Upper Eden Medical Practice

Quality Report

The Health Centre
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Date of inspection visit: 19 November 2014
Date of publication: This is auto-populated when the report is published

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?	Outstanding ☆
Are services effective?	Good ●
Are services caring?	Good ●
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 inspected Upper Eden Medical Practice on 19 November 2014 and visited the surgery in Kirkby Stephen and one of the practice's two branch surgeries in Brough. We did not visit the practice's other branch surgery in Tebay as part of this inspection, however we did receive some CQC comment cards from patients who attended the branch. We inspected this service as part of our comprehensive inspection programme.

Overall, we rated the practice as outstanding. Our key findings were as follows:

- Patients reported good access to the practice and continuity of care, with urgent appointments available the same day. All appointments could be booked online, regardless of how far in advance of the appointment date they were released.
- Patients said, and our observations confirmed, they were treated with kindness and respect.
- Patient outcomes were in line with averages for the locality and good practice guidance was referenced and used routinely.
- The practice understood the needs of the local rural population and provided services from three sites, which helped patients to access the service locally.
- The main practice and branch surgery we visited were visibly clean and tidy.
- The practice learned from incidents and took action to prevent a recurrence.

We saw the following areas of outstanding practice:

- The practice was considered to be outstanding in terms of their safety. Patients were protected by a very strong safety system with a focus on openness, transparency and learning.
- There was a genuinely open culture in which all safety concerns raised by staff and patients were highly valued as being integral to learning and improvement. The impact of this was lessons were learned and improvements made to prevent reoccurrence when things went wrong.
- The practice had low referral rates to secondary and other community care services compared to other practices in the area. All the GPs we spoke with said this was as a direct result of their ability to complete in-house referrals to their GP colleagues within the

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practice. GPs in the practice had a number of special interests, including in the areas of ophthalmology, dermatology, diabetic and paediatric care. This reduced the length of time patients had to wait to see specialists in these areas.

- The practice was considered to be outstanding in terms of being well-led. The leadership, governance and culture had a positive impact on the delivery of care. The quality of care was high and very person centred.
- Constructive challenge from patients, the public and stakeholders was welcomed and seen as a vital way of holding the practice to account.
- There were strong governance and performance management arrangements which reflected good practice and were proactively reviewed.

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?

Outstanding ☆

The practice is rated as outstanding for providing safe services. This practice was safer than other similar practices and was improving consistently. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were in line with averages for the locality. Staff referred to best practice guidance and used it routinely. People'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 have been identified and planned. The practice were able to show us examples of staff appraisals and their personal development plans. Staff worked well with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for caring. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the CCG to secure service improvements where these were identified. Patients reported good access to the practice, a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

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Are services well-led?

Outstanding 

The practice is rated as outstanding for well-led. The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Governance and performance management arrangements were robust and took account of current models of best practice. There were robust arrangements for identifying, recording and managing risks, issues and mitigating actions. Incident reporting was encouraged and was reviewed frequently at all levels across the practice. We found there was a high level of constructive staff engagement and a high level of staff satisfaction. The practice actively sought feedback from patients and had a large patient group called 'The Patient Voice'.

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 related to all population groups. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered personalised care to meet the needs of the older people in its population. This included developing care plans for their most at risk patients, which included patients who were housebound and those who lived in local nursing and care homes. The practice had written to patients over the age of 75 years to inform them who their named GP was. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Outstanding

The practice is rated as outstanding for the population group of people with long term conditions. There were aspects of the practice which were outstanding and related to all population groups. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. Patients had reviews to check their health and medication needs were being met. Where possible the practice completed reviews for patients with more than one long term condition at the same appointment; reducing the need for patients to attend on multiple occasions. For those people with the most complex needs the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Outstanding

The practice is rated as outstanding for the population group of families, children and young people. There were aspects of the practice which were outstanding and related to all population groups. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, the practice had processes in place to identify and support local families who were in these circumstances. Immunisation rates were relatively high for all standard childhood immunisations. For example, Hib/Men C Booster rates for five year old children were 97.7% compared to an average locally of 92.8%. Patients told us that children and young people were treated in an

Summary of findings

age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding for the population group of the working-age people (including those recently retired and students). There were aspects of the practice which were outstanding and related to all population groups. 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, flexible and offered continuity of care. Appointments were available outside normal working hours and also on a Saturday. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for 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 related to all population groups. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice had carried out health checks for people with learning disabilities. The practice offered longer appointments for people, if required.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector 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 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 outstanding and related to all population groups. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had a nominated GP lead for people experiencing poor mental health.

