPswSI in eye problems and ran eye clinics at the practice. All the GPs had expressed interests in a range of clinical areas and a female GP had completed further study in obstetrics and gynaecology. One GP was responsible for GP education within the practice, including providing teaching to medical students.

GPs partners and associate GPs were up-to-date with their annual, continuing professional development requirements. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council). Arrangements were in place to provide all other staff with an annual appraisal.

Records showed staff were up-to-date with training that required an annual refresh, such as annual basic life support. The staff we spoke with confirmed the practice was happy to fund and support training to further develop their skills and competencies.

Working with colleagues and other services

The practice worked collaboratively with other agencies and regularly shared patient information to ensure good, timely communication of changes in care and treatment. The practice provided the out-of-hours and emergency care services with access to care plan information, for patients who had palliative care or complex health needs. We were told care plan information for patients on the high risk disease registers was forwarded to CHOC via email. Each of these patients had a yellow care plan folder in their home which could be accessed by community healthcare and emergency services staff. This enabled them to access important information about these patients when necessary and provide appropriate care. The local

Good

Are services effective?

(for example, treatment is effective)

out-of-hours service, CHOC, provided the practice with feedback on any patient they had seen. A process was in place to make sure this feedback was seen by an appropriate clinician.

The practice received communications from local hospitals, the out-of-hours provider and the 111 service, both electronically and by post. Staff we spoke to were clear about their responsibilities for reading and actioning any issues arising from communications with other care providers. They understood their roles and how the practice's systems worked.

The practice held regular primary healthcare team meetings. These multi-disciplinary meetings were used to discuss patients with complex needs, for example, those with end of life care needs and children on the at-risk register. These meetings were attended by the district nursing staff as well as other local healthcare professionals such as health visitors and family nurses. Patients' records were updated following these meetings where appropriate.

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out-of-hours provider. This enabled patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals using the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

Consent to care and treatment

The practice had a consent policy which provided clinical staff with guidance about how to obtain patients' consent to care and treatment, and what to do in the event a patient lacked the capacity to make an informed decision. This policy also highlighted how patients' consent should be recorded in their medical notes, and it detailed what type of consent was required for specific interventions. The practice nurses we spoke with had a good understanding of consent processes. Patients undergoing minor surgery were asked to sign a consent form once they had decided to go ahead with a planned procedure.

Staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in complying with it. (The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.) The GPs we spoke with confirmed they had received suitable training. The GP partner we spoke with demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention

The practice offered all new patients a health check with a member of the practice nursing team. New patient assessments covered a range of areas, including past medical history and on-going medical problems. A practice nurse told us any health concerns identified during a new patient's assessment would be flagged up so they could be followed up by a GP. The practice offered NHS Health Checks to all patients aged between 40 and 75 years of age. (This NHS programme aims to keep patients healthier for longer.) Between November 2013 and October 2014 the practice carried out 1177 patient health checks.

The practice was good at identifying patients who needed additional support and were pro-active in offering this. For example, there was a register of all patients with dementia. Nationally reported data for 2013/14 showed that: 86.0% of patients with dementia had received a range of specified tests six months before or after being placed on the practice's register; 81.3% of patients on the dementia register had had their care reviewed in a face-to-face interview in the preceding 12 months. (Both of these scores were above the regional CCG average.) The practice had systems in place to identify patients who might be at risk of developing dementia. Flags had been placed on patients' notes where they fell into specific categories such as, for example, patients over 50 with learning disabilities and patients with Down's Syndrome who were over 40 years of age.

Steps had been taken to identify the smoking status of patients over the age of 16 who came into contact with the practice. Nationally reported data for 2013/14 showed the

Good

Are services effective?

(for example, treatment is effective)

practice supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy. The practice manager told us 71.9% of smokers aged 15 had been given smoking cessation advice.

Nationally reported data for 2013/14 showed the practice had protocols that were in line with national guidance, covering such areas as the management of cervical screening. The practice also had a system in place for informing women of the results of cervical screening tests. The practice manager told us 81.4% of women aged between 24 and 64 had received a cervical screening test in the last five years.

