Ambleside Health Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Ambleside Health Centre on 7 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the following population groups: Older people; People with long-term conditions; Families, children and young people; Working age people (including those recently retired and students); People whose circumstances may make them vulnerable; People experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The majority of patients said they were able to get an appointment with a GP when they needed one, with urgent appointments available the same day.
- The practice offered pre-bookable early evening appointments one day per week, which improved access for patients who worked full time.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure in place and staff felt supported by management. The practice proactively sought feedback from staff and patients, which they acted on.

Summary of findings

- Staff throughout the practice worked well together as a team.

We saw the following area of outstanding practice:

- The senior GP partner had undertaken to lead a 2 year pilot of 'Mindfulness' training in the local area, funded by Public Health England. The project aimed to train both patients and local teachers to deliver Mindfulness sessions across the local area, so helping to address high levels of anxiety and mental health issues. Although still at an early stage, this project will directly influence the management of mental health issues in the practice and represents an example of outstanding commitment to support both practice patients with mental health issues and the locality as a whole.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider should:

- Review the systems in place to measure the implementation or effectiveness of any changes to practise made as a result of significant events.
- Seek to improve storage arrangements for blank prescription forms at the branch surgery in Grasmere.
- Review and improve the systems in place to record the maintenance and calibration of equipment within the practice.
- Ensure that clinical audits include at least two cycles. The practice should aim to demonstrate an on-going audit programme where they have made continuous improvements to patient care in a range of clinical areas as a result of clinical audit.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. We found significant events were recorded, investigated and learned from on an individual basis, however systems were not in place to measure the effectiveness of any changes to practise made. Risks to patients were assessed and well managed. Disclosure and Barring Service (DBS) checks had been completed for all staff that required them. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were in line with national averages. The practice used the Quality and Outcomes Framework (QOF) as one method of monitoring its effectiveness and had achieved 93.4% of the points available. This was slightly lower than the local average of 94.9% and similar to the national average of 93.5%. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for staff. Staff worked with multidisciplinary teams which helped to provide effective care and treatment. The clinical audits we reviewed had been through one audit cycle and required repeating. The practice should aim to demonstrate an on-going audit programme where they have made continuous improvements to patient care in a range of clinical areas as a result of clinical audit. The practice had achieved higher cervical screening rates (87.8%) compared to the national average (81.9%).

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice in line with or above others for several aspects of care. For example, the National GP Patient Survey showed 79% of practice respondents said the last GP they saw or spoke to involved them in decisions about their care and 70% said the last nurse they saw or spoke to involved them in decisions about their care. Both these results were higher than the local clinical commissioning group (CCG) area and national

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averages. The CCG averages were 77% and 70%, with the national averages being 75% and 66% respectively. Patients said they were treated with compassion, dignity and respect and they felt involved in decisions about their care and treatment. A total of 91 patients registered with the practice had been identified to be at high risk of hospital admission and had agreed care plans in place. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained privacy and confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. They reviewed the needs of their local population and engaged with the clinical commissioning group (CCG) to secure improvements to services where these were identified. Most patients said they found it easy to make an appointment with a GP. Patients were able to book longer appointments on request and pre-bookable appointments with a GP were available in the evening one day per week. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. They had clear aims and objectives. Staff were clear about their responsibilities in relation to these. There was a clear leadership structure in place with designated staff in lead roles and staff said they felt supported by management. Team working within the practice between clinical and non-clinical staff was good. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which they acted on. The practice had an active and relatively diverse patient participation group (PPG) and was looking to expand this further. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. They offered proactive, personalised care to meet the needs of the older people in its population. For example, all patients over the age of 75 had a named GP and patients at high risk of hospital admission and those in vulnerable circumstances had care plans. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs. The practice liaised with Age UK on a regular basis and supported the 'Ambleside Older People's Project Group'.

The practice maintained a palliative care register and offered immunisations for pneumonia and shingles to older people.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients were offered a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the practice worked with relevant health and care professionals to deliver a multidisciplinary package of care. A traffic light system was used to highlight those patients that required more intense input from the clinical team. The list was reviewed on a regular basis and discussed at multidisciplinary meetings.

The practice held regular chronic disease management clinics in rheumatology, diabetes, asthma and for patients with respiratory and cardiovascular conditions. A medicines optimisation pharmacist supported the practice and kept them updated on medication guidelines.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. The practice ran baby clinics for immunisations and immunisation rates were generally slightly below average for

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the local clinical commissioning group (CCG). For example, Dtap/ IPV/Hib vaccination rates for one year old children were 93.8% compared to 97.1% across the CCG and for two year old children were 90.3% compared to 97.8% across the CCG.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. The practice's patient participation group included a young parent, which helped to ensure the views of these patients were heard. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

The practice had achieved higher cervical screening rates (87.8%) compared to the national average (81.9%).

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible and flexible. The practice offered some online services as well as a full range of health promotion and screening which reflects the needs for this age group. GP appointments could be booked in advance online.

The practice offered extended opening hours one evening per week. Patients could pre-book appointments to see a GP at these times. Telephone consultations with clinicians could also be booked on a daily basis. This made it easier for people of working age to get access to the service. NHS health checks were offered to patients between the ages of 40 and 74 and the practice also carried out joint injections as part of its minor surgery service.

The University of Cumbria had a campus next to the main surgery in Ambleside and practice staff attended induction days to promote their services and to offer students the opportunity to register with the practice. They also attended the Ambleside Community Liaison Group meetings run by the university and have actively sought representation from the student community on their patient group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances, including

those with a learning disability. Patients with learning disabilities were invited to attend the practice for annual health checks. The practice offered longer appointments for people with a learning disability, if required.

