The Lakes Medical Practice

Inspection report

Penrith Health Centre
Bridge Lane
Penrith
Cumbria
CA11 8HW
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Date of inspection visit: 05/04/2018
Date of publication: 06/06/2018

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 location	Outstanding ☆
Are services safe?	**Good** ●
Are services effective?	**Outstanding** ☆
Are services caring?	**Good** ●
Are services responsive?	**Good** ●
Are services well-led?	**Outstanding** ☆

Overall summary

This practice is rated as Outstanding overall.

We last inspected the service in November 2014, when it was rated as good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Outstanding

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Outstanding

We carried out an announced comprehensive inspection at The Lakes Medical Practice on 5 April 2018, as part of our inspection programme.

At this inspection we found:

•The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them, involved all staff, shared the information internally and externally, and improved their processes.

•The practice proactively reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines. We were able to see the positive impacts on patient care and outcomes. Innovation was valued and actively encouraged, and we saw where, for instance, changes to clinics had resulted in improved access for patients. Treating patients holistically was seen as a cornerstone to good results.

•Staff involved and treated patients with compassion, kindness, dignity and respect. Patient feedback was positive.

•Patients found the appointment system easy to use and reported that they were able to access care when they needed it. Telephone triage allowed GP advice within two hours, or one hour for children, and direction to the most appropriate member of staff.

•There was a strong focus on continuous learning, improvement and innovation at all levels of the organisation. Staff were heavily invested in their roles and were empowered to develop their skills.

We saw areas of outstanding practice:

•The Infection Prevention Control (IPC) lead had initiated a series of weekly 'Soapbox' emails, which she used to communicate any infection control updates and best practice to all staff, or to communicate good news stories.

•The practice had proactively reduced opiate and benzodiazepine prescribing as part of a programme with input from the Patient Participation Group (PPG). The practice were the lowest prescribers for hypnotics in the area, reducing the numbers of patients prescribed these drugs from 180 to 20. We saw further evidence of the success of this programme through decreasing opiate usage, for instance a 30% reduction in codeine use, and a 42% reduction in Tramadol usage. The practice had shared their learning from this with others at Clinical Commissioning Group (CCG) learning events.

•Staff innovation and suggestions were valued and encouraged and we saw patient outcomes had improved as a result, for instance improving rates for asthma review clinics after a telephone consultation option was offered.

•The practice had developed an in-house service to offer extra support, psychotherapy, advice and signposting to patients who had undergone a termination of pregnancy. The practice proactively contacted these patients.

•Patients could receive additional holistic support from an in-house Emotional Wellbeing Practitioner who provided psychotherapy. The practice could demonstrate this had significantly improved patients well-being scores and also reduced the frequency of GP contacts from people suffering poor mental health.

•The practice were committed to supporting their staff. Staff were invited to complete a Professional Quality of Life Questionnaire to help them reflect on their roles and stress. Staff could access extra support including a two hour Personal Development session where they could discuss issues such as stress and burn out.

•Staff were given high levels of support and access to training, and were encouraged and empowered to develop specialisms and skill sets. Practice staff had developed specialist interest areas, including for women's health and sexual health services. As a result of this the practice offered a same day appointment or call back service for sexual health, contraception or menopause advice,

Overall summary

ensuring fast access for patients. The service generally dealt with over 100 call backs each month. The specialist staff member was given protected time and additional support to facilitate this service.

•Staff meeting minutes were mapped to CQC domains of safe, effective, caring, responsive and well led to provide structure and clear direction, to ensure not only legislative compliance but also to encourage continuous improvement.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser and a practice manager adviser.

Background to The Lakes Medical Practice

The Lakes Medical Practice is registered with the Care Quality Commission to provide primary care services. The practice provides services to around 10,000 patients from the following location: Penrith Health Centre, Bridge Lane, Penrith, CA11 8HW. We visited this address as part of the inspection. The practice website is www.thelakesmedicalpractice.co.uk. The practice is part of NHS North Cumbria Clinical Commissioning Group (CCG).