We did not see any evidence during the inspection of how children and young people were treated by staff. However, neither the patients we spoke to, nor those who completed CQC comment cards, made us aware of any concerns about how staff looked after children and young people.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice regarding levels of patient satisfaction. This included information from the 2014 National GP Patient Survey and the 2014 patient survey carried out by the practice. The evidence from all these sources showed the majority of patients were satisfied with how they were treated and the quality of the care and treatment they received.

Data from the National GP Patient Survey 2014 showed the practice was rated above the regional CCG average in most of the areas covered. For example, of the patients who responded: 90% said the last GP they saw, or spoke to, was good at giving them enough time; 92% said the last GP they saw, or spoke to, was good at listening to them; 90% said the last GP they saw, or spoke to, was good at treating them with care and concern.

We received three completed CQC comment cards. The feedback was positive and no concerns were raised. We also spoke with six patients on the day of our inspection. Patients told us the practice offered a good service and staff were helpful and caring. They said staff treated them with dignity and respect and overall they were satisfied with the care provided by the practice.

All consultations and treatments were carried out in the privacy of a consulting or treatment room. There were disposable curtains in these rooms to enable patients' privacy and dignity to be maintained during examinations and treatments. Consultation and treatment room doors were kept closed when the rooms were in use, so conversations could not be overheard. Data from the National GP Patient Survey 2014 showed 68% of patients were satisfied with the level of privacy provided when speaking to a receptionist at the practice. This score was above the regional CCG average.

Care planning and involvement in decisions about care and treatment

Data from the National GP Patient Survey 2014 showed patients were positive about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. For example, 80% of respondents said their GP involved them in decisions about their care; 86% felt the GP was good at explaining treatment and results. Both of these responses were above the regional CCG average. The patients who completed CQC comment cards did not raise any concerns about their involvement in decisions about their care and treatment, and neither did the patients we spoke to on the day of our inspection. Staff told us translation and interpreter services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

We observed patients in the reception area being treated with kindness and compassion by staff. None of the patients we spoke with, or who completed CQC comment cards, raised any concerns about the support they received to cope emotionally with their care and treatment. Notices and leaflets in the waiting room sign-posted patients to a number of relevant support groups and organisations. The practice's computer system alerted clinicians if a patient was also a carer, so this could be taken into consideration when clinical staff assessed their needs for care and treatment. Clinical staff referred patients struggling with loss and bereavement to CRUSE Bereavement Care.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had participated in the development and implementation of innovative approaches to providing integrated person-centred care and treatment that involved working with other providers and fellow GP practices in the Carlisle area. The practice had supported the implementation of an internet delivered self-care service that enables patients to set their own goals and, with the support of their GP, monitor their own health and wellbeing. They were also involved in developing and supporting the implementation of a Telehealth Scheme to monitor patients who are at higher risk of having health problems. The Scheme went live shortly before our inspection took place. (This Scheme uses remote monitoring to enable patients in Carlisle care homes to monitor and manage their health.) We were told both approaches are mainly likely to benefit older patients and patients with long-term conditions.

The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of older patients and those with long-term conditions. They had used a risk assessment tool to profile patients according to the risks associated with their conditions. This had enabled practice staff to identify patients at risk of, for example, an unplanned admission into hospital. The practice kept a register of patients who were considered to be at risk of an unplanned admission into hospital, and they had written to each patient aged 75 years and over, explaining which GP would act as their named doctor.

The practice nursing team were responsible for the delivery of chronic disease management. The practice offered patients with long-term conditions, such as asthma and Chronic Obstructive Pulmonary Disease (COPD – a severe shortness of breath caused by chronic bronchitis, emphysema, or both), an annual check of their health and wellbeing. The practice website provided patients who did not always attend their annual asthma review with access to an Asthma Control Test. (The Test devised by Asthma UK provides patients with a snapshot of how well their asthma has been controlled over the last four weeks.)

