Wigton Group Medical Practice

Quality Report

Wigton Group Medical Practice,
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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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Good ●
Are services well-led?	Outstanding ☆

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a planned comprehensive inspection of Wigton Group Medical Practice on 4 November 2014.

We rated the practice overall as outstanding.

Our key findings were as follows:

- The practice covered a semi-rural area; services had been designed to meet the needs of the local population.
- The practice had a strong focus on safety, putting patient need first and learning from incidents. There was evidence of a strong track record of safety over the long term.
- The practice was visibly clean and tidy and arrangements were in place to periodically review and improve the approach to infection control.
- Data showed the practice was performing highly when compared to England and local Clinical Commissioning Group (CCG) averages across a number of areas.
- Feedback from patients about their care and treatment was consistently and strongly positive.
- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. There was strong leadership and strategic vision within the practice.

We saw several areas of outstanding practice including:

- The leadership, governance and culture within the practice were used to drive and improve the delivery of high-quality person-centred care.
- The practice had developed approaches to improve the rate of patients taking up flu vaccinations and bowel cancer screening. This had led the practice to achieve higher rates when compared to national averages.
- The practice worked actively with a partner organisation, West Cumbria Carers, to ensure they met the needs of patients with caring responsibilities.
- The practice recognised that to provide good quality care to patients, it also needed to look after its staff. We saw evidence of this in a number of areas including the process for reviewing significant events, governance and the induction processes for GPs new to the practice.

Summary of findings

- The practice demonstrated a strong commitment to seeking and listening to patient views. Throughout the inspection they demonstrated how patient views had influenced improvements in patient care and service. They showed us a range of evidence (such as case studies, patient feedback and complaints) they had used to focus improvements on the needs and wishes of patients. This included celebrating what had gone well as well as identifying areas for improvement.
- The practice performed well against a number of key indicators, such as the low rate of emergency cancer admissions.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. The practice had a strong focus on safety, putting patient need first and learning from incidents. There was evidence of a strong track record of safety over the long term. There was evidence where incidents did take place the practice used these as learning opportunities to improve patient safety. This was approached in a constructive way that supported staff to learn, rather than apportioning blame. Information about safety was highly valued and was used to promote learning and improvement. The practice had systems in place to manage and review risks to vulnerable children, young people and adults. The practice had systems in place to safely manage medicines. The practice was visibly clean and tidy and arrangements were in place to periodically review and improve the approach to infection control. There were enough staff to keep people safe.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. Our findings showed that systems were in place to ensure all clinicians were up to date with available national and local guidance. We also saw evidence to confirm guidelines were positively influencing and improving practise and outcomes for patients. Data showed the practice was performing highly when compared to practices in the same Clinical Commissioning Group (CCG) and England averages. The practice was using proactive methods to improve patient outcomes. The practice was using clinical audits and other audits to improve patient care. The rates of patients who had received flu vaccinations were consistently high and the practice had taken a proactive approach to encouraging patients to undertake routine screening for bowel cancer. The practice had in place an effective induction process for new and salaried GPs. Staff from a number of local stakeholder community health and care organisations spoke highly of the professional and multi-disciplinary approach the practice took in meeting the needs of patients.

Are services caring?

Outstanding

The practice is rated as outstanding for caring services. Data showed patients rated the practice higher than others for a number of aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer

Summary of findings

kind and compassionate care and worked to overcome obstacles to achieving this. Views of external stakeholder were very positive and aligned with our findings. The practice was proactively identifying and referring patients with caring responsibilities, and working in partnership with West Cumbria Carers to meet the needs of carers. There were robust approaches to supporting patients at the end of their life. An audit carried out by the practice demonstrated the effectiveness of the practices approach to supporting patients in making choices about palliative care.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. We found the practice was responsive to patient need and had sustainable systems in place to maintain the level of service provided. The practice tracked and adjusted the number of available appointments to ensure sufficient capacity to meet the needs of the local population. The practice had reviewed its approach following incidents to ensure they were able to respond to medical emergencies. The practice had defined pathways for patients with vascular long term conditions to ensure they got the right care at the right time. Patients told us it was easy to get an appointment, with continuity of care and urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding

The practice is rated as outstanding for being well-led. The practice had a clear vision to deliver high quality care and promote good outcomes for patients. There was strong leadership and strategic vision within the practice. The practice had a strong focus on improvement and learning was shared by all staff. There was a clear and defined approach to leadership, with each GP identified as leads for areas of practice. There was a well-established GP buddy system to ensure continuity of care and clear accountabilities. The practice had systems in place to monitor and improve quality. High standards were promoted and owned by all staff and teams worked together across all roles. The practice had invited a number of key stakeholders to speak with us during the inspection. All spoke highly of the practice and how well the interfaces worked between the practice and their organisation. This demonstrated the practice had an open approach and recognised the value other organisations could provide into quality improvement. The practice carried out proactive succession planning.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as outstanding for the care of older people. There were aspects of the practice which were outstanding and this related to all population groups. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. The practice was proactively identifying and referring patients with caring responsibilities, and working in partnership with West Cumbria Carers to meet the needs of carers. There were robust approaches to supporting patients at the end of their life. An audit carried out by the practice demonstrated the effectiveness of the practices approach to supporting patients in making choices about palliative care.

There were care plans in place for the frailest older patients. The practice was responsive to the needs of older people, including offering home visits for the most old and frail patients. There were good communication mechanisms with other providers of care and treatment for frail older patients, including communication with district nurses.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of patients with long term conditions. There were aspects of the practice which were outstanding and this related to all population groups. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named clinician and a structured annual review to check that their health and medication needs were being met. For those patients with the most complex needs, the practice worked with relevant health and care professionals to deliver a multidisciplinary package.