Deprivation indicators place this practice in an area with a score of eight out of ten. A lower number means an area is more deprived. People living in more deprived areas tend to have greater need for health services. This practice had lower levels of deprivation when compared to the local CCG and England averages. The practice has greater numbers of patients aged 65 and over compared to CCG and England averages.

The practice occupies a purpose built building which it shares with another practice. Consultation rooms and patient areas are on the ground floor and fully accessible, for patients with mobility needs. There is car parking directly outside, with disabled bays.

The practice has five GP partners, one salaried GP, a physician's associate, an Emotional Wellbeing Practitioner (a psychotherapist), five practice nurses, four healthcare assistants and a phlebotomist. These are supported by a team of administrative and management staff. The practice is a training practice, although no GP registrars were there at the time of our inspection. A GP Registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice. They work under supervision of a senior GP or trainer.

The practice reception is open at the following times:

•Monday 8.30am to 6.30pm

•Tuesday 8.30am to 7.30pm

•Wednesday 8.30am to 7pm

•Thursday 8.30am to 7pm

•Friday 8.30am to 6.30pm

The surgery also provides a Saturday morning surgery from 8.30am until 11.30am, for pre-booked appointments. When the practice is closed patients are directed to the NHS 111 service, with out of hours services being provided by Cumbria Health on Call (CHoC). This information is also available on the practices' website and in the practice leaflet.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had comprehensive systems to keep patients safe and safeguarded from abuse.

•The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training.

•The practice had comprehensive systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. The practice held twice monthly multi-disciplinary safeguarding meetings, attended by a wide range of professionals including community psychiatric nurses, midwives and mental health teams. The practice was proactive in forging new contacts, for instance initiating closer contacts with local schools. This was to ensure information was shared quickly and appropriately to keep children safe, and to recognise emerging risk such as home schooled children, who may not have much contact with other health professionals.

•All staff received up-to-date safeguarding and safety training appropriate to their role, and had good awareness of how to identify and report concerns, including female genital mutilation (FGM) and under the 'Prevent' programme, to help identify people who may have been radicalised. We saw detailed examples of safeguarding discussions, including potential and emerging concerns, such as children's referrals into mental health services. There was robust coding under patient records allowing for easy identification and cross referencing.

•The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks or risk assessments for roles were undertaken where required. (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).

•Staff who acted as chaperones were trained for the role and had received a DBS check.

•There was a comprehensive system to manage infection prevention and control (IPC). The IPC lead had received further training relevant to her role, and oversaw daily, weekly and monthly checks. A yearly IPC audit was carried out, and we could see that any identified action points had been promptly addressed. The IPC lead had initiated a series of weekly 'Soapbox' emails, which she used to communicate any infection control updates and best practice to all staff, or to communicate good news stories, such as when administrative staff had completed hand washing training.

•There was still one consulting room where the carpet had not been replaced by hard flooring. The practice was in talks with the landlord to have this replaced, and in the meantime had risk assessed the use of this room, minimised its use, and had appropriate cleaning schedules in place.

•The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

•There were arrangements for planning and monitoring the number and mix of staff needed.

•There was an effective induction system for staff tailored to their role.

•Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Comprehensive emergency procedures were in place, which staff had good awareness of. Staff carried contact cards with them at all times with emergency numbers, Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.

•When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

Good

Are services safe?

•Individual care records were written and managed in a way that kept patients safe. Information needed to deliver safe care and treatment was available to relevant staff in an accessible way.

•The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.

•Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines. The practice proactively managed and monitored risks to ensure medicines were being used and prescribed safely.

•The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.

•Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice audited antimicrobial prescribing, and had the lowest prescribing rates in the CCG area following a proactive drive to reduce this.

•Nurse prescribers were supported in their role with six monthly reviews with the GP prescribing lead, in addition to ongoing supervision and support.

•Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

•The practice had introduced successful reduction programmes for benzodiazepines and opiates, and had shared this learning with others through CCG events, where the senior partner had presented their findings. The practice created a letter jointly with the Patient Participation Group (PPG) to inform patients of their concerns and plans around opiate use, and also informed the neighbouring practice so they were aware of possible impact on them.