The practice also provided vascular clinic appointments for patients with a range of long-term conditions such as diabetes and heart failure. The two-visit approach was used. This meant patients attended an appointment where a range of screening tests were carried out by a healthcare assistant. Patients then returned for a second appointment with a practice nurse, where the results of any tests carried out would be reviewed and their current condition assessed. Nursing staff told us they had access to range of leaflets which they would give to patients to help them manage their condition.

The practice had a register of (145) patients who were in need of palliative care. Nationally reported data for 2013/14 showed that multi-disciplinary team (MDT) meetings took place at least every three months, to discuss and review the needs of each patient on this register. The practice's IT system alerted clinical staff about patients who were receiving palliative care, and who their Power of Attorney was. It has also included a scanned copy of 'Do Not Attempt Resuscitation' forms where these had been completed.

The practice completed a standardised Cumbria Health on Call (CHOC) care plan for patients on their at-risk disease registers. This provided the out-of-hours service with access to information covering, for example, any significant health conditions patients had details of their prescribed medicines, and a case management plan. The practice manager told us this information could be accessed by the CHOC service, as well as other healthcare professionals and emergency services.

Nationally reported data also showed that 99.3% of women aged 54 or under, who were prescribed an oral or patch contraceptive method, had received advice about long acting reversible methods of contraceptive during the previous 12 months.

The practice had identified the needs of babies, children and younger patients, and put plans in place to meet them. Nationally reported data for 2013/14 showed, for example, that child development checks were offered at intervals that were consistent with national guidelines and antenatal care and screening were offered in line with current local guidelines. The practice's paediatric nurse practitioner reviewed all accident and emergency reports for children under 16. All newly registered children under 16 received an appointment with the paediatric.

The practice offered a full range of immunisations for children, as well as travel and flu vaccinations. Information about the range of vaccines offered to babies and children

Good

Are services responsive to people's needs?

(for example, to feedback?)

was available on the practice website. Twice weekly immunisation clinics were provided by members of the nursing team. Nationally reported data indicated the practice had mostly performed better than other local practices with regards to the delivery of childhood immunisations.

The practice had planned its services to meet the needs of the working age population, including those patients who had recently retired. It provided an extended hours service on a number of evenings each week, to facilitate better access to appointments for working patients. Pre-bookable telephone consultations were also available from 7:00am to 6:00pm. The practice told us they were involved in developing a response to the Prime Minister's Challenge Fund, which has invited practices to provide a service from 8:00am to 8:00pm seven days a week.

The practice had identified those patients who were also carers. This was flagged on the practice's computer system to alert clinicians so it could be taken into account when assessing these patients' care and treatment needs. A procedure was also in place to ensure information would only be released to a carer after consent had been sought from the person they were caring for.

Advice on the criteria for requesting a home visit was available on the practice website. Clinical staff responded to requests for home visits by carrying out a telephone assessment. This helped them to decide whether a home visit was required, or whether a patient's needs might be more effectively met by accessing another type of service, such as the community nursing service.

Tackle inequity and promote equality

The majority of patients did not fall into any of the marginalised groups that might be expected to be at risk of experiencing poor access to health care, for example, homeless people and Gypsies and Travellers. We were told the practice took whatever action it could to meet the needs of patients who fell within this population group. For example, the practice had made suitable arrangements to identify and meet the needs of patients with learning disabilities, complex health conditions, and those receiving palliative care.

Reasonable adjustments had been made which helped patients with disabilities and patients whose first language was not English to access the practice. For example, clinical and consultation rooms, and the reception area in the main practice, were located on the ground floor. There was a disabled toilet which had appropriate aids and adaptations and a pull chord alarm. Baby changing facilities were also available. Disabled parking was available to the side of the main practice. The practice had a small number of patients whose first language was not English. Practice staff had access to a telephone translation service and interpreters should this be required. The practice web site explained to patients how to access these services. A member of the reception team said staff knew how to access this service if they needed to do so.