The practice had defined pathways for patients with vascular long term conditions to ensure they got the right care at the right time. The practice had high rates of flu vaccination for patients under the age of 65 who were most at risk. This was higher than national and local averages.

Families, children and young people

Outstanding ☆

The practice is rated as outstanding for the care of families, children and young people. There were aspects of the practice which were outstanding and this related to all population groups. There were

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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 accident and emergency attendances.

Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside school hours and the premises were suitable for children and babies. Staff gave us good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

The practice took steps to increase access to sexual health, advice and support by attending a local youth festival.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding for the care of working age people (including those recently retired and students). There were aspects of the practice which were outstanding and this related to all population groups. The needs of the working age, recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering a full range of health promotion and screening, which reflected the needs of this age group.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the population group of people whose circumstances may make them vulnerable. There were aspects of the practice which were outstanding and this related to all population groups. The practice held a register of patients who may be more vulnerable, such as people with learning disabilities. The practice had carried out annual health checks and offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. 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 and out of hours.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding for the population group of people experiencing poor mental health (including people with dementia). There were aspects of the practice which were

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outstanding and this related to all population groups. The practice held a register for those patients experiencing poor mental health and was reviewing the health needs of these patients on a regular basis. Data about the practice in the Quality and Outcomes Framework (QOF) demonstrated that 91.7% of people with physical or mental health conditions had received an offer of support and treatment within the last 15 months. 88.0% of patients with dementia had their care reviewed within the preceding 15 months. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

Summary of findings

What people who use the service say

We spoke with two members of the Patient Participation Group (PPG) in advance of the inspection, and another member on the day. We also spoke with eight other patients on the day of the inspection. They all gave very positive feedback about the practice overall.

The patients we spoke with reported they would recommend the practice to family and friends and they thought it was well run. They also told us they felt safe and had no concerns when using the practice. Patients told us that the practice was kept clean and tidy, and that staff were very friendly. They also said they felt listened to and were supported to understand the assessment and treatment options available to them. They spoke of not feeling rushed when in an appointment with clinical staff and that staff treated them with dignity and respect.

They told us that access to the service was very good, and they could normally get an appointment in a reasonable timescale and on the same day in the case of an emergency.

We reviewed 39 CQC comment cards completed by patients prior to the inspection. All were complimentary about the practice, staff who worked there and the quality of service and care provided. Phrases used to describe the service included five star, excellent, dedicated to quality of care, first class, entirely satisfied and good in every way. Two patients commented that it could sometimes be difficult to see a doctor of choice, but both also said they were very satisfied with the practice, with one calling it fabulous and the other saying it was very good.

A number of patients also commented positively on the cleanliness of the practice.

The latest GP Patient Survey completed in 2013/14 showed the majority of patients were satisfied with the services the practice offered.

- Overall experience of their GP surgery rated as fairly good or very good - 94%
- Would probably or definitely recommend the surgery to someone new to the area – 90%
- GP good or very good at involving them in decisions about care - 79%
- The GP was good or very good at treating them with care and concern – 89%.
- The nurse was good or very good at treating them with care and concern- 88%

These results are based on 119 surveys that were returned from a total of 253 sent out; a response rate of 47%.

Outstanding practice

- The leadership, governance and culture within the practice were used to drive and improve the delivery of high-quality person-centred care.
- The practice had developed approaches to improve the rate of patients taking up flu vaccinations and bowel cancer screening. This had led the practice to achieve higher rates when compared to national averages.
- The practice worked actively with a partner organisation, West Cumbria Carers, to ensure they met the needs of patients with caring responsibilities.
- The practice recognised that to provide good quality care to patients, it also needed to look after its staff. We saw evidence of this in a number of areas including the process for reviewing significant events, governance and the induction processes for GPs new to the practice.
- The practice demonstrated a strong commitment to seeking and listening to patient views. Throughout the inspection they demonstrated how patient views had influenced improvements in patient care and service. They showed us a range of evidence (such as case studies, patient feedback and complaints) they had used to focus improvements on the needs and wishes of patients. This included celebrating what had gone well as well as identifying areas for improvement.

Summary of findings

- The practice performed well against a number of key indicators, such as the low rate of emergency cancer admissions.

Wigton Group Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector. The team included a GP and a specialist adviser with a background in practice management.

Background to Wigton Group Medical Practice

The Wigton Group Medical Practice covers a semi-rural area and is based in the market town of Wigton. It is the only GP practice in the town. The practice building is also used by other healthcare providers for the delivery of community services, such as district nurses and midwives.

All patient services are delivered from the ground floor. There are good access facilities for patients with disabilities.

The practice provides primary medical care services to patients in the Solway plain within the borders of Anthorn and Thurstonfield to the North, Thursby and Rosley to the East, Ireby and Bothel to the South and Abbeytown to the West. It is based 12 miles from the nearest accident and emergency department.

The practice provides services to approximately 8,000 patients of all ages. The practice is commissioned to provide services within a General Medical Services contract with NHS England.

The provider is a partnership of six doctors. There are also two salaried GPs, a foundation year 2 (F2) doctor, a lead nurse, two practice nurses, three health care assistants, a practice manager, a medicines manager, 12 reception and administration staff and three cleaners. The practice is a teaching practice.

The service for patients requiring urgent medical attention out of hours is provided by Cumbria Health on Call Ltd (CHOC).

Why we carried out this inspection

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

How we carried out this inspection

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

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

Detailed findings

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included the local Clinical Commissioning Group (CCG) and the NHS England Area Team. We spoke with three members of the practice's Patient Participation Group (PPG).