One of the GPs was identified as the lead for the practice on drugs and alcohol. The practice facilitated drug and alcohol counselling and substance abuse services, with a fortnightly clinic being run by a specialist counsellor from Unity. The counsellor also met regularly with the lead GP to review the medical needs of dependant patients.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. They made vulnerable patients aware of how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice was involved in setting up a local group to help homeless and vulnerable people with access to hot meals and transport to a local town. They held vouchers at the Ambleside surgery which could be given to any vulnerable person on request.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people living with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those living with dementia. They carried out advance care planning for patients with dementia.

The practice had informed patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had received training on how to care for people with mental health needs and dementia.

The practice facilitated on-site counselling through the 'First Step Scheme' for patients who lived with anxiety and depression, which enabled them to see therapists locally. Bi-monthly meetings with the practice's designated Community Psychiatric Nurse (CPN) were held, where the care of patients with more severe mental health problems was reviewed.

The senior GP partner had undertaken to lead a 2 year pilot of 'Mindfulness' training in the local area, funded by Public Health England. The project aimed to train both patients and local teachers to deliver Mindfulness sessions across the local area, so helping to

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address high levels of anxiety and mental health issues. Although still at an early stage, this project will directly influence the management of mental health issues in the practice and represents an example of outstanding commitment to support both practice patients with mental health issues and the locality as a whole.

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What people who use the service say

We spoke with 33 patients in total; 31 patients on the day of the inspection and two patients before the inspection who were members of the practice's Patient Participation Group (PPG). They were mostly complimentary about the services they received from the practice. They told us the staff who worked there were helpful and friendly. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. Patients were generally happy with the appointments system.

We reviewed 43 CQC comment cards completed by patients prior to the inspection. The large majority were complimentary about the practice, staff who worked there and the quality of service and care provided. Of the 43 CQC comment cards completed, 28 patients made direct reference to the caring manner of the practice staff. Words used to describe the approach of staff included caring, thorough, helpful, friendly, kind, approachable and patient.

The latest National GP Patient Survey showed that the practice's results were mainly in line with or better than other GP practices within the local clinical commissioning group (CCG) area and nationally. The practice scored slightly lower than the local and national averages for patients' satisfaction with opening hours. Some of the results were:

- The proportion of respondents who were able to get an appointment to see or speak to someone the last time they tried – 88% (CCG average 88%, national average 85%);
- The proportion of respondents who said the last GP they saw or spoke to was good at explaining tests and treatments – 91% (CCG 84%, national 82%);
- The proportion of respondents who said the last GP they saw or spoke to was good at involving them in decisions about their care – 79% (CCG 77%, national 75%);
- The proportion of respondents who said they had confidence and trust in the last GP they saw or spoke to – 95% (CCG 94%, national 92%);
- The proportion of respondents who said the last nurse they saw or spoke to was good at explaining tests and treatments – 80% (CCG 81%, national 77%);
- The proportion of respondents who said the last nurse they saw or spoke to was good at involving them in decisions about their care – 70% (CCG 70%, national 66%);
- The proportion of respondents who said they had confidence and trust in the last nurse they saw or spoke to – 87% (CCG 89%, national 86%).

These results were based on 121 surveys that were returned from a total of 299 sent out; a response rate of 40%.

Areas for improvement

Action the service SHOULD take to improve

The provider should:

- Review the systems in place to measure the implementation or effectiveness of any changes to practise made as a result of significant events.
- Seek to improve storage arrangements for blank prescription forms at the branch surgery in Grasmere.
- Review and improve the systems in place to record the maintenance and calibration of equipment within the practice.
- Ensure that clinical audits include at least two cycles. The practice should aim to demonstrate an on-going audit programme where they have made continuous improvements to patient care in a range of clinical areas as a result of clinical audit.

Outstanding practice

- The senior GP partner had undertaken to lead a 2 year pilot of 'Mindfulness' training in the local area, funded by Public Health England. The project aimed to train both patients and local teachers to deliver Mindfulness

sessions across the local area, so helping to address high levels of anxiety and mental health issues. Although still at an early stage, this project will directly influence the management of mental health issues in the practice and represents an example of outstanding commitment to support both practice patients with mental health issues and the locality as a whole.

Ambleside Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser and an expert by experience. An expert by experience is somebody who has personal experience of using or caring for someone who uses a health, mental health and/or social care service.

Background to Ambleside Health Centre

The practice is based within the Ambleside Health Centre, with a small branch surgery in Grasmere. The practice serves those living in Ambleside, Grasmere, Windermere, Storrs Park, Troutbeck, Hawkshead and the surrounding areas. They provide services from the following addresses and these are where we carried out the inspection:

Main surgery: The Health Centre, Rydal Road, Ambleside, Cumbria, LA22 9BP.

Branch surgery: 1 Field Foot, Grasmere, Ambleside, LA22 9TB.

The surgeries in Ambleside and Grasmere both provide services to patients at ground floor level. The practice offers on-site parking including disabled parking, accessible WC's and step-free access. They provide services to just over 5,000 patients of all ages based on a General Medical Services (GMS) contract agreement for general practice.

The practice has four GPs in total (three female, one male); two GP partners and two salaried GPs. The practice is a training practice, with one F2 foundation doctor (a fully qualified doctor allocated to the practice as part of a two-year, general postgraduate medical training programme) and one Year 5 medical student. There are also two nurse practitioners, four practice nurses, one healthcare assistant, one phlebotomist, a practice manager and a team of administrative support staff.