•As a result of these programmes, the practice were the lowest prescribers for hypnotics in the CCG area, reducing the numbers of patients prescribed these drugs from 180 to 20. We saw evidence of decreasing opiate usage, for instance from June 2017 to March 2018, patients prescribed codeine had reduced from 92 to 64 (30% reduction). In the same period Tramadol usage reduced from 43 patients to 25 (42% reduction).

•We saw other examples where high risk medicines such as sodium valproate were audited monthly for appropriate prescribing and the staff involved had in depth knowledge of the patients prescribed these drugs.

Track record on safety

The practice had a good safety record.

•There were comprehensive risk assessments and a health and safety policy in relation to safety issues, although staff awareness of these was variable.

•The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice had an open culture where safety concerns raised were highly valued and seen as integral to learning and improvement.

•There were clear systems for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so, and all staff described a genuinely open and honest culture, where the emphasis was on learning points and not blame. Feedback from staff was valued and encouraged, and staff were committed to reporting incidents.

•There were good systems for reviewing and investigating when things went wrong. In addition to weekly clinical or management meetings, significant events were also discussed during protected learning times to involve the whole practice. The practice took time to reflect on safety incidents at the end of each year and carry out trend analysis to identify any common themes.

•We saw where learning was shared back through team meetings and changes were implemented and reviewed. An example was a patient who had been given the wrong vaccine. The patient was involved in discussion and given an apology, and the incident was discussed at team meetings. Changes implemented included assessing

Good

Are services safe?

vaccine placement within fridges to ensure medicines with similar names were not stored beside each other, and a system for a second member of staff to check prior to administration.

•There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts. We saw one example of a recent safety alert around the use of oxygen cylinders. At a team meeting a staff member had ensured this alert was brought to everyone's attention, and demonstrated the use of the practice cylinder so that all staff had received refresher training.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services effective?

We rated the practice as outstanding for providing effective services overall. Population groups were rated as good except for families, children and young people, and people experiencing poor mental health, who we rated as outstanding.

(Please note: Any Quality Outcomes (QOF) data unless otherwise stated relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.)

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians holistically assessed needs and delivered care and treatment in line with current legislation, standards and guidance, supported by clear clinical pathways and protocols. Staff sought new guidance and best practice from specialist peer reviewed sources to support their knowledge development.

•The practice was committed to a holistic approach in assessing patients' needs. This included their clinical needs and their mental and physical wellbeing. The practice aimed to provide a holistic service looking at the patient as a whole, and actively promoted lifestyle advice. Treatment protocols were developed with staff which emphasised collaborative working within the practice and externally.

•The Quality and Outcomes Framework (QOF) is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing and preventing some of the most common long-term conditions e.g. diabetes. The results are published annually. QOF data for 2016/17 showed the practice received 99% of the possible points, 0.2% above the CCG average and 3.5% above the England average.

•We saw no evidence of discrimination when making care and treatment decisions.

•The practice was an early adopter of a text message reminder system for hypertension monitoring and long-lasting contraception reminders, which had received positive patient feedback.

•Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

•16% of the practice population was aged over 75, higher than the CCG average of 13% and the England average of 10%. The practice had a good understanding of their population group needs including those in care homes. The practice had assessed that approximately a fifth of their patients aged over 75 required documented care plans and these patients had had a full assessment of physical, mental and social health needs. Those identified as being frail had a clinical review including a review of medication. The practice employed a specialist frailty nurse who visited all housebound patients and nursing homes once a week, and a named GP for each nursing home helped ensure continuity of care.

•Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.

•The practice followed up on older patients with care plans discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

•67 patients over the age of 75 (6% of this population group) were also documented as being carers. The practice offered extra support to these patients such as flu jabs and annual health reviews.

•The practice held bi-monthly multi-disciplinary safeguarding meetings specifically for older adults.

People with long-term conditions:

•Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met, in the patients' own home where necessary. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.