We carried out an announced visit on 4 November 2014. During our visit we spoke with a range of staff. These included GPs, Practice Nurses, Healthcare Assistant, Reception and Administrative staff. We also spoke with eight patients who used the service. We reviewed 39 CQC comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, they used reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. We saw the practice had improved processes as a result of incidents, and the practice discussed a number of anonymised case studies with us to demonstrate their focus on safety, putting patient need first and learning from incidents.

We reviewed safety records and incident reports, and the minutes of meetings where these had been discussed, for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred over the last 12 months and we were able to review a number of these. The practice told us that 16 significant events had taken place within the last 12 months. We saw that regular meetings were held to discuss significant events and complaints. There was evidence that there was a practice wide approach to identify and support each other in learning from these in a constructive way. There was evidence that where learning was identified, this was shared with relevant staff.

The practice had appropriately notified us of a death on the premises within the last year. We saw the practice had reviewed the action, processes and arrangements in place to deal with an emergency of this type, to identify and share learning following this incident. They sent a copy of the subsequent report to both CQC and the NHS England Local Area Team following the incident.

We found evidence that where significant events were identified, the practice had a focus on identifying how patient safety could be improved rather than apportioning blame. This led to a more open and constructively challenging approach to incidents. For example, the practice told us about the action they took following events where patients had presented at the practice in medical emergencies. We saw in the significant event analysis the practice had identified what went well, as well as what they had learnt as a result of the incident. Staff told us how they supported each other emotionally following these events to help cope with the trauma of being present through a medical emergency. We found the practice had robust processes for disseminating the learning to all staff and confirmed this by speaking with staff, who told us about the incidents and the learning that had been identified and implemented. Staff spoke of the team working well together during these incidents and how well supported they felt.

National patient safety alerts were disseminated by email to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. We spoke with the medicines manager about this process. They showed us the process they followed when a patient safety alert was received. They showed us an example of a report that had been received that day and the action they had taken to minimise risk to patients. We found the practice had in place thorough process for identifying and disseminating patient safety alerts.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults.

The practice had recently changed its approach to monitoring the risks for these patients. Previously information shared within multidisciplinary meetings was recorded within meeting notes. The practice had identified that this did not allow a chronological record to be kept to show the changing level of needs and risks. Therefore they had implemented patient specific concerns register, which allowed them to more easily access and review the level of risks for these patients. The records for children and adults were easily distinguished between as different colours were used for each. There were also high level notes recorded for those patients identified as at risk within the electronic clinical records.

The practice manager told us that the GP who led on safeguarding for the practice took an active role in monitoring the needs of those at risk.

Good

Are services safe?

We saw evidence that staff had received relevant training on safeguarding contained within staff files. Staff knew their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible on a shared drive.

The GP lead in safeguarding had completed level three training and the expectation was that all GPs would undertake level three training on a three yearly cycle.

A chaperone policy was in place and we saw this service was advertised in the practice waiting room area. Only healthcare assistants or practice nurses were asked to act as chaperones for patients. The clinical staff we spoke with understood their responsibilities when acting as chaperones. Clinicians documented that a chaperone had been offered and either accepted (with name of chaperone) or declined by the patient, in the patient record.

Medicines management

We found there were medicines management policies in place and staff we spoke with were familiar with them. We saw that medicines for use in the practice were stored securely, with access restricted to those that needed it. Records were kept whenever any medicines were used.

Medicines were regularly checked to ensure that they were in date and remained safe to use. This included medicines kept by the GPs in their emergency bags. The Healthcare Assistants carried out regular checks of the bags and medication expiry dates.

We saw fridge temperatures where medicines were stored were checked daily to ensure the medicines were stored in line with manufacturer's guidance. Records of these checked were maintained. We checked a sample of medicines stored in the fridge in the treatment and minor surgery rooms and found they were all in date.

The practice held emergency medicines on site, including those for the treatment of anaphylactic shock and injectable antibiotics. We saw regular checks had been carried out to ensure these drugs remained in date and were safe to use.

When changes had been requested to a prescription for medication for patients by other health professionals, such as NHS consultants and / or following hospital discharge, the surgery had a system for ensuring these changes were carried out in a timely manner. The request was seen by either the patient's GP or their buddy, who then identified any actions to be taken. This was logged on the practice computer system.

Cleanliness and infection control

We saw the practice was visibly clean and tidy. There was a daily and weekly cleaning schedule with other less frequent tasks also identified. Patients we spoke with told us they were happy with the cleanliness of the facilities. Comments from patients who completed CQC comment cards reflected this. The practice had a range of policies and procedures relating to infection control.

The practice had identified that the chairs used previously in the treatment and minor surgery rooms were not easy to wash and keep clean as they had fabric seats and backing. They had therefore replaced these with ones that could be wiped down.

Staff used single use instruments to reduce the risk of the spread of infections. We saw that personal protective equipment, such as gloves and aprons were available in clinical areas. Cleaning kits for dealing with spillage of bodily fluids were available in the reception area. There were also sufficient supplies of hand sanitising gel and hand soaps available in clinical areas and toilet facilities.

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles. There were also contracts in place for the collection of both general and clinical waste. There were sharps disposal boxes in all the clinical areas of the practice. It was noted that not all of the sharps boxes within the practices had been dated or signed on commencing use. It is best practice that sharps boxes are signed on commencing and collection to provide an audit trail.

The practice had completed an audit of infection control procedures provided by the Cumbria Clinical Commissioning Group in April 2014. This related to minor procedures and minimal access interventions carried out in primary care. As a result actions were identified to have documented yearly hand hygiene training for staff and to implement a minor procedures checklist for patients. The practice was still in the process of implementing these.