Access to the service

Appointments at the main site were available from 08:00am to 6:30pm each weekday, or until 8:00pm on selected days. The branch surgery was open between 08:00am and 5:30pm weekdays. Patients were able to book appointments by telephone, by visiting the practice or on-line via the practice web site. Of the patients who participated in the 2014 National GP Patient Survey, 83% said they were satisfied with the practice's opening hours; 44% of those who had a preferred GP, usually got to see or speak to that GP; 58% said they found it 'easy' to get through on the telephone to someone at the practice; 59% said they usually waited 15 minutes or less after their appointment time to be seen, and 47% said that they didn't normally have to wait too long to be seen. All of these scores fell below the regional CCG average.

As part of our preparation for this inspection, the practice made us aware it was in the process of completely overhauling the appointment system to address the concerns patients had raised about getting through to the practice and accessing appointments. We were told the partners had made a decision to introduce an evidence based appointment system which had worked well in other practices. Each patient had been sent a letter explaining the changes that were being introduced and how these might affect them. The new system, which had been in operation for approximately two weeks at the time of our visit, meant that any patient who rang for an appointment would first be offered a telephone consultation with a GP of their choice, at a pre-agreed time. We were told that, on the basis of the telephone consultation, patients would either be offered a same day appointment, an appointment on another day or advice about how to manage any healthcare concerns they had. Patients requiring a nurse appointment were still able to book an appointment with

Good

Are services responsive to people's needs?

(for example, to feedback?)

the reception team. The practice website encouraged patients to think about whether a nurse practitioner appointment was more appropriate and reminded them that these staff could also provide treatment and prescribe medicines.

We saw that the practice website offered patients an apology for any inconvenience caused as the new system bedded in. It was unclear at the time of our visit as to whether the new arrangements would address patients' concerns. However, all but one of the patients we spoke to said they were aware of the new appointment system and had experienced no problems accessing appointments. The newly introduced system was being reviewed daily to address patient concerns and to deal with logistical problems as they arose. It was clear to the inspection team that the practice were committed to making the new appointment system work, but would not know for some time how effective the changes were in addressing patients' concerns.

An open access clinic was available daily at the main practice site between 2.30pm and 5:30pm for patients who felt they needed to be seen 'on the day' for acute problems. This clinic provided patients with access to a GP and nurse practitioners.

The practice's website and leaflet provided patients with information about how to access out-of-hours care and treatment. When the practice was closed there was an answerphone message giving the relevant telephone numbers patients should ring.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and the contractual obligations for GPs in England. The practice manager was the designated responsible person for handling all complaints.

Information was available to help patients understand the complaints process. The practice website provided a link to a complaints registration form. Information about how to complain was also available within the practice reception area.

The patients we spoke with said they had never had to make a complaint but would feel comfortable in doing so. A suggestions box was available in the waiting area providing patients with an opportunity to raise concerns anonymously.

The practice had received seven complaints since our last inspection visit in April 2014. From the information supplied by the practice we were able to confirm they responded appropriately to concerns raised and apologised when they did not do as well as they should have done. We were able to see from the information supplied to us that most complaints had been resolved to the satisfaction of the complainant.

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. In September 2014, the practice team agreed that changes needed to be made to address patients' concerns about access to appointments. This included the identification and implementation of an alternative appointment system and an upgrade of the practice IT system. During this inspection, we were able to see that the practice was in the process of implementing these improvements and had taken steps to deliver its vision of being a more responsive service that listened to the needs of patients. Staff told us they knew and understood what the practice was committed to providing and what their responsibilities were in relation to these aims.

Governance Arrangements

The practice had a range of policies and procedures in place concerning its activities and the services it provided to patients. Nationally reported QOF data for 2013/14 also confirmed the practice participated in an external peer review with other practices in the same CCG group, in order to compare data and agree areas for improvement. (Peer review enables practices to access feedback from colleagues about how well they are performing against agreed standards.) The practice had also carried out a range of clinical audits aimed at improving the quality of care and treatment provided to patients.