Summary of findings

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. Information and leaflets about services were made available to patients within the practice.

Summary of findings

What people who use the service say

All of the 15 patients we spoke with were complimentary about the services they received at the practice. They told us the staff who worked there were very 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 largely happy with the appointments system.

We reviewed 53 CQC comment cards completed by patients prior to the inspection. Most were complimentary about the practice, staff who worked there and the quality of service and care provided. A small number of the patients who filled out CQC comment cards said they didn't like the new appointments system; however similar numbers of patients said they preferred the new system.

The latest National GP Patient Survey completed in 2013/14 showed patients were satisfied with the services the practice offered. The results were mainly in line with other GP practices nationally, and in some areas better. The results were:

- The proportion of respondents who would recommend their GP surgery– 94.7%;
- GP Patient Survey score for opening hours– 85.1%;
- The proportion of respondents who gave a positive answer to 'Generally, how easy is it to get through to someone at your GP surgery on the phone – 88.47%;
- Percentage of patients rating their experience of making an appointment as good or very good – 90.8%;
- The proportion of respondents who described the overall experience of their GP surgery as good or very good – 92.27%.

These results were based on 132 surveys that were returned from a total of 251 sent out; a response rate of 53%.

Outstanding practice

- The practice was considered to be outstanding in terms of their safety. Patients were protected by a very strong safety system with a focus on openness, transparency and learning.
- There was a genuinely open culture in which all safety concerns raised by staff and patients were highly valued as being integral to learning and improvement. The impact of this was lessons were learned and improvements made to prevent reoccurrence when things went wrong.
- The practice had low referral rates to secondary and other community care services compared to other practices in the area. All the GPs we spoke with said this was as a direct result of their ability to complete in-house referrals to their GP colleagues within the practice. GPs in the practice had a number of special interests, including in the areas of ophthalmology, dermatology, diabetic and paediatric care. This reduced the length of time patients had to wait to see specialists in these areas.
- The practice was considered to be outstanding in terms of being well-led. The leadership, governance and culture had a positive impact on the delivery of care. The quality of care was high and very person centred.
- Constructive challenge from patients, the public and stakeholders was welcomed and seen as a vital way of holding the practice to account.
- There were strong governance and performance management arrangements which reflected good practice and were proactively reviewed.

Upper Eden Medical Practice

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, a CQC Pharmacy Inspector 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 Upper Eden Medical Practice

Upper Eden Medical Practice is located in Kirkby Stephen in Cumbria. The main surgery is in Kirkby Stephen and there are branch surgeries in Brough and Tebay. The practice provides primary medical care services to patients living in and around these areas. The practice provides services from the following addresses and we visited the main site in Kirkby Stephen and the branch surgery in Brough during this inspection:

The Health Centre, Silver Street, Kirkby Stephen, Cumbria, CA17 4RB.

Main Street, Brough, Kirkby Stephen, Cumbria, CA17 4AY.

Off Church Street, Tebay, Cumbria, CA10 3XB

The practice is based at ground floor level at the main surgery and both branch surgeries. It offers on-site parking including disabled parking bays, a WC and step-free access. The practice provides services to just over 6,700 patients of all ages based on a General Medical Services (GMS) contract agreement for general practice.

The practice has five GP partners and a salaried GP (four male and two female GPs in total), two nurse practitioners, three practice nurses, four health care assistants, a practice manager, dispensary staff and staff who complete secretarial, administrative and reception duties.

The practice had been inspected before in May 2014 as part of our pilot programme. At that inspection we identified some action the practice must take to improve. This was because the practice did not have appropriate arrangements in place to manage medicines. As part of this inspection we reviewed whether the practice had made improvements. We found improvements had been made in this area.

The CQC intelligent monitoring did not categorise the practice in a priority band as an inspection report has been published recently. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

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

Why we carried out this inspection

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

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

• Mothers, babies, children and young people

• The working-age population and those recently retired

• People in vulnerable circumstances who may have poor access to primary care

• People experiencing poor mental health

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. This included the local Clinical Commissioning Group (CCG). This did not highlight any significant areas of risk across the five key question areas.

We carried out an announced visit on 19 November 2014. We visited the practice's main surgery in Kirkby Stephen and branch surgery in Brough. We spoke with 15 patients and a range of staff from the practice. We spoke with the practice manager, three GPs, a nurse practitioner, two practice nurses, a health care assistant and some of the practices' dispensing, administration and reception staff. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 53 CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Outstanding ☆

Are services safe?