We saw the most recent legionella risk assessment carried out in March 2014 and that the practice had processes in place to monitor and reduce the risk of infection by waterborne legionella.

Good

Are services safe?

Equipment

The practice had a range of equipment in place that was appropriate to the service. We saw regular checks took place to ensure it was in working condition. We saw that where required, equipment was calibrated (adjusted for accuracy) in line with manufacturer's guidelines.

Staffing and recruitment

We saw the practice had recruitment policies in place that outlined the process for appointing staff. These included processes to follow before and after a member of staff was appointed. For example, applicants would be invited to attend an interview and satisfactory references would be sought prior to a firm job offer and start date being agreed.

We reviewed the records for a number of staff and found the appropriate checks had been completed. The practice undertook Disclosure and Barring Service (DBS) checks for all clinical staff members. The practice had a policy in place for employment of offenders and disclosure and barring service. This set out the risk assessment to be undertaken for each role to determine whether a staff member would be subject to a standard or enhanced DBS check prior to the offer of employment.

The practice employed sufficient numbers of suitably qualified, skilled and experienced staff for the purposes of carrying on the regulated activities. There were arrangements in place to ensure cover for staff absences. Each GP worked in a buddy group to cover work in case of absence. As well as ensuring there was sufficient cover for clinical sessions and other work, this also helped achieve continuity of care. They were able to familiarise themselves with patients with complex healthcare needs on each other's patient list.

Monitoring safety and responding to risk

Feedback from patients we spoke with and those who completed CQC comment cards indicated they would always be seen by a clinician on the day if their need was urgent.

Appropriate staffing levels and skill-mix were provided by the practice during the hours the service was open. The practice regularly monitored the number of extra urgent appointments used to ensure that staffing levels were sufficient to meet demands.

We found that the practice ensured that the clinical staff received annual cardiopulmonary resuscitation (CPR) training and training associated with the treatment of anaphylaxis. Staff trained to use the defibrillator received regular update training to ensure they remained competent in its use.

Staff had access to a defibrillator for use in a medical emergency. All of the staff we spoke with knew how to react in urgent or emergency situations. We also found the practice had a supply of medicines for use in the event of an emergency.

The practice had conducted relevant health and safety risk assessments. For example, this included an assessment of risk within the physical environment of the practice. Risk assessments of this type made sure the practice was aware of any potential risks to patients, staff and visitors and planned mitigating action to reduce the probability of harm.

Arrangements to deal with emergencies and major incidents

The practice had emergency response plans in place. These identified the action to take during disruption due to unforeseen changes in staffing levels or loss of essential supplies or facilities. We saw that arrangements were in place to ensure this could be accessed by staff if they were unable to gain entry to the building. The practice manager told us they were in the process of making arrangements for the emergency box to be stored at the local community hospital. This box contained important documents and forms essential to delivering services in an emergency. This would enable staff to access this in an emergency or major incident where they cannot access the practice premises.

We saw there was equipment for dealing with medical emergencies available within the practice, including emergency medicines, oxygen and a defibrillator. There were appropriate arrangements in place to ensure that staff knew what to do in the event of a fire in the practice.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. All clinical staff we spoke with were able to describe and demonstrate how they accessed both guidelines from the National Institute for Health and Care Excellence (NICE) and from the local health commissioners.

Data showed patient outcomes were at or above average for the local area. NICE guidance was referenced and used routinely. Patient's needs were assessed and care was considered in line with current legislation. We saw meeting presentation notes where new guidelines were disseminated and the implications for the practice's performance and patient care were discussed. All GPs we spoke with were aware of their professional responsibility to update and maintain their knowledge.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. We saw several examples of completed clinical audits over the last few years. For example these included an audit of referrals for ear, nose and throat consultations; audit of place of death for those patients on end of life pathways; and, audit of minor surgical procedures. These were completed clinical audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, the practice had demonstrated improvement in the reduced prescribing rates of benzodiazepine medicines.

Doctors undertook minor surgical procedures in line with their registration and NICE guidance. Clinical audits were undertaken on their results and the audits were used as a learning tool.

We reviewed a range of data available to us prior to the inspection relating to health outcomes for patients. This demonstrated that the practice was performing the same as, or better than, average when compared to other practices in England. There were no areas of risk identified from available data.

Older patients and those identified as most at risk were offered pneumococcal and flu vaccination to help them stay healthy and well. The practice monitored the number of people who attended the practice to receive flu vaccinations and were proactive in encouraging take up by patients. The practice had implemented a project to increase the uptake of flu vaccinations by patients. This had involved staff across the practice, including clinical and reception staff, working together to identify those who were eligible to receive flu jabs and administering them. Eligible patients were invited in for a flu jab. Where patients did not attend, they were contacted three times to encourage uptake. Data from the Health and Social Care Information Centre supported the success of this approach for the practice. In 2013/14, 83.5% of the practice population over the age of 65 were vaccinated, compared to 73.2% nationally. For those under the age of 65 considered to be most at risk, 80.7% of patients had been vaccinated compared to the national average of 52.3% nationally. The practice told us that the process they had in place for contacting and following up with these patients had helped them achieve this rate, as well as staff working together as a team.

Similarly the practice had a proactive approach to encourage patients to take part in the NHS Bowel Cancer Screening Programme. Where a patient did not respond the practice followed this up with the patient. They told us this had helped them achieve a 70% screening rate for eligible patients. Overall the emergency cancer admissions per 100 patients on the disease register was low at 4.5% compared to a national average of 11.3%.

We looked at the most recent results from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. This demonstrated that 91.7% of people with physical or mental health conditions had received an offer of support and treatment within the last 15 months. 88.0% of patients with dementia had their care reviewed within the preceding 15 months. Also that 100% of patients with atrial fibrillation were treated with anti-coagulation drug therapy or an antiplatelet therapy.