•Clinics were delivered flexibly and holistically, with a focus on the wellbeing of the patient as a whole. One member of staff had protected time to monitor due dates and booking of annual reviews. Staff described a system of collaborative working, where patients were first seen by health care assistants for baseline measurements, lifestyle advice and where appropriate referral to weight loss or exercise services. Care plans were sent to patients to review ahead of their appointments and then clinics were run flexibly to suit the patient, looking at the whole patient rather than

their condition in isolation. For instance, the practice had produced a 'Stress Cycle' information leaflet to help inform patients how their mental health and stressors could affect their condition, to allow patients to become more aware and involved in the management of their condition.

•Staff who were responsible for reviews of patients with long term conditions had received specific training, and had been encouraged and empowered to develop their roles and special interests, for instance wound care and catheter care. Two HCA's had been trained to perform diabetic foot checks, with a third undergoing training.

•The safe use of innovative and pioneering approaches to care and how it is delivered were actively encouraged. For instance, the in-house well-being practitioner, a qualified psychotherapist, ran a six-week in house chronic pain group where patients could learn about stress responses, meditation and relaxation.

•Another example was where the respiratory specialist nurse had identified a high number of non-attenders and cancellations for asthma review appointments. The practice implemented a flexible system where patients with mild or well-controlled asthma could be offered a telephone review instead, with safeguards in place for patients to still be offered a face-to-face review where this was required. This resulted in an improvement in patient attendance, evidenced by the latest QOF figures which showed in November 2017 the practice had achieved 19 out of 45 points, and by March 2018 had achieved all the available 45. However, it should be noted that this data is not yet verified or published and the exception rate was not available.

All staff were actively engaged in activities to monitor and improve quality and outcomes. The practice looked to continually improve and develop care pathways for long term conditions. For instance, we looked at a diabetes pathway which used a co-ordinated approach across the practice, involving administrative teams, healthcare assistants, nursing team and GPs. This considered all aspects of the patient's well-being and current life pressures. QOF scores demonstrated an improvement from 87% in 2015/16 to 92% in 2016/17. The unverified data for March 2018 indicated the practice had reached 98% of the indicators.

We saw where the practice had shared protocols they had developed with other practices, such as an extended annual review for patients with hypertension by a healthcare assistant, which in addition to clinical measurements stressed the importance of personalised lifestyle advice and support, and what barriers the patient may struggle with.

Families, children and young people:

•Childhood immunisations were carried out in line with the national childhood vaccination programme. The practice had exceeded the 95% target rate on all four indicators.

•The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

•The practice had a system to flag up a one hour call-back slot for those ringing for advice about a child under five.

•The practice participated in the Syrian refugee resettlement programme with families on their list.

•The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high-quality care. Staff were proactively encouraged to acquire new skills and share best practice. For instance, the practice had identified a lack of services in the area to offer support to women following a termination of pregnancy, and that there may be concurrent vulnerability or safeguarding concerns. A nurse had been supported in her role to develop a sexual health and women's health speciality, and offer services accordingly. This staff member now offers these patients a review including contraception advice, support and if necessary referral to other services, including an in-house emotional well-being practitioner.

•This service was also developed to offer a same day appointment or call back service for sexual health, contraception or menopause advice, ensuring fast access for patients, who may also be vulnerable, and at risk of not attending for a prebooked GP appointment. The service generally dealt with over 100 call backs each month. The staff member was given protected time and additional support to facilitate this service.

Working age people (including those recently retired and students):

Outstanding ☆

Are services effective?

•The practice's uptake for cervical screening was 78%, above the CCG average and above the England average of 72%. It was however slightly below the 80% target for the national screening programme. Patients were sent reminders by phone and letter.

•Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

•The practice participated in a pilot for an in-house musculo-skeletal practitioner to offer telephone or face-to-face reviews, to provide a better patient service and reduce waiting times. Orthopaedic referrals reduced from 126 in 2016 to 77 for the same period in 2017. MRI requests reduced from 45 to 20 across the same period. Positive patient feedback had also been received from direct questionnaires. The pilot is now being rolled out across the CCG.