Information taken from Public Health England placed the area in which the practice was located in the second least deprived decile. In general, people living in more deprived areas tend to have greater need for health services. The practice's age distribution profile is weighted towards a slightly older population than national averages. There are significantly fewer patients registered between the ages of 0-19 years than the national averages.

The service for patients requiring urgent medical attention out-of-hours is provided by the 111 service and Cumbria Health on Call (CHoC).

Why we carried out this inspection

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

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

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 Care Quality Commission at that time.

Detailed findings

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

• Families, children and young people

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

• People whose circumstances may make them vulnerable

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

Before visiting, we reviewed a range of information that we hold about the practice. This did not highlight any areas for follow-up. We also asked other organisations to share what they knew. This included the local clinical commissioning group (CCG).

We carried out an announced inspection on 7 May 2015. We visited the practice's main surgery in Ambleside and the branch surgery in Grasmere. The branch surgery was not open to patients on the day of the inspection. We spoke with 33 patients and a range of staff from the practice. We spoke with the practice manager, three GPs, two nurse practitioners, one phlebotomist and some of the practice's administrative and support staff. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 43 CQC comment cards where patients from the practice had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Safe Track Record

As part of our planning we looked at a range of information available about the practice. This included information from the latest GP Patient Survey results published in January 2015 and the Quality and Outcomes Framework (QOF) results for 2013/14. The latest information available to us indicated there were no areas of concern in relation to patient safety.

Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed Care Quality Commission (CQC) comment cards reflected this. Three patients commented directly about safety; they said they felt the environment was safe, hygienic and suitable for children.

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts and comments and complaints received from patients. Staff we spoke with were aware of their responsibility to raise concerns, and how to report incidents and near misses. For example, we saw records of an incident where there had been a delay in the provision of secondary care for one of their patients.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could demonstrate a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting and recording significant events, incidents and accidents. We saw records were kept of significant events that had occurred, any learning to be taken from them and changes to be made as a result. However systems were not in place to routinely review the implementation or effectiveness of any changes to practise made. The summary the practice provided us with showed there had been seven events recorded during the last 12 months and we looked at the records of these. Many of these events had been 'near misses'; however we saw some evidence of other significant events that were positive events recorded within the GPs appraisal files. We saw each significant event was recorded, investigated and discussed at informal daily meetings initially. These daily meetings were attended by the GPs, the practice manager and nurses and allowed for decisions to be made quickly. Incidents and significant events were also brought to the practice's weekly clinical meetings where any action required to be taken was formally agreed. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff, were aware of the system for raising significant events.

We saw incident forms were available on the practice's shared drive computer system. Once completed these were sent to the practice manager or the relevant clinician who managed and monitored them. Where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken.

National patient safety alerts were received into the practice electronically. The alerts were reviewed and sent to the appropriate staff for their attention by the practice manager. Copies of alerts were also filed in the locum GP pack. Staff we spoke with were aware of the system and were able to give examples of recent alerts relevant to the care they were responsible for. Staff said alerts were also discussed at the weekly clinical meetings to ensure they were aware of any relevant to their area of work and where action needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records we reviewed showed that staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out-of-hours. We saw contact details were easily accessible to staff throughout the practice.

The practice had a dedicated GP partner appointed as the lead in safeguarding vulnerable adults. The same GP and one of the nurse practitioners were the leads for safeguarding children. These staff had been trained to child safeguarding level three to enable them to fulfil this role.

Good

Are services safe?

The other GPs had been trained to this level too. Staff we spoke with were aware of who the leads for the practice were and who to speak with if they had any safeguarding concerns.

The practice's electronic records could be used to highlight vulnerable patients. This included information so staff were aware of any relevant issues when patients attended appointments.

A chaperone policy was in place and a notice was displayed in the patient waiting area to inform them of their right to request one. The practice manager said chaperoning was only carried out by the nursing staff, healthcare assistant or a few selected members of the administrative staff. All of the staff that carried out chaperone duties had been checked via the Disclosure and Barring Service (DBS).

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals.

Medicines Management

We checked a sample of vaccines stored in the medicine refrigerator and found they were stored securely and were only accessible to authorised staff. There was a process for checking medicines were kept at the required temperatures and this was being followed by the practice staff. This ensured the medicines in the fridge were safe to use.

Processes were in place to check medicines were within their expiry date and suitable for use. However, we found a small number of flu vaccines had passed their expiry date and these were disposed of immediately. All of the other medicines we checked were within their expiry dates. This included the supply of emergency medicines kept by the practice. The practice held a small stock of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had standard procedures in place that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

At the branch surgery in Grasmere, there was a box in the consulting room that contained among other things, individually wrapped dressings and wipes. We found a number of these dressings and wipes had passed their use by dates. The practice manager disposed of these immediately and said the contents of the box were normally checked by the nurses.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw that nurses had received appropriate training to administer vaccines.

There was a protocol for repeat prescribing which was followed in practice to ensure that patients' repeat prescriptions were still appropriate and necessary.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We saw blank prescription forms were stored securely at the main surgery in Ambleside; however storage arrangements at the branch surgery in Grasmere could be improved. We saw blank forms were stored in a cardboard box under a desk on the floor of the consulting room. The room was locked when it was not in use, however these arrangements were not in line with latest best practice guidance.