The QOF data also demonstrated that the processes for monitoring the health needs of patients with diabetes were good. The percentage who had their cholesterol levels checked within the preceding 15 months was 81.7% compared to a national average of 81.2%. The percentage who had a foot examination was 94.9% compared to a national average of 90.4% and the rate of influenza immunisation for these patients was 92.9% compared to a national average of 90.0%.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The practice had processes in place that covered child health and family support. This included a programme of health and development reviews. These were to allow them to assess growth and development of young children, identify risk factors and opportunities for improving health. It also gave parents the opportunity to routinely discuss any concerns they had about their children. This routinely ran from an initial neo-natal examination within the first 72 hours of birth through to vaccinations up to the age of 18 years.

The practice had systems in place to identify patients, families and children who were most at risk or vulnerable. For example, practice staff told us that they had a register of patients who had a learning disability and also those with poor mental health. They also told us that annual health checks were carried out for patients on these registers. QOF data demonstrated that registers were in place and that patients were having their health needs assessed on a regular basis.

The practice delivered an ophthalmology service as part of a GP with Special Interest (GPSI) contract with the local Clinical Commissioning Group (CCG). This included delivery of two clinics a week to meet the eye health needs of the local community. The clinics provided medical and surgical treatments of many common ophthalmology problems including glaucoma in patients aged 16 and over. These were led by a partner GP who had a background in ophthalmology.

Effective staffing

Staff employed to work within the practice were appropriately qualified and competent to carry out their roles safely and effectively. This included the clinical and non-clinical staff.

We reviewed staff training records for a selection of staff, and we saw that they had attended mandatory training, such as annual basic life support. Staff had their training needs assessed and were supported to update their skills and knowledge, The staff we spoke with confirmed this.

GPs were up to date with their yearly continuing professional development requirements and all either had been through the revalidation process or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed can the GP continue to practice and remain on the performers list.)

The practice had processes in place for managing the performance of staff. The practice manager told us they used team and one-to-one meetings to discuss these matters where appropriate. We found that there were clear mechanisms for communicating with staff and between different staff groups to ensure that all staff remained up to date with changes made as a result of identified learning.

We spoke with a salaried and locum GP about their experiences when joining the practice. They told us that there was a comprehensive induction process. They told us that all GPs were supported though this induction period, even if they were an experienced GP. This focussed on the things that GPs would need to know whilst working in Wigton Group Medical Practice, including, for example, the practice specific processes for referring patients onto other services. They told us this helped them, as GPs new to the practice, to be effective in the practices processes quickly.

Working with colleagues and other services

The practice arranged for us to speak with a number of key partners and stakeholders in patient care during the inspection. This included a manager from the local rehabilitation service, a local residential care home manager, a manager from the local community nursing team and the linked staff member from a local carers' organisation. They all spoke highly of the way the practice worked with them to ensure patients received the right care at the right time. They told us they worked together as partners to support patients in their health and wellbeing.

These stakeholders told us they felt the practice respected their professional input into patient care. For example, the manager from the rehabilitation service told us that GPs would often ask for the opinion of staff from the rehabilitation centre to see if a patient would benefit from their support or the best approach to support patients after hospital discharge. They told us that as some of the GPs also worked in the Community Hospital; this helped to improve communication and understanding of patient needs.

We saw evidence the practice staff worked with other services and professionals to meet patients' needs and manage complex cases. There were regular monthly meetings with the multi-disciplinary team within the local area. This usually included district nurses, Macmillan

Are services effective?

(for example, treatment is effective)

Nurses and health visitors. There were also regular meetings with the community mental health team, child and adolescent mental health team and old age psychiatry team.

There were also regular informal discussions with these staff. These meetings were important as they helped to share important information about patients, including those who were most vulnerable and high risk.

There was a range of community health services located at the practice provided by other organisations. This included District Nurses, Health Visitors, Podiatry, Improving Access to Psychological Therapies (IAPT) counselling, Child and Adolescent Mental Health Services (CAMHS), Speech Therapy and Childrens' Audiology. Staff told us that being in the same building helped the communication between different organisations.

Staff told us that all test results were first seen by a GP. All test results went directly to the requesting doctor's electronic mailbox. Necessary actions from these were identified and carried out. Patient letters from consultants and other specialists were administratively coded, and then scanned onto the clinical record and sent to the patient's usual GP. They reviewed the correspondence and were responsible for any action required. They recorded the action required, made changes and updates to medicines and where appropriate arranged for the patient to be contacted and seen by a clinician. In the usual GP's absence, the GP's buddy would be responsible for this.

Information sharing

The practice had systems in place for recording information from other health care providers. This included out of hours services and secondary care providers, such as hospitals.

We spoke with clinical staff about how information was shared with the out of hours services in the local area, Cumbria Health on Call ltd (CHOC). Staff told us that patient information received from the out of hours service was of good quality and received on time in the morning. The practice manager confirmed that all information from the out of hours provider was attached to the electronic clinical patient notes and directed to the patient's usual GP to review. The GP then identified any action needed, such as patient follow up or review. Staff told us this happened on the same day the information was received. The buddy system in place ensured where a GP was on leave a buddy GP was identified to ensure that all correspondence was reviewed and acted upon.

Consent to care and treatment

We found before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. We asked staff how they ensured they obtained patients' consent to treatment. Staff were all able to give examples of how they obtained verbal or implied consent. Staff told us that when patients underwent minor surgery, written consent was obtained before the procedure took place and this was recorded in the patients' notes.