People whose circumstances make them vulnerable:

•End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

•The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. Vulnerable families and adults were reviewed regularly at safeguarding meetings.

People experiencing poor mental health (including people with dementia):

•93% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months, above the CCG average of 83% and the England average of 84%.

•The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption was 94%; comparable to the CCG average, and above the England average of 91%.

•Staff were consistent in supporting people to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill-health. The practice employed a 'Well-being Practitioner', a qualified psychotherapist, who staff could refer patients to. This was in recognition that patients with poor mental health, often associated with traumatic experiences, will frequently present to a GP with low-level physical complaints. It was recognised this was not the best route for the patient and a poor use of resources. The well-being practitioner carries out an initial assessment within two weeks, before deciding whether existing pathways, such as referrals to counselling services or mental health teams are appropriate, or whether the patient can be offered an in-house service. In a group of patients who had completed their intervention, we saw that in the quarter preceding their referral the group had made 96 separate GP contacts. In the quarter after, this had dropped to 34. Patient scores for depression and anxiety also improved considerably. One case study showed a patient had been able to access 18 sessions, which included relaxation techniques, before being discharged.

•The practice was also supporting a health care assistant in developing her skills as an Emotional Health support worker, to offer additional support and services to patients.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

The most recent published Quality Outcome Framework (QOF) results for 2016/17 showed that overall, the practice received 99% of the total number of points available, comparable to the CCG average, and above the England average of 97%. The overall exception reporting rate was 9.8% compared to the overall target 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

•The practice used information about care and treatment to make improvements. We saw examples of audits of prescribing activity, treatment of prostate cancer, the appropriateness of HRT therapy, and a review of two week

Are services effective?

referrals for suspected cancers. Actions identified, such as coding correctly in patients records, were carried out. Monthly checks on the safety of prescribing of contraceptives were carried out.

•The practice was actively involved in quality improvement activity, and had initiated a number of improvement projects which were at different stages, such as improving the number of patients having an asthma review, which had showed an improvement, or the identification of patients with conditions who may benefit from an annual review not covered by QOF. This was ongoing to identify patients and offer them a review.

•The practice proactively pursued opportunities to participate in benchmarking. For instance, the Cumbria Quality Improvement Scheme to improve patient outcomes. This provided another method for the practice to monitor and benchmark their performance, and showed positive outcomes against baseline figures, such as for unplanned admissions (558 against the CCG average of 713).

Effective staffing

The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care, and staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included taking samples for the cervical screening programme had received specific training, could demonstrate how they stayed up to date, and audited their performance.

•The practice understood the learning needs of staff and carried out yearly training needs analyses through the appraisal process, which was mapped to the practice values. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop, and this was seen as integral to patient care. We saw examples where staff had been supported in their roles to develop particular specialisms or areas of interest. For instance the practice paid for the women's and sexual health specialist nurse to be a member of the British Menopause Society, to access new information and training. Staff input was valued and we saw where systems had been changed or introduced as a result of staff input, such as the nurse call back service for sexual health or contraception queries.

•The practice provided staff with ongoing support. This included an induction process, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including six monthly audits for non-medical prescribing. Staff spoke highly of the levels of training they could access and the support given.

•There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

•We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.

•Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.

•The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. Data from the Quality Improvement Scheme showed the percentage of patients who died having an advanced care plan in place was 66.4% against the CCG average of 36.5%.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives, and this was identified as a priority.

•The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.

•The percentage of new cancer cases that were detected using the urgent two week wait referral pathway was 65%, which showed the practice was making appropriate referrals, and was above the CCG and England averages of 52%.

Outstanding ☆

Are services effective?

•Staff encouraged and supported patients to be involved in monitoring and managing their health, and this was supported through treatment templates which prioritised this. Staff proactively referred to diet and exercise programmes within the community.

•Staff discussed changes to care or treatment with patients and their carers, with patient involvement and engagement seen as crucial to treatment success. Staff were coordinated across the practice and worked together to improve health.