Cleanliness & Infection Control

We saw the premises at the main and branch surgeries were clean and tidy. There were cleaning schedules in place and cleaning records were kept. Regular checks on the quality of cleaning were completed. 'Monthly Cleanliness Inspections' were completed at the main surgery in Ambleside and the results of these inspections were displayed in the entrance foyer. The results of inspections completed between January 2014 and March 2015 ranged from 97% to 100%. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

One of the nurse practitioners had been the designated led for infection control until recently. The practice manager had now taken on this role and met regularly with the nursing team to discuss infection control. Staff were able to describe the precautions they took on a daily basis with regards to infection control; for example on the receipt of specimens from patients. Clinical staff had received training about infection control specific to their role; however it was not clear whether non-clinical staff had completed any recent training in this area.

Good

Are services safe?

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement infection control measures. For example, personal protective equipment including disposable gloves, aprons and coverings was available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy for needle stick injuries and the disposal and management of clinical waste. All the staff we spoke with knew how to access the practice's infection control policies and procedures.

The clinical rooms we checked contained personal protective equipment such as latex gloves and there were privacy curtains and paper covers for the consultation couches. Arrangements were in place to ensure the curtains were regularly cleaned and replaced. Where sharps bins (used to dispose of needles and blades safely) were contained within consultation rooms at the main surgery, these where appropriately labelled, dated and initialled. The sharps bin at the branch surgery in Grasmere had not been dated or initialled on construction. The treatment rooms contained hand washing sinks, antibacterial gel and hand towel dispensers to enable clinicians to follow good hand hygiene practice. Hand hygiene techniques signage was displayed throughout the practice. Spillage kits were available to deal with any biological fluid spills.

The practice had processes in place for the management, testing and investigation of legionella (bacteria found in the environment which can contaminate water systems in buildings). We saw the practice was carrying out regular checks in line with this to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw a small number of equipment maintenance logs and other records to support this. The practice manager said record keeping in this area could be improved and they were aware of the need to do so. We saw some evidence of repair of relevant equipment; for example, weighing scales.

All portable electrical equipment at the main surgery in Ambleside had been tested recently, however some at the branch surgery in Grasmere had stickers attached that indicated they were last tested in September 2007.

Staffing & Recruitment

The practice had a recruitment policy that set out the standards they followed when recruiting staff. Records we looked at included evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with an appropriate professional body and criminal record checks via the Disclosure and Barring Service (DBS). Two of the staff files we looked at did not contain hard copies of proof of identification. The practice manager explained that documents confirming their identity, including passports and driving licenses, had been seen for these staff as part of their Disclosure and Barring Service (DBS) check application process.

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There were arrangements in place for members of staff to cover each other's annual leave. The practice used locum GPs to cover for their GPs holidays and arrangements had already been made for cover in the coming months. The practice had a locum pack in place.

Staff told us there were enough staff to maintain the smooth running of the practice and there was always enough staff on duty to ensure patients were kept safe. Clinical staff we spoke with reported work pressures had increased since the practice had lost a GP partner whose sessions had not been replaced; however there was a plan to rationalise sessions in the future.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff and patients to see.

Identified risks had been recorded and each risk was assessed with mitigating actions noted to manage the risk.

Good

Are services safe?

We saw where risks had been identified; action plans had been drawn up to reduce these risks. For example, fire risk assessments were in place and two members of staff had completed fire warden training, with one of these being the designated fire warden.

Staff were able to identify and respond to changing risks to patients, including deteriorating health and medical emergencies. For example, staff who worked in the practice were trained in cardiopulmonary resuscitation (CPR) and basic life support skills.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Emergency equipment was available and staff were trained to use it. This included a defibrillator (used to attempt to restart a person's heart in an emergency) and oxygen. Records of daily checks of the defibrillator and oxygen were up-to-date. All the staff we asked knew the location of this equipment.

Emergency medicines were available in a secure area of the practice and all the staff we spoke with knew of their location. Medicines included those for the treatment of cardiac arrest, breathing difficulties and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure and loss of access to the building and IT systems. It also included a detailed list of contact details. The plan had been updated recently to reflect some telephone number changes. A number of staff in different roles had copies of the plan, with some held at home. This included the practice manager, office manager, a GP partner and the contracted cleaner who would normally be the first person to arrive at the main surgery each day. This ensured they had the information they needed to report any problems if they discovered anything that would impact on the operation of the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could describe the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE). We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs and these were reviewed when appropriate. For example, a GP we spoke with showed us how they routinely referred to NICE guidelines when care plans were agreed with patients living with diabetes.

GPs and nurses led in specialist clinical areas such as diabetes. GP leads had overall responsibility for ensuring the disease or condition was managed effectively in line with best practice. Nursing staff were jointly responsible with GPs for ensuring the day-to-day management of a disease or condition was in line with practice protocols and guidance. Clinical staff we spoke with said they would not hesitate to ask for or provide colleagues with advice and support. Staff had access to the necessary equipment and were skilled in its use; for example, blood pressure monitoring equipment.

Patients we spoke with said they felt well supported by the GPs and clinical staff with regards to decision making and choices about their treatment. This was reflected in the comments left by patients who completed CQC comment cards.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff from across the practice had roles in the monitoring and improvement of outcomes for patients. These included data input, clinical review scheduling and medicines management. The information staff entered and collected was then used by the practice staff to support the practice to carry out clinical audits and other monitoring activity.

The practice staff were able to show us some clinical audits that had been completed. We looked at three examples of clinical audits that had been undertaken in the last few years. The audits had been through one audit cycle and required repeating. One of the audits (on the uptake of cervical screening) had a review date of June 2015 recorded. The other audits we reviewed related to minor surgery and joint injections and on the use of bisphosphonate therapy in osteoporosis (osteoporosis is a condition that affects the bones, causing them to become weak, fragile and more likely to break). The initial reviews of these clinical areas had confirmed good practice, however the number of patients identified as part of the reviews were relatively small. The practice should aim to demonstrate an on-going audit programme where they have made continuous improvements to patient care in a range of clinical areas as a result of clinical audit.