The GP we spoke with showed they were knowledgeable of Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Decisions about or on behalf of people who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the Mental Capacity Act 2005 (MCA). We found the doctors were aware of the MCA and used it appropriately. The doctors described the procedures they would follow where people lacked capacity to make an informed decision about their treatment. The doctors told us an assessment of the person's capacity would be carried out first. If the person was assessed as lacking capacity then a "best interest" discussion needed to be held. They knew these discussions needed to include people who knew and understood the patient, or had legal powers to act on their behalf.

Health promotion and prevention

The practice offered all new patients a consultation to assess their past medical and social histories, care needs and assessment of risk. These were completed by the GP or nursing staff employed by the practice. We found patients with long term conditions were recalled at regular intervals, to check on their health and review their medications for effectiveness. Processes were also in place to ensure that regular screening of patients was completed, for example, cervical screening.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

We saw a number of leaflets were displayed in the waiting room for patients to access. This included information about common conditions and their symptoms, promotion of healthy lifestyles and prevention of ill health.

Practice staff had attended a festival (Something for the Summer) organised by a local community youth group in 2013. They had attended this together with staff from the local sexual health genito-urinary medicine team. Practice staff attended to give young people access to sexual health information, advice and support. This demonstrated the practice engaged with their local community.

There were regular presentations delivered to the Practice Participation Group (PPG) about things that were important to patients, such as support available locally for carers and information and advice about common health conditions.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

All the patients we spoke with said they were treated with respect and dignity by the practice staff. Comments left by patients on CQC comment cards we received reflected this. We received 39 completed comment cards all of which were very positive about the practice as a whole. Patients spoke highly of the practice, reception staff, the practice nurse team and GPs. None of the CQC comment cards completed raised any concerns about the practices approach to respect, dignity, compassion and empathy.

We observed staff who worked in reception and other staff as they received and interacted with patients. Their approach was seen to be considerate, understanding and caring, while remaining respectful and professional.

We saw that the reception desk was separate to the waiting room area. This allowed patients to speak with reception staff in confidence. We saw staff who worked in these areas made every effort to maintain people's privacy and confidentiality. We saw voices were lowered and personal information was only discussed when absolutely necessary. In data from the National Patient Survey 87% were satisfied with the level of privacy when speaking to receptionists at the surgery. Within this 38.9% reported they could not be overheard in the reception area, compared with an England average of 9.3%.

We reviewed the most recent data available for the practice overall on patient satisfaction from the national patient survey. This demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. 94% described their overall experience of the practice as good. 91.3% of patients who responded would recommend the surgery. This compared with a local CCG average of 84.1% and an England average of 79.9%. The patients we spoke with also confirmed they would be happy to recommend the practice to family and friends.

Results on the NHS patient survey were all similar or better than expected when compared with other practices.

People's 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. A private room or area was also made available when people wanted to talk in confidence with the reception staff.

Staff told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy curtains were provided in the treatment room so that patients' privacy was maintained during investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff were aware of the need to keep records secure. We saw patient records were mainly computerised and systems were in place to keep them safe in line with data protection legislation.

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.

Care planning and involvement in decisions about care and treatment

Patients told us they felt they had been involved in decisions about their care and treatment. They said the clinical staff gave them plenty of time to ask questions and responded in a way they could understand. They were satisfied with the level of information they had been given. Information provided by patients who filled in CQC comment cards reflected this. The staff we spoke with said consent to treatment was always sought and documented within the patients' records.

The results of the national GP survey from July 2014 showed 79% of patients surveyed rated the question 'Rating of GP involving you in decisions about your care' as good or very good. This was slightly lower than the average for the local clinical commissioning group (CCG) area. However, 95% said the last GP they saw or spoke to was good at listening to them and 92% said the last GP they saw or spoke to was good at explaining tests and treatments. These were both better than the local CCG area average.

Patient/carer support to cope emotionally with care and treatment

The practice worked in partnership with a local carers support organisation, West Cumbria Carers. The practice arranged for us to speak with a worker from West Cumbria Carers. They told us that the practice was active in supporting the identification of carers and referring them onto support through West Cumbria Carers. They said the

Are services caring?

practice supported them to deliver a carers clinic on a weekly basis within the practice premises. This included administrative arrangements to support the clinic, including appointment booking. They told us that referrals to the service came from a number of sources across the practice, including reception staff, practice nurses and GPs. Patients were also able to self-refer for this service.

The worker from West Cumbria Carers told us they felt the practice was immensely supportive of the role that West Cumbria Carers had and was supportive of the needs of carers overall. Patients were able to continue to access this service for a period after their carer role ceased. This helped support carers with practical considerations, such as finances and benefits, but also the emotional impact, such as coping with grief or loss of identity/role. By working in partnership, patients of the practice could access the services and support provided by West Cumbria Carers. In addition the practice was able to identify where patients had caring responsibilities and build a carers register, so they could plan for and meet the needs of patients on this register.

Support was provided to patients during times of bereavement. There was evidence of sharing information for those patients who were reaching the end of their life with other healthcare professionals. Support was tailored to the needs of individuals, with consideration given to their preferences at all times. Staff we spoke with in the practice recognised the importance of being sensitive to people's wishes at these times. We saw that there was a range of leaflets and information available in the waiting area relating to bereavement and end of life services, such as hospices. These directed patients to support agencies and others sources of advice and support.

The practice had considered the arrangements in place to support people at the end of their lives. The practice had audited its approach to palliative care, and in particular places of death. This looked at the approach to advance care planning, advanced decision to refuse treatment, emergency health care plans and resuscitation decisions on a patients' place of death. The practice compared the audit numbers from 2012/13 to a re-audit in 2013/14 and found that the number of patients on end of life pathways dying at home had increased from 30.4% to 41.6%. The practice planned to carry out a follow up audit in 2014/15 to continue to monitor this aspect of care.