•The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

•Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Consent was obtained verbally and recorded, or separate written procedures were followed for minor surgery.

•Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

•The practice monitored the process for seeking consent appropriately.

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

•Staff understood patients' personal, cultural, social and religious needs.

•The practice gave patients timely support and information.

•Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

•All of the 26 patient Care Quality Commission comment cards we received were positive about the service experienced. This is in line with the results of the NHS Friends and Family Test. The practice had also carried out a patient survey in conjunction with the PPG, the results of which were still to be fully analysed. Of 70 paper forms received, 96% stated they had confidence and trust in the GP team.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

•Interpretation services were available for patients who did not have English as a first language. A notice in the reception area informed patients this service was available. The website had a translate service clearly visible.

•Staff communicated with patients in a kind manner and were helpful, although we noted staff awareness of how to work the hearing loop was variable, and there were no easy read materials available in reception.

•Staff helped patients and their carers find further information and access community and advocacy services. Information on carer's services including for young carers was available in reception.

•Patient involvement and engagement was seen as a cornerstone to better health, with all staff viewing treatment holistically within the context of the patient's emotional and social needs. This was supported through the well-being practitioner.

•The practice identified patients who were carers opportunistically through contacts. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 487 patients as carers (approx. 4% of the practice list) of whom 15 were young carers. Carers were offered annual health reviews.

•The practice had a bereavement policy where a patient who was recently bereaved would receive a call from the GP at a time convenient to them to offer support.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

•Staff recognised the importance of patients' dignity and respect, and were highly motivated to provide care that promoted the patients dignity.

•The practice complied with the Data Protection Act 1998. Patient Participation Group members had not signed a confidentiality agreement. The practice was going to introduce this as a result of discussion.

Please refer to the Evidence Tables for further information.

Good

Are services responsive to people's needs?

We rated the practice as good for providing responsive services. Population groups were rated as good.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs, taking into account flexibility, choice and continuity of care.

•The practice understood the needs of its population and tailored services in response to those needs. For example extended opening hours were available and online services such as repeat prescription requests. Calls were triaged by a GP with all patients being offered a two hour call back, or one hour for the under 5s. This enabled many calls for minor illnesses to be dealt with via phone consultation, and allocation to the most appropriate member of clinical staff.

•This kind of access enabled the GP to monitor patients' symptoms and to only prescribe when appropriate. For instance where appropriate patients were guaranteed another telephone consultation in two days if symptoms persisted. This strategy was reflected in the low antibiotic prescribing rates associated with this practice.

•The practice proactively identified unmet needs within the community, and where possible improved services with an innovative approach, for instance introducing the call back service after termination of pregnancy. The practice proactively analysed skill mix of staff and how best they could improve patient access. Changes included the introduction of nurse call-back systems, the employ of a physician's associate and upskilling of health care assistants. This meant patients could access GP advice the same day and then if necessary see the most appropriate member of staff first time. Positive patient feedback was received via patient surveys for how easy patients found it to contact the practice.

•The practice was proactive in assessing future need, for instance by carrying out workforce modelling in response to new housing developments in the town.

•The practice was proactive in improving continuity of care. For instance, the practice had approached another small rural practice to work with them for mutual benefit. GPs from the small practice provide three clinical sessions at The Lakes for their patients, and in return the small practice received clinical support, sharing of good practice and peer review. This was seen as improving patient access and providing continuity at a time when the practice list size grew by 10%, and was reflected in patient feedback results.

•The facilities and premises were appropriate for the services delivered.

•The practice made reasonable adjustments when patients found it hard to access services, such as booking an appointment straightaway for elderly or vulnerable patients who may struggle waiting for a call back.

•Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

•All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.

•The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The practice also accommodated home visits for those who had difficulties getting to the practice. The practice employed a specialist frailty nurse who visited all housebound patients and nursing homes once a week.

People with long-term conditions:

•Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Staff worked together so multiple conditions were reviewed collaboratively, and consultation times were flexible to meet each patient's specific needs. How the consultations were structured was also flexible to reflect emotional or life pressures the patient was experiencing at the time. Telephone consultations and review appointments were offered with specialist respiratory and women's health nurses.