Our findings

Safe Track Record

Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards reflected this.

As part of our planning we looked at a range of information available about the practice. This included information from the General Practice High Level Indicators (GPHLI) tool, the General Practice Outcome Standards (GPOS) and the Quality Outcomes Framework (QOF). The latest information available to us indicated there were no areas of concern in relation to patient safety.

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 as well as comments and complaints received from patients. Staff we spoke to were aware of their responsibility to raise concerns, and how to report incidents and near misses. Staff said there was an individual and collective responsibility to report and record matters of safety. For example, a recent incident had been recorded where a patient had been given an appointment with a nurse when they needed to see a GP. This incident had been recorded as an 'administration error' and had resulted in a poor experience for the patient. In response to this, reception staff were reminded to follow the checklist for allocating appointments to the correct clinicians. There had been no more examples of this type of incident since then.

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

Learning and improvement from safety incidents

The practice had robust systems in place for reporting, recording and monitoring significant events, incidents and accidents. We asked for and saw records were kept of significant events that had occurred during the last three years, and these were made available to us. The significant event audit report covering 2013 noted the number of significant events recorded annually since 2010. Significant events were reviewed and discussed at all levels across the practice. For example, at dedicated significant event meetings which all staff attended and at team meetings for smaller groups of staff, such as nurses or administrative staff.

In 2012 the practice had introduced a system where significant events were 'categorised' in to one of seven categories. For example, two of the categories were 'administration' and 'drug'. Within each of these event types, further breakdowns were made; for example 'drug error – clinician' or 'drug error – dispensing'. The 'risk level' of each event was also categorised as one of high, medium or low. This helped the practice with its analysis and allowed for more detailed comparisons to be made from year to year. Dedicated significant event meetings were held every four to six weeks and all staff were encouraged to attend. One in every three meetings was held at lunchtime in an attempt to make the meetings accessible to as many staff as possible, with other meetings held at 8am. Significant events were discussed and any actions taken or to be taken as a result were discussed and agreed. The practice manager said this helped to promote a culture of openness and an acceptance that mistakes could happen.

There was evidence that appropriate learning had taken place and that findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff confirmed they were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so. We saw the practice carried out an annual review of significant events and produced an audit report to support its findings. The '2013 Significant Events Audit Report' showed 69 significant events were reported in 2013, compared to 60 in 2012 (In 2014, 62 significant events had been recorded up to and including the 6th November). The regular, consistent and thorough recording of incidents demonstrated the open, honest and blame-free culture within the practice. The report showed a breakdown of event by type, comparisons of data from one year to the next, key findings and recommendations. The recommendations section included reference to improvements already made as a result of significant event reporting, as well as a number of further action points that had been developed. For example, at the time of the report a new system for carrying out baby immunisations had

already been introduced and a new document scanning protocol was in the process of being implemented. This showed lessons were learned and action was taken as a result of investigations when things went wrong.

We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager who managed and monitored them. We looked at some incidents recorded to date in 2014 and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, confidentiality training had been completed by a number of staff in July 2014 in response to two events that occurred earlier in the year.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings to ensure all were aware of any relevant to the practice 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 made available to us showed that all staff had received, or were booked to receive, 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.

The practice had a dedicated GP appointed as lead in safeguarding vulnerable adults and children who had been trained to level three for safeguarding children to enable them to fulfil this role. As part of their role they had developed links with a number of external organisations who had regular contact with younger people. These included counselling services, youth services and school nursing services. The practice were also in the process of developing a leaflet for young people to help with how they accessed the practice. Staff we spoke with were aware of who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example, patients who had been subjected to, or were deemed to be at risk of domestic violence, were flagged on the system. The practice also had a nominated 'Domestic Violence Champion' who led on patient safety in this field.

The practice had a chaperone policy in place and notices were displayed in the patient waiting areas to inform patients of their right to request one. Clinical staff carried out chaperoning duties during minor surgical procedures when patients requested this service. Administrative staff who had been trained were able to act as chaperones for GP examinations, if required. We saw all staff who acted as chaperones had completed training on this.

Patient's 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

At the previous inspection in May 2014 we identified some action the practice must take to improve. This was because the practice did not have appropriate arrangements in place to manage medicines. As part of this inspection we reviewed whether the practice had made improvements. We found improvements had been made in this area.