We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and support groups.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had sustainable systems in place to maintain the level of service provided.

As part of our pre-inspection preparation we looked at the latest demographic population data available for the practice overall from Public Health England, published in 2013. The practice population was largely an aging population, with higher numbers of patients over the age of 40 than average. The average male life expectancy was 79.26 years and female life expectancy 81.22 years. There was a lower than average percentage of patients with a long-standing health condition (47.2%) and percentage of patients with health-related problems in daily Life (45.7%). There was also a slightly lower than average number of patients reporting caring responsibilities (16.7%).

The practice had a robust system for monitoring patient needs for appointments. They tracked the number of appointments used over and above the planned levels, which they called red extras, to ensure there was on-going sufficient capacity to meet need. They adjusted the number of appointments to meet patient need.

The practice was in a semi-rural location and access to other healthcare provision, such as A&E department were some miles from the practice. The practice have had a number of emergency situations where patients have presented at the practice requiring immediate emergency treatment. We saw evidence the practice had reviewed its approach and actions following each of these events to learn from and ensure appropriate arrangements were in place for any future similar emergencies.

We found that the practice understood the needs of the practice population and systems were in place to address identified need.

The practice worked collaboratively with other agencies, regularly sharing information (such as special patient notes) to ensure good, timely communication of changes in care and treatment.

The practice had defined patient pathways for vascular long term conditions, which recognised the likelihood that patients could develop other related long term conditions. This included a series of tiered clinics for patients with vascular conditions. For example, patients were referred to an appropriate clinic when first diagnosed with one long term condition, for example a blood pressure monitoring clinic. If they developed another long term condition, such as diabetes they would be referred to the next level of clinic, which could support them with both conditions.

Tackling inequity and promoting equality

The practice had recognised the needs of the different groups in the planning of its services.

The practice had made arrangements so that people with physical disabilities were able to access the service. All treatment and consultation rooms were based on the ground floor. There was a bell at the front door for patients to ring and a sign telling patients to ring it if they needed assistance to access the building. We saw there were low level buttons on the walls at the entrance to the practice, when pressed the doors would open automatically. There was ample parking near to the surgery, including designated spaces for people with disabilities. The consulting rooms were large with easy access for all patients. There were also toilets accessible to disabled patients. There was a large waiting room with plenty of seating.

We asked staff how they made sure patients who spoke a different language were kept informed about their treatment. Staff told us only a small minority of patients did not speak English as their first language. There were arrangements in place to access interpretation services.

The practice had access to large print information for patients who were visually impaired, and gave us examples of how they had met the needs of visually impaired patients. The practice had a hearing loop available for those with a hearing impairment.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Access to the service

Patients could make appointments by calling into the practice or requesting an appointment over the telephone. The practice website outlined how patients could book appointments and organise repeat prescriptions. Patients were able to organise repeat prescriptions via telephone, in the surgery or on-line.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had appointments available between 8:30am to 5:40pm on most weekdays. There were also two early morning surgeries on Tuesday and Friday from 7:45. This allowed people who worked, were at school during the day or were unable to get to the practice a choice of when they wanted to see the GP.

All patients who needed to be seen urgently were offered same-day appointments and there was an effective triage system in place. Staff told us that double appointments could be booked for those who requested them. They told us where patients were identified as needing more flexibility with appointments, such as always having double appointments booked; this was noted on their medical records so staff could make suitable arrangements when an appointment was requested.

The latest NHS GP survey results demonstrated that patients were satisfied with access to appointments. 88% were able to get an appointment to see or speak to someone the last time they tried. 100% said the last appointment they got was convenient. It also showed that most patients surveyed were satisfied with how easy it was to contact the practices by phone. 94% said it was easy to get through, which on average was higher than other local practices.

Out of hours enquiries were redirected to the provider's contracted out of hour's provider, Cumbria Health on Call (CHOC) ltd.

Consultations were provided face to face at the practice, advice given over the telephone, or by means of a home visit by the GP. This helped to ensure people had access to the right care at the right time. There were both male and female GPs in the practice; therefore patients had choice over the gender of doctor they wished to see.

Listening and learning from concerns and 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.

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.

We asked to see a summary of all the complaints the practice had received this year. We looked at two complaints in detail. We found the complaints had been recorded and fully investigated. We found the practice listened and learned from the complaints.

The practice told us that complaints were considered at whole team meetings to increase learning from these. We saw evidence of this in a presentation given at a team meeting.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

Leaders within the practice had inspiring shared purpose; they strove to deliver and motivated staff to succeed. The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found that there was strong leadership and strategic vision within the practice. Staff were able to demonstrate their understanding and commitment to providing high quality patient centred care. There was a strong focus on improvement and learning shared by all staff.

The 11 staff we spoke with demonstrated an understanding of their area of responsibility and each took an active role in ensuring a high level of service was provided on a daily basis. We found that managers in the practice understood their role in leading the organisation and enabling staff to provide good quality care.

The practice had a patient charter in place. This detailed what patients could expect from the practice and what they would in turn expect from patients. This focused on mutual respect and the right to privacy, dignity and confidentiality.

The practice had a strategic approach to future planning, and was putting in place succession arrangements to identify and address future risks to personnel leaving or retiring.

Governance arrangements

The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. The practice had a number of policies and procedures in place to govern activity and these were available on a shared drive which staff could access from any computer in the practice. We looked at a number of these policies and procedures and found that they had been reviewed regularly and were up to date.