The practice used the information they collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. The Quality and Outcomes Framework is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions (e.g. diabetes) and implementing preventative measures. The results are published annually. This practice was not an outlier for any QOF (or other national) clinical targets. It achieved 93.4% of the total QOF target in 2013/2014, which was similar to the national average of 93.5%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was better than the national average (91.2% compared to the national average of 90.1%).
- Performance for asthma related indicators was better than the national average (100% compared to the national average of 97.2%).
- Performance for chronic obstructive pulmonary disease (COPD) related indicators was lower than the national average (94.3% compared to the national average of 95.2%).

The practice's prescribing rates were similar to national figures. For example, prescribing of hypnotics (medicines regularly prescribed for insomnia and other sleep disorders) and antibiotics were in line with national averages. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been

Good

Are services effective?

(for example, treatment is effective)

reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, the practice had used its clinical commissioning group (CCG) funded Clinical Interface Manager (CIM) time to review the practice's referral rates to secondary care services using a referral support management tool. This had initially identified the practice to be a high referrer compared to other practices within Cumbria. Further investigation identified this to be a clinical coding issue rather than being high referrer's, with the appropriate corrective action being taken. We also saw an antibiotic prescribing audit completed for the whole CCG showed the practice had achieved a 12.5% reduction in prescribing between quarter 3 of 2013/14 and quarter 3 of 2014/15. The audit also showed that the prescribing of several expensive medicines and antibiotics had increased. A CCG-funded pharmacist visited the practice once a week and completed further detailed reviews of prescribing.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending mandatory courses such as cardiopulmonary resuscitation (CPR) and the information governance toolkit. Staff had completed fire training and two members of staff had completed fire warden training. All GPs were up to date with their yearly continuing professional development requirements and had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Nursing staff were appraised by the practice manager and lead nurse, nurse practitioners and the practice manager were appraised by GPs, and the practice manager appraised the administrative and support staff. We saw records in staff files of appraisals completed within the last 12 months. Staff interviews confirmed that the practice was supportive in providing training and funding for relevant courses. For example, one of the staff we spoke with said they had asked to be trained in phlebotomy (taking blood from a vein) and this had been provided.

Nursing staff had defined duties they were expected to carry out and were able to demonstrate they were trained to fulfil these duties. For example, one of the nurse practitioners said they gave joint injections and had been trained (with the support of the practice) to do so.

The administrative and support staff had clearly defined roles, however they were also able to cover tasks for their colleagues. This helped to ensure the team were able to maintain levels of support services at all times, including in the event of staff absence and annual leave.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage patients with complex health conditions. Blood results, X-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service, were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers promptly and efficiently. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team (MDT) meetings to discuss the needs of high risk patients, for example, those with end of life care needs. These meetings were attended by a range of healthcare professionals including district nurses, community matrons, palliative care nurses and health visitors and decisions about care planning were recorded. The practice maintained lists of patients who had learning disabilities, those at high risk of unplanned admissions and patients diagnosed as living with dementia. These and other at risk patients were reviewed and discussed at the MDT meetings.

The practice met monthly with district nurses and palliative care nurses and discussed the practice's register of 'very ill people'. The practice's GPs attended these meetings and felt this system worked well. They remarked on the

Good

Are services effective?

(for example, treatment is effective)

usefulness of the meetings as a means of sharing important information. A 'traffic light system' was used to indicate those patients that required more intense input from the clinical team. The practice also held bi-monthly meetings with midwives and health visitors to discuss safeguarding matters. The community psychiatric nurse (CPN) also attended these meetings. Practice staff also met informally on a daily basis with district nurses to share information and discuss any concerns they had with their patients.

Information Sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, for example, through 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). Staff reported that this system was easy to use and patients welcomed the ability to choose their own appointment dates and times.

Hospital discharge summaries were checked at daily lunchtime meetings of GPs, and then passed to the administrative staff for coding and any actions that were required. Pathology results were received electronically and were dealt with through the use of electronic tasks within the clinical systems, which provided a full audit trail.

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.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. They also demonstrated an 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).

There was a practice policy for recording consent for specific interventions. For example, verbal consent was taken from patients for routine examinations and verbal and implied consent for the measurement of blood pressure.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. Staff we spoke with gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

Health Promotion & Prevention

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance (2013/14) for immunisations was generally slightly below the averages for the local clinical commissioning group (CCG). For example, Dtap/IPV/Hib vaccination rates for one year old children were 93.8% compared to 97.1% across the CCG and for two year old children were 90.3% compared to 97.8% across the CCG.

We found patients with long-term conditions were recalled to check on their health and review their medicines for effectiveness. The practice's electronic system was used to flag when patients were due for review. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively. Staff said this worked well and helped to prevent any patient groups from being overlooked.

Processes were also in place to ensure the regular screening of patients was completed, for example, cervical screening. Performance in this area for 2013/14 was higher than the national average at 87.8% (the national average was 81.9%).

There was a range of information on display within the main and branch surgery's patient waiting areas. This included a number of health promotion and prevention leaflets, for example on alcohol consumption among children and outreach clinics regarding matters of sexual health. The practice's website included links to a range of patient information, including for family health, long term conditions and minor illnesses.

Good

Are services effective?

(for example, treatment is effective)

The University of Cumbria had a campus next to the main surgery in Ambleside. Practice staff attended induction days to promote their services and to offer students the opportunity to register with the practice.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with said they were treated with respect and dignity by the practice staff. Comments left by patients on Care Quality Commission (CQC) comment cards reflected this. Of the 43 CQC comment cards completed, 28 patients made direct reference to the caring manner of the practice staff. Words used to describe the approach of staff included caring, thorough, helpful, friendly, kind, approachable and patient.