We saw a clear system for managing the repeat prescribing of medicines that was followed in practice and was in line with national guidelines. Dispensary staff managed the ordering and supply of repeat prescriptions and the GPs oversaw this by signing all prescriptions before they were supplied to patients. Changes in patients' medicines, for example when they had been discharged from hospital, were checked by the GP who made any necessary amendments to their medicines records. This helped ensure patients' medicines and repeat prescriptions were appropriate and correct.

There were systems in place for the management of high risk medicines. This included regular monitoring in line with national guidance by a multidisciplinary team within the practice. We saw records of actions taken in response to the review of prescribing data. For example, work was ongoing to reduce hypnotic prescribing (medicines whose

primary function is to induce sleep) and improve the prescribing of inhaled corticosteroids (medicines for controlling asthma) within the practice. We saw evidence that National Institute for Health and Care Excellence (NICE) guidelines about prescribing and good practice were properly considered. The use and application of NICE guidance was monitored through self-audit and practice meetings.

We checked treatment rooms, medicine refrigerators and GPs bags and found medicines were safely stored, with access restricted to authorised staff. Suitable procedures were in place for ensuring medicines that required cold storage were kept at the required temperatures, including arrangements for when medicines were transported out of the surgery. Staff were aware of the correct processes to follow and a recent incident regarding a break in the medicines 'cold chain' was properly managed by staff (A cold chain is a system that ensures and demonstrates that a medicine is always kept at the right temperature).

Processes were in place to check medicines were within their expiry date and suitable for use. Out of date and unwanted medicines were disposed of in line with waste regulations.

Vaccines were administered by nurses using Patient Group Directions (PGDs) that had been produced in line with national guidance. PGDs were up to date and there were clear processes in place to ensure staff that were named in the PGDs were competent to administer vaccines. Stocks of controlled drugs (medicines that have potential for misuse) were managed, stored and recorded properly following standard procedures that reflected national guidelines.

Blank prescription forms were handled according to national guidelines and were kept securely. A record of the distribution of forms to practice staff was kept. The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines. The practice was signed up to the Dispensing Services Quality Scheme (DSQS) to help ensure processes were suitable and the quality of the service was maintained. Dispensing staff had all completed appropriate training and had their competency annually reviewed.

Patients could choose to collect their dispensed prescriptions at the Brough and Tebay branch surgeries and we saw systems were in place to manage this service safely. A new system for automatically producing repeat prescriptions, making it simpler for patients to obtain regular medicines, was being trialled with suitable patients.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again. Significant event review meetings were held every four to six weeks to ensure incidents were managed effectively. We saw processes in place for managing national alerts about medicines such as safety issues. Records showed that the alerts were distributed to relevant staff and appropriate action taken.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead GP nominated for infection prevention and control. All staff received induction training about infection control specific to their role and received annual updates. This had included staff from the infection control team at a local hospital attending protected learning time (PLT) events at the practice to deliver training on hand washing techniques. We saw evidence that the lead GP had carried out infection control audits and that improvements identified for action were completed. For example, treatment rooms now had two sinks and disposable blinds were used in consulting and treatment rooms rather than fabric curtains. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff we spoke with were able to describe how they would use these in order to comply with the practice's infection control policies. There was also a policy for needle stick injuries.

Hand hygiene techniques signage was displayed throughout the practice. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Outstanding ☆

Are services safe?

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 records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

We saw that sharp bins were available along with bins for the disposal of household and clinical waste which had lids and foot operated pedals. There was a contract in place for the removal of all household, clinical and sharps waste and we saw that waste was removed by an approved contractor. We saw equipment used in the practice was clean.

The practice manager and lead GP for infection control both told us about a programme of planned works by NHS Property Services (who owned the premises at the main surgery site in Kirkby Stephen). This included replacing some of the flooring in treatment and consulting rooms and the installation of some new sinks.

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 equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment; for example, weighing scales and blood pressure monitoring equipment.

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff 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 were enough staff on duty. There were also arrangements in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

The practice manager said when a GP was on leave or unable to attend work, a small number of locum GPs familiar with the practice were used. We saw the practice had a 'locum GP pack' in place to support locum GPs with their work. It included logistical information on the practice itself, copies of any safety alerts received recently and information on prescribing and referral processes within the practice.

Staff told us there were enough staff to maintain the smooth running of the practice and to ensure patients were kept safe.

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.