Nationally reported data taken from the QOF for 2013/14 showed the practice had achieved an overall score of 98.2% of the maximum points available to them, for delivering care in line with the QOF clinical indicators. This achievement was above both the local CCG and the England averages. This confirmed the practice had delivered care and treatment in line with expected national standards. Staff discussed QOF performance data at practice meetings and it was regularly monitored by the practice management team. In-house audits were carried out to check the practice was performing in line with projected expectations. The practice had been awarded an orthopaedic contract. The practice manager told us that as part of delivering the contract, the practice had had to carry out an audit to confirm compliance. We were told the audit outcomes were shared with other practices involved in the same contract, so that shared learning could take place. This helped to ensure all staff were aware of how the practice was performing and to reach consensus about any actions that needed to be taken.

Leadership, openness and transparency

There was a well-established management structure and a clear allocation of responsibilities, such as clinical lead roles. We were able to talk with several GPs and nursing staff as well as the practice manager. All of them demonstrated a good understanding of their areas of responsibility and took an active role in trying to ensure patients received good care and treatment. They were also clear about their own roles and responsibilities. Staff told us they felt respected, were well supported and would feel comfortable raising concerns with the practice manager.

There were systems and processes in place which facilitated the extraction of information to enable effective judgements to be made about the performance of the practice and where improvements needed to be made.

Regular practice and MDT meetings took place where operational issues and patients' needs were discussed. Staff used these to discuss practice based issues and significant events, and to agree ways of working together to improve how the practice operated and promote good outcomes for patients. Staff told us there was an open culture within the practice and they were happy to raise issues at team meetings.

Systems were in place to identify and manage risks. For example, the practice had a comprehensive business continuity plan to help ensure the service could be maintained in the event of foreseeable emergencies.

Practice seeks and acts on feedback from users, public and staff

Patients were provided with opportunities to comment on the services provided by the practice. The practice had arranged for an external organisation to carry out a survey of its patients so that the feedback received could be independently collected, collated and verified. The survey covered areas such as patients' satisfaction with the performance of their doctor or nurse, and whether appropriate systems were in place to ensure patient recall was effective. The outcome of the survey had been discussed at practice meetings to identify what

Are services well-led?

Good

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

improvements could be made to address the feedback received. Information about the outcome of the survey had been placed on the practice website so this could be accessed by patients, and other interested parties.

The staff we spoke to felt valued and said they felt they were an important part of the practice team. Practice nursing and reception team staff said the practice team worked well together in a positive manner to deliver good patient care.

At our last inspection in April 2014, we were told the practice did not have an active patient participation group (PPG). However, since their last inspection, the practice had joined the National Association for Patient Participation. (This organisation provides general practices with guidance about how to develop a PPG.) A date had been set for the practice's first PPG meeting and this had been posted on the practice's website.

Management lead through learning & improvement

A range of systems were in place to monitor and improve the quality of the service. For example, staff had access to comprehensive guidance about how they should capture all patient contacts and other information such as referrals for further assessment and diagnosis. Staff knew which colleagues had responsibility for ensuring patient information, and outcomes of consultations, were correctly coded. The practice manager told us this helped ensure the practice was able to submit timely and accurate information to external bodies monitoring the performance of the service. Regular audits were undertaken to ensure data quality was maintained to a good standard.

The practice provided staff with opportunities to continuously learn and develop. For example, practice nursing staff told us they had opportunities for continuous learning to enable them to retain their professional registration. All of the staff we spoke to said their personal development was encouraged and supported. Staff said they took part in regular 'time-out' sessions which enabled them to complete the training required for their continuing professional development. The practice demonstrated its strong commitment to learning by providing opportunities for GP registrars to complete their training at the practice.

Reviews of significant events had taken place and the outcomes had been shared with staff via meetings to help ensure the practice improved outcomes for patients through continuous learning.