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was considerate and caring, while remaining respectful and professional. This was clearly appreciated by the patients who attended the practice. We saw that any questions asked or issues raised by patients were handled appropriately and the staff involved remained polite and courteous at all times.

The reception area at the main surgery was separate from the main patient waiting area, with a viewing window separating the two. There was no formal reception at the branch surgery due to its small size; patients would arrive and wait to be seen in a small waiting room. We saw staff who worked in the main surgery reception area made every effort to maintain patients' privacy and confidentiality. Voices were lowered and personal information was only discussed when absolutely necessary. Phone calls from patients and other healthcare professionals were taken by administrative staff in a separate area where confidentiality could be maintained.

Patients' privacy, dignity and right to confidentiality were maintained. For example, the practice offered a chaperone service for patients who wanted to be accompanied during their consultation or examination. Staff we spoke with said a spare room was made available for patients to use at the main surgery if they wanted to speak about matters in private. This reduced the risk of personal conversations being overheard.

We saw patient records were mainly computerised and systems were in place to keep them safe in line with data protection legislation. Any paper records held were stored in the locked records room. Staff had completed information governance training and were aware of the need to keep records secure.

The practice had policies in place to ensure patients and other people were protected from disrespectful, discriminatory or abusive behaviour. The staff we spoke with were able to describe how they put this into practice. A small number of staff employed by the practice were registered as patients. The practice manager described the arrangements in place to ensure confidentiality was not compromised, for example for the scanning of correspondence. They said when staff that lived in the area started to work at the practice, the importance of maintaining confidentiality was explained to them.

Care planning and involvement in decisions about care and treatment

The National GP Patient Survey information we reviewed (published in January 2015) showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. For example, the survey showed 79% of practice respondents said the last GP they saw or spoke to involved them in decisions about their care and 70% said the last nurse they saw or spoke to involved them in decisions about their care. Both these results were in line with or higher than the local clinical commissioning group (CCG) area and national averages. The CCG averages were 77% and 70%, with the national averages being 75% and 66% respectively.

In general, the National GP Patient Survey results for the practice were a little above the local CCG area and national averages. For example, 92% of respondents said the last GP they saw or spoke to was good at listening to them and 85% of respondents reported the same for the last nurse they saw or spoke to. The CCG averages were 90% and 83%, with the national averages being 87% and 79% respectively. The practice had also scored well in terms of patients feeling GPs (91% of respondents) and nurses (80%) explained tests and treatments to them well. This compared to the CCG averages of 84% and 81%, with the national averages being 82% and 77% respectively.

Feedback from patients we spoke with reflected the results from the latest National GP Patient Survey. They told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also said they felt listened to and supported by staff and felt they had sufficient time during

Good

Are services caring?

consultations to make informed decisions about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and supported these views.

The practice had identified its most at risk and vulnerable patients. They had signed up to the enhanced service for 'Avoiding Unplanned Hospital Admissions' and were completing the work associated with this service. Enhanced Services are services which require an enhanced level of service provision beyond their contractual obligations, for which they receive additional payments. A total of 91 patients had been originally identified as being at high risk of hospital admission. The practice had contacted these patients and with their involvement and agreement, had put agreed plans of care in place. The GPs we spoke with described some examples of care plans agreed with a number of at risk patients.

Staff told us that translation services were available for patients who did not have English as a first language. We saw that support was available for patients with hearing difficulties, with an induction loop system in place at the main surgery.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice and rated it well in this area. The CQC comment cards we received were also consistent with this feedback. For example, patients commented the GPs and staff knew them well and were caring and supportive.

Notices in the patient waiting areas signposted patients to a number of support groups and organisations. The practice website included information to support its patients. For example, information was provided for patients who had drug and alcohol problems and a range of information from Age UK and South Lakeland Carers was displayed. The practice maintained records of patients who were carers.

Support was provided to patients during times of need, such as in the event of bereavement. A GP would carry out a home visit or a telephone call was made to bereaved relatives at these times to offer support and guidance. Staff we spoke with in the practice recognised the importance of being sensitive to patients' wishes at these times.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients we spoke with and those who filled out Care Quality Commission (CQC) comment cards said they felt the practice was meeting their needs. This included being able to access repeat medicines at short notice when this was required.

The practice engaged regularly with the clinical commissioning group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. For example, the practice had agreed with another small local practice to provide contraceptive and family planning services for their patients.

The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. Staff said patients were encouraged to see the same GP if possible, which enabled good continuity of care. Patients could access appointments face-to-face in the practice, receive a telephone consultation with a GP or be visited at home. Longer appointments were available for people who needed them on request.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients and their families' care and support needs. The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment.

The practice had a patient participation group (PPG) and met with them on a bi-monthly basis. We spoke with two members of the group ahead of the inspection. They said the group was quite small; however they were actively looking to expand its membership beyond the current level of seven to eight patients. The group membership included patients from a variety of backgrounds, including males, females, a young parent, older people and retired professionals. The practice manager and patients on the group we spoke with all said they were actively seeking to recruit membership from within the local student population. The University of Cumbria had a campus located next to the health centre in Ambleside.