There was a clear leadership structure with named members of staff in lead roles. The practice provided us with a list of the areas that each partner GP in the practice led on. We found that for each of the lead roles there was an expectation that the lead GP would undertake and provide evidence annually of how their work had improved outcomes for patients. For example the lead GP for rota and access produced regular reports on appointment use and led discussions in partner and team meetings. The safeguarding lead had introduced a new approach to recording information about patient risk and was implementing recommendations from the local CCG and NHS England Area Team in relation to safeguarding training. We saw that buddy arrangements between doctors were clearly documented and staff told us this worked very well in practice.

We spoke with 11 members of staff and they were all clear about their roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns. We found that the responsibility for improving outcomes for patients was shared by all staff. The practice gave us examples where both non–clinical and clinical staff had worked together for example the project to increase the number of patients vaccinated against flu.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice was in line with national standards and was above average for the local Clinical Commissioning Group (CCG) and England average in a number of clinical indicators.

The practice had systems in place to monitor and improve quality. The practice had an ongoing programme of clinical audit which it used to monitor quality and systems to identify where action should be taken. For example, palliative care, minor surgeries, audit of attendance at accident and emergency departments and audit of ear, nose and throat referrals.

The practice held weekly governance meetings to discuss quality audits, serious and significant events, complaints, patient feedback, performance data and other information relating to the quality of the service. We saw presentations and reports that demonstrated the practice routinely reviewed data and information to improve quality of service and outcomes for patients.

We found the practice approached governance and improvement in a supportive and collaborative way. There was evidence that the practice took the welfare of its staff seriously.

The practice ensured risks to the delivery of care were identified and mitigated before they became issues. The practice had a system in place for monitoring all aspects of the service.

Are services well-led?

Outstanding ☆

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

Leadership, openness and transparency

There was a well-established management structure with clear allocation of responsibilities. We spoke with a number of staff, both clinical and non-clinical, and they were all clear about their own roles and responsibilities. They were able to tell us what was expected of them in their role and how they kept up to date.

Staff told us there was an open culture in the practice and they could report any incidents or concerns about the practice. This ensured honesty and transparency was at a high level. We saw evidence of incidents that had been reported by staff, and these had been investigated and actions identified to prevent a recurrence.

Staff told us they felt confident about raising any issues and felt that if incidents did occur these would be investigated and dealt with in a proportionate manner. The staff we spoke with were clear about how to report incidents. Staff told us they felt supported by the practice manager and the clinical staff and they worked well together as a team.

The practice had invited a number of key stakeholders to speak with us during the inspection. All spoke highly of the practice and how well the practice worked jointly with their organisation. This demonstrated the practice had an open approach and recognised the value other organisations could provide in quality improvement. The practice also invited a member of the patient participation group to sit in on the presentation practice staff gave to the inspectors. This confirmed an open and transparent approach by the practice and demonstrated their commitment to patient involvement.

Practice seeks and acts on feedback from its patients, the public and staff

The practice demonstrated a strong commitment to seeking and listening to patient views. They welcomed rigorous and constructive challenge from people who used the service, the public and stakeholders. Throughout the inspection they demonstrated how patient views had influenced improvements in patient care and service. They showed us a range of evidence (such as case studies, patient feedback and complaints) they had used to focus improvements on the needs and wishes of patients. This included celebrating what had gone well as well as identifying areas for improvement. For example, positive patient feedback was used to support the approach to medical emergencies.

The practice had an active patient participation group (PPG) to help it engage with a cross-section of the practice population and obtain patient views. We spoke with three representatives of the PPG who explained their role and how they worked with the practice. They told us that staff at the practice were open to listening to their feedback and ideas for improvement.

The group met two or three times a year. The PPG members we spoke with gave examples of the areas the group had been asked to comment and provide ideas for. This included giving their opinion on questions included in the practice patient questionnaire. They also said the practice had listened to feedback from patients channelled by the PPG, for example, they had increased the frequency that music was changed in the waiting room area.

We spoke with the practice manager about how the practice had used feedback from patients to improve the service offered. They told us they had a number of mechanisms for collecting and analysing feedback from patients. This included the patient participation group, patient complaints and compliments and patient surveys. Members from the PPG told us the practice responded quickly to any feedback. For example, when they raised concerns about minor maintenance issues these were acted upon quickly.

They told us they used patient feedback in team meetings to encourage learning, by sharing where things had gone well, for example where the practice had received compliments, and where the practice needed to improve. Sharing a balanced view with staff ensured they were not overly demoralised by just focussing on areas for improvement.

Staff we spoke with told us they regularly attended staff meetings. They said these provided them with the opportunity to discuss the service being delivered, feedback from patients and to raise any concerns they had. Staff gave us examples where they had been able to contribute to projects which helped improve the quality of service offered. For example, using a module of the Productive General Practice programme the practice had looked at referrals to other services. The Productive General Practice programme was an improvement approach to support practices in their drive to improve

Are services well-led?

Outstanding ☆

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

productivity. This had identified a number of referrals that could be made without the need for a patient to see a GP first. This gave staff greater autonomy and the practice told us this had led to greater staff satisfaction and motivation.

There were high levels of staff satisfaction. Staff told us they were proud to work for the practice.

Management lead through learning and improvement

We saw practice staff met on a regular basis. Presentations from the meetings showed the team discussed clinical care, audit results, significant events and areas for improvement. Staff from the practice also attended the CCG protected learning time (PLT) initiative. This provided staff with dedicated time for learning and development.

The management team met weekly to discuss any significant incidents that had occurred. The practice had a robust approach to incident reporting in that it reviewed all incidents. Staff we spoke with discussed how action and learning plans were shared with all relevant staff and presentations we reviewed confirmed this occurred. Staff we spoke with could describe how they had improved the service following learning from incidents and reflection on their practice. We were told this was done in an open, supportive and constructive way.