•The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

Good

Are services responsive to people's needs?

•We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.

•All parents or guardians calling with concerns about a child under the age of five were offered a one hour call back for triage and a same day appointment where necessary.

•Following staff innovation, same day appointments or a call back service was offered for sexual health, contraception or menopause advice, ensuring fast access for patients, who may also be vulnerable, and at risk of not attending for a prebooked GP appointment.

Working age people (including those recently retired and students):

•The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours and Saturday appointments.

•Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours, with a variety of clinical staff including a musculo-skeletal specialist and the Emotional well-being practitioner.

People whose circumstances make them vulnerable:

•The practice held a register of patients living in circumstances that made them vulnerable including homeless people, travellers and those with a learning disability. This was reviewed regularly at the relevant safeguarding meeting.

People experiencing poor mental health (including people with dementia):

•Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. Annual health checks were offered.

•Information about various voluntary groups and support organisations was promoted in conjunction with the PPG.

•Patients had access to an in-house Emotional well-being practitioner, and another member of clinical staff was also undergoing training to provide additional support.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

•Patients had timely access to initial assessment, test results, diagnosis and treatment.

•Waiting times, delays and cancellations were minimal and managed appropriately.

•Patients with the most urgent needs had their care and treatment prioritised.

•The appointment system was easy to use and received positive patient feedback.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

•Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.

•The complaint policy and procedures were in line with recognised guidance. 44 complaints were received in the last year; however this included 26 verbal complaints and one negative NHS choices comment. 17 written complaints were received. We reviewed all written complaints and found that they were satisfactorily handled in a timely way. The practice recorded all negative feedback and informal 'grumbles' as complaints and discussed these to identify any learning points.

•The practice learned lessons from individual concerns and complaints. It acted as a result to improve the quality of care, such as clinical review meetings, changes to IT procedures or telephone message systems.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services well-led?

We rated the practice as outstanding for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care. Leaders inspired continuous improvement and motivated staff to succeed.

•Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it. The practice had developed a practice management team with different responsibilities and specialities within to increase flexibility and collaboration. Skill sets were clearly mapped to roles.

•They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were proactive and innovative in addressing them.

•Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. Staff consistently described the high levels of support and encouragement given from the leadership team, with the freedom to innovate and develop areas of special interest.

•The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

•There was a clear vision, mission statement and set of values. The values originated from the Foundation Trust and had been adopted by different services throughout the CCG. The practice had proactively adopted these to help provide consistency and a coherent approach throughout the region. Staff were enthusiastic and invested in the values, and these were embedded through the appraisal system. The practice had a realistic strategy and supporting business plans to achieve priorities.

•Staff meeting minutes were mapped to CQC domains of safe, effective, caring, responsive and well led to provide structure and clear direction to ensure not only legislative compliance but to encourage continuous improvement.

•The practice developed its vision, values and strategy jointly with patients, staff, the PPG and external partners. Staff were aware of and understood the vision and values and their role in achieving them. Staff described the values as relevant and important.

•The strategy was in line with health and social priorities across the region. The practice planned its services to meet the current and future needs of the practice population.

•The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

•There were high levels of staff satisfaction, and staff stated they felt respected, supported and valued. They were proud to work in the practice. The practice was proud of their culture and leaders told us at a difficult time for recruitment, they were fully staffed and had not struggled to recruit to any roles. Staff were highly engaged and motivated, and consistently described how they were empowered and supported to develop their roles and skill sets, where they could demonstrate this would have an improvement on patient outcomes.

•Leaders proactively sought constructive challenge and feedback, and this was seen as integral to improving the service.

•The practice focused on holistic needs of patients and their well-being as a whole.

•Leaders and managers acted on behaviour and performance inconsistent with the vision and values.

•Openness, honesty and transparency were demonstrated when responding to incidents and complaints. We saw where the provider had, for instance, acknowledged human error and a need for further training, and had been open about this. Staff described an open, transparent and supportive culture. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.

•Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.

•There were processes for providing all staff with the development they need. This included appraisal and career

Are services well-led?

development conversations. All staff received regular annual appraisals, and spoke highly of how useful and relevant they found this process. Staff were supported to meet the requirements of professional revalidation where necessary.

•Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.

•There was a strong emphasis on the safety and well-being of all staff. Staff could access additional support including a two hour Personal Development session where they could discuss issues such as stress and burn out. The practice explained their ethos was 'happy staff equals happy patients' and gave accordingly high levels of support to their staff.

•The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.

•There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. These were proactively reviewed to reflect best practice.

•Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The practice had set out a vision of a 'holacracy not a hierarchy' (a method of decentralized management where decision making and authority is distributed). This was described as a flexible and adaptable approach where the skills set could be continuously developed. The practice had carried out mapping exercises to explain the structure, how different roles worked together, and what this meant for patients. These were mapped to the domains of safety, effectiveness, caring, responsiveness and leadership in order to encourage continuous improvement.

•The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care. For instance, the practice had approached another practice in the area to work together for different mutual benefits.

•Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control

•Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

•There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.

•The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Staff were well supported clinically, for instance a nurse prescriber received six monthly audits and supervision as well as ongoing support, and the physician's associate worked very closely with GPs with immediate access to ongoing support. Practice leaders had comprehensive oversight of MHRA alerts, incidents, and complaints.

•Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.

•The practice had comprehensive plans in place and had trained staff for major incidents. Staff carried contact cards with them at all times with emergency numbers, and staff described how their procedures were implemented during recent heavy snow. Due to supported technology, some GP's unable to physically attend were able to remotely triage calls from home, supporting staff who managed to access the building.

•The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

Outstanding ☆

Are services well-led?

•Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.

•Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.

•The practice used performance information which was reported and monitored and management and staff were held to account.

•The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.

•The practice used information technology systems to monitor and improve the quality of care, and was using a text messaging patient engagement tool to gain more feedback and also to monitor 'Friends and Family' test results. This was in conjunction with the PPG.

•The practice submitted data or notifications to external organisations as required, and where they thought learning points could benefit others.

•There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

•A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. Reviewing feedback was seen as a valuable way to improve the service. The practice recorded all feedback verbal and written, however minor, and used this to improve. We saw examples where feedback from the PPG had resulted in change, for instance a patient letter sent to opiate users was reworded after consultation with the PPG.

•There was an active patient participation group, which was carrying out analysis and an action plan for how to raise their profile with patients, and how best to define and carry out their role. The PPG was asked to give input into the quarterly patient newsletters, changes to the phone system, and changes during refurbishment to increase confidentiality at reception. Quarterly practice newsletters were sent to patients who had signed up and were published on the website. These included useful contact numbers in the area and information on other health service and charitable organisations. These were seasonally themed to be relevant, for instance hay fever information in spring and meningitis information for students in summer.

•The service was transparent, collaborative and open with stakeholders about performance, and were consistent early adopters or contributors in pilot projects in the region, including a text message reminder service.

•The practice took opportunity to share learning through CCG and other events, or direct to local practices. Examples of this included long term condition treatment templates, how they managed calls to improve access, and opiate reduction programmes.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

•There was a strong focus on continuous learning and improvement at all levels within the practice. Innovation at all levels was encouraged and supported, and we saw many examples where systems had changed to improve patient care as a result of staff input. This included the call back service for women's and sexual health issues, and improvements to asthma review clinics. Staff said they had excellent access to training and were supported in any area where they could demonstrate it would benefit patient care. Staff spoke highly of the appraisal system and said this provided a clear and structured route to raise issues or innovation which then resulted in change.

•The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements. In addition to weekly internal meetings, significant events were also discussed at protected learning time events to involve as many staff as possible. The practice actively shared events externally through the SIRMS system where they thought learning points could benefit others.

Outstanding ☆

Are services well-led?

•Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance. Staff across the practice were able to attend team meetings and there was clear information sharing between teams.

Please refer to the Evidence Tables for further information.