The group members we spoke with said feedback from the group was well received by the practice and a number of changes had been made by them in response to patient feedback. For example, the clock had been re-instated in the patient waiting area in Ambleside following some refurbishment work and a number of trials and changes to the practice's appointments system had been made.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, opening times had been extended to provide pre-bookable early evening appointments with a GP one day per week. The day of the week varied from one week to the next, depending on the GP who was running the surgery. This information was displayed on the practice's website to keep patients informed. The early evening surgery was run from the main surgery in Ambleside. This helped to improve access for those patients who worked full time. The majority of the practice population were English speaking patients but access to translation services were available if they were needed. The practice maintained registers for patients with caring responsibilities, patients with learning disabilities and patients receiving palliative care. All of these measures helped to ensure that all of their patients had equal opportunities to access the care, treatment and support they needed.

The premises and services had been adapted to meet the needs of people with disabilities. The surgeries at Ambleside and Grasmere were both situated on the ground floor. There were plans in place for the main entrance door at Ambleside to be automated to improve access and all of the treatment and consulting rooms could be accessed by those with mobility difficulties. There was currently a bell at the main entrance door that patients who required assistance to access the building could use. The reception desk at Ambleside had an area where the counter had been lowered to enable patients who used wheelchairs to speak face to face with the reception staff. We saw that the waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. This made movement around the practice easier and helped to maintain patients' independence. The patient toilets could be accessed by patients with disabilities. Dedicated car parking was provided for patients with disabilities in the car park close to the entrance. An induction loop system was in place for patients who experienced hearing difficulties.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice was involved in setting up a local group to help homeless and vulnerable people with access to hot meals and transport to a local town. They held vouchers at the Ambleside surgery which could be given to any vulnerable person on request.

Access to the service

Most of the patients we spoke with and those who filled out Care Quality Commission (CQC) comment cards said they were satisfied with the appointment systems operated by the practice. Comments included; appointment always made within a week of phoning, always try their best to fit you in and we have received prompt appointments. Three of the 43 patients who filled in CQC comment cards were not as satisfied. They made comments such as; a non-emergency appointment is usually too long to wait, difficulty in getting an appointment and more regular practice nurse – had to wait six weeks for a test. The practice manager said the practice was currently advertising for a practice nurse and they were aware there had been some issues with access to practice nurse appointments. All of the patients we spoke with did say they had been able to see a GP the same day if their need had been urgent.

The latest results from the National GP Patient Survey published in January 2015 were mostly positive in terms of patient feedback regarding appointments. 88% of respondents said they were able to get an appointment to see or speak to someone the last time they tried. This was in line with the local CCG average of 88% and higher than the national average of 85%. The practice achieved slightly lower than the CCG average results from patients on their experience of making an appointment and the convenience of their last appointment. 76% of respondents said their experience of making an appointment was good (compared to the CCG average 78%) and 93% said their last appointment was convenient (compared to the CCG average 94%). However both of these results were higher than the national averages of 74% and 92% respectively.

The practice had conducted their own patient survey in 2014/15 and analysed the results. 100 surveys had been handed out and 97 of these had been returned. The analysis of responses received had highlighted waiting times for appointments as one of three identified priorities. We saw these priorities had been discussed with the practice's patient participation group (PPG) and were being monitored on an on-going basis. The practice had reviewed its provision of appointments on a regular basis and had recently adjusted the ratio of appointments that could be booked in advance to those released on the day for urgent same-day access. The practice manager said this was under continual review and would be monitored closely during the approaching holiday season, when demand for appointments could increase from temporary residents. This showed the practice had responded to feedback received and were attempting to improve access for their patients.

We looked at the practice's appointments system in real-time on the afternoon of the inspection. Routine appointments to see a nurse were available within seven days and to see a GP were available to be booked within five days. Urgent same-day appointments were released for patients to book each day. The practice offered telephone consultations with GPs too and these were available to be booked on the day.

The practice was open from 8.30am to 6.00pm Monday to Friday. In addition, an early evening surgery with pre-bookable GP appointments was held one day per week. The day of the week varied from one week to the next, depending on the GP who was running the surgery. The practice's extended opening hours one evening per week were particularly useful to patients with work commitments. This was confirmed by patients we spoke with who normally worked during the week. The branch surgery in Grasmere was open on Monday and Wednesday afternoons and a short surgery was held on Friday mornings. This helped to improve access for those patients who found it easier to attend the surgery in Grasmere.

Longer appointments were available for patients who needed them. This also included appointments with a GP or nurse. Home visits were made to those patients who were unable to attend the practice.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments online. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. A notice with

Good

Are services responsive to people's needs?

(for example, to feedback?)

this information was also displayed for patients on the main entrance door. The service for patients requiring urgent medical attention out-of-hours was provided by the 111 service and Cumbria Health on Call (CHoC).

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Information about services and how to complain was available and easy to understand.

We saw the practice had received eight complaints in the last 12 months and these had been investigated in line with their complaints procedure. Where mistakes had been made, it was noted the practice had apologised formally to patients and taken action to ensure they were not repeated. Complaints and lessons to be learned from them were discussed at staff meetings.

Staff we spoke with were aware of the practice's policy and knew how to respond in the event of a patient raising a complaint or concern with them directly.

None of the patients we spoke with on the day of the inspection said they had felt the need to complain or raise concerns with the practice before. In addition, none of the 43 CQC comment cards completed by patients indicated they had raised a complaint with the practice.

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's aims and objectives were to provide a caring, effective service which was safe and tailored to the needs of their practice population and temporary residents who visited the area. This was reflected in the practice's statement of purpose.

We spoke with a variety of practice staff including the practice manager, GPs, nurse practitioners and some of the practice's administrative and support staff. They all knew and shared the practice's aims and objectives and knew what their responsibilities were in relation to these. Staff regularly spoke of working towards the same aim – making sure their patients got the best treatment available whist maintaining their position in the community as a 'traditional doctors'. For example, GPs often visited patients they knew were unwell at home at weekends.

Governance Arrangements

The practice had policies and procedures in place to govern activity and these were available to staff within the staff handbook on the shared drive on any computer within the practice. We looked a sample of these policies and procedures and our discussions with staff demonstrated they had read and understood these. All of the policies and procedures we looked at had been reviewed regularly and were up to date.

The practice used the Quality and Outcomes Framework (QOF) as a means to measure its performance. The QOF data for this practice showed it was generally performing in line with national standards. We saw that QOF data was discussed at practice meetings and actions were taken to maintain or improve outcomes. For example, reminders were sent to patients if they failed to respond to the request to attend the practice for reviews of their long-term conditions.

The practice had completed a number of reviews or first cycles of clinical audits which it used to monitor quality and systems to identify where action should be taken. The initial reviews had confirmed good practice, however the number of patients identified as part of the reviews were relatively small. The audits had been through one audit cycle and required repeating in order to demonstrate how outcomes for patients had improved. One of the audits was due to be repeated in June 2015.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and actions to mitigate these risks had been put into place.

The practice held regular meetings for staff. These included daily meetings between the office manager and clinicians, weekly clinical meetings, weekly meetings of the practice manager and nursing staff and whole staff meetings at times when the surgery closed for 'protected learning time' (PLT). We looked at minutes from some of these meetings and found that performance, quality and risks had been discussed. Some of these meetings, for example the weekly clinical meetings, had not been formally minuted in the past; however arrangements had been made for this to be done moving forward.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. For example, the practice manager had recently taken on the lead role for infection control and a GP was the lead for safeguarding. We spoke with a range of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice manager was responsible for the application of the provider's human resource policies and procedures. We reviewed a number of policies, for example on the recruitment of staff, chaperoning and infection control, which were in place to support staff. We saw policies were available for all staff to access electronically. Staff we spoke with knew where to find the practice's policies if required.

We found there were good levels of staff satisfaction across the practice. Staff we spoke with were proud of the organisation as a place to work and spoke of the open and honest culture. There were good levels of staff engagement and there was a real sense of team working across all of the staff, both clinical and non-clinical. We saw from minutes that whole staff meetings were held. Staff told us they had the opportunity and were happy to raise issues at meetings.

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

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions on a daily basis. Staff we spoke with told us they attended staff

Are services well-led?

Good

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

meetings. They said these provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We saw the practice also used the meetings to share information about any changes or action they were taking to improve the service and they actively encouraged staff to discuss these points. Staff told us they felt involved in the practice to improve outcomes for both staff and patients. For example, one of the staff had suggested the practice could improve the recording of requests for private work (e.g. insurance reports) and this was being progressed. Changes to the duty doctor's responsibilities had also been suggested and implemented.

The staff we spoke with, including the practice manager and GPs told us forward planning was discussed. Refurbishment of the main surgery in Ambleside was on-going and succession planning for one or two staff members who were approaching retirement in the next few years had been considered. We saw plans were in place to develop and improve the services provided. For example, a member of the clinical team was being trained to be able to provide an increased range of services and the practice was planning to introduce text message alerts for patient recalls later this year. Staff said they felt listened to and their opinions were valued and contributed to shaping and improving the service.

The practice had a patient participation group (PPG). The PPG had seven or eight members from diverse backgrounds; however plans were in place to promote the group in order to increase the diversity further. Encouraging student participation from the local university campus had been identified as a priority. The PPG met bi-monthly and representatives from the practice always attended to support the group. We spoke with some members of the PPG and they felt the practice supported them fully with their work and took on board and reacted to any concerns they raised. The practice had made some changes as a result of feedback from the PPG. This included changes to the appointments system. Patient feedback from the practice's own patient survey was also routinely reviewed at group meetings, including any actions taken by the practice in response.

The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of the policy, how to access it and said they wouldn't hesitate to raise any concerns they had. Staff said significant events were handled within a blame-free culture, which helped to create a culture of dealing positively with circumstances when things went wrong.

Management lead through learning & improvement

The senior GP partner had undertaken to lead a 2 year pilot of 'Mindfulness' training in the local area, funded by Public Health England. The project aimed to train both patients and local teachers to deliver Mindfulness sessions across the local area, so helping to address high levels of anxiety and mental health issues. Although still at an early stage, this project will directly influence the management of mental health issues in the practice and represents an example of outstanding commitment to support both practice patients with mental health issues and the locality as a whole.

Staff said that the practice supported them to maintain their clinical professional development through training and mentoring. We saw that appraisals took place which included a personal development plan. Staff told us that the practice was supportive of training and development opportunities.

The practice had completed reviews of significant events and other incidents and shared these with staff via meetings. These events were discussed, with actions taken to reduce the risk of them happening again.

The practice manager met with other practice managers in the area and shared learning and experiences from these meetings with colleagues. GPs met with colleagues at locality and clinical commissioning group (CCG) meetings. They attended learning events and shared information from these with the other GPs in the practice.

Information and learning was shared verbally between staff. The practice's schedule of meetings was used to facilitate the flow of information, including meetings of administrative staff, clinical staff and whole staff team meetings. Learning needs were identified through the appraisal process and staff were supported with their development. For example, one of the administrative staff had asked for and been trained in phlebotomy.

Are services well-led?

Good

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

Improvements and achievements were recognised and celebrated with staff. The practice manager said the GPs had funded two outings during the year for the whole staff team in order to show their appreciation for the work the staff did on a daily basis. Staff we spoke with reflected on this positively and it was clear these gestures were appreciated and well received.