We saw that any identified risks were discussed at GP meetings and within team meetings. The practice manager told us about plans the practice had put into place in anticipation of changes in demand on the service. For example, when planning for flu clinics and when care planning for patients with diabetes was formally introduced. They told us staffing levels had been reviewed in advance to ensure the practice was able to meet the demands from patients who required those services.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and medical emergencies. For example, all 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. We saw records showing staff had received training in basic life support. Emergency equipment was

available including access to oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). The staff we spoke with knew the location of this equipment.

Emergency medicines were available in secure areas of the practice and branch surgeries and staff knew of their location. We looked at the resuscitation trolley kept in the reception area of the branch surgery at Brough. There was a good selection of paediatric and adult masks and airways. We saw records that clearly listed the contents of the trolley and this corresponded to the medicines available. The defibrillator and oxygen were accessible and records of regular checks of the defibrillator and other items on the trolley were up to date. 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, adverse weather and access to the building. The practice manager led on this area.

The practice manager, GPs and other staff we spoke with told us about the protocol the practice had put in place in response to the threat from a virus. The practice had received guidance to cover the steps primary healthcare practitioners should take in the event of a person with a specific virus making first contact with the service. The practice manager told us the practice team had reviewed this guidance and drawn up a local protocol based upon this for staff to refer to. This was to help the practice's staff to understand and become familiar with how to respond, in practice, to the threat of the virus.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline 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, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, we were told that patients with long term conditions such as asthma or diabetes were invited into the practice to have their medication reviewed for effectiveness.

The GPs told us they led in specialist clinical areas such as heart failure, epilepsy and diabetes. The nursing team supported this work which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. Staff had access to the necessary equipment and were skilled in its use; for example, blood pressure monitoring equipment and an electrocardiogram (ECG) machine.

The practice used computerised tools to help identify patients with complex needs who had multidisciplinary care plans documented in their case notes. GPs and nurses spoke about the work the practice had completed to identify and support their most at risk patients. Holistic care plans (a system of comprehensive or total patient care that considers the physical, emotional, social, economic, and spiritual needs of the patient) had been developed for over 130 patients. This included patients who were housebound, living in care homes and some children identified as at risk. We were told these patients were provided with 'yellow folders' for their care records which were widely recognised by health care professionals across Cumbria.

The practice had low referral rates to secondary and other community care services compared to other practices in the area. All the GPs we spoke with said this was as a direct result of their ability to complete in-house referrals to their GP colleagues within the practice. GPs in the practice had a number of special interests, including in the areas of ophthalmology, dermatology, diabetic and paediatric care. This reduced the length of time patients had to wait to see specialists in these areas.

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.

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.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles 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.

The practice had a number of mechanisms in place to monitor their performance and their clinicians' adherence with best practice guidance. The practice had a system in place for completing clinical audit cycles, including audit and re-audit. The practice showed us their clinical audit programme for 2014. A total of 11 audits had been completed and the practice was able to demonstrate the resulting changes since the audits had been carried out. For example, the practice had completed an audit of its patients with diabetes who were prescribed a specific medicine. The audit showed this medicine had not been effective for these patients; therefore this medicine was stopped for this group.

The practice also 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 practice had achieved 92.8% of the total points available in 2013/14, which included all of the points available for palliative care, rheumatoid arthritis and epilepsy.

The team was making use of clinical audit tools and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

Good

Are services effective?

(for example, treatment is effective)

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes. The electronic patient record system flagged up relevant medicines alerts when the GP went to prescribe medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice also participated in local benchmarking. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. For example, the practice compared favourably to others in the area on referral rates to secondary and other community care services.

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 annual basic life support. All GPs were up-to-date with their yearly continuing professional development requirements.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. For example, we spoke with a nurse who had joined the practice in the last six months. They told us they had been supported well by the practice and the senior nursing staff and training was provided on a regular basis.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, we found they were trained to administer vaccines. Nurses were responsible for the review of patients with long-term conditions such as asthma and were trained to fulfil this role. Each of the nurses led on the management of specific long term conditions based on their training, skills and experiences. The GPs and the practice manager told us they were working on a practice nurse development plan to train the nurses in all long term conditions. This was to reduce the risk of becoming too reliant upon specialist staff for this work and would mean patients could still be seen quickly if the lead nurse for their condition was not available.

We saw the practice had an induction programme to be used when staff joined the practice. This covered individual areas of responsibility and general logistical information about how the practice operated. A pack had also been developed to support locum GPs with their work.

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 people's needs and manage complex cases. 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 on the day they were received. The GP who reviewed 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.

GPs and the nursing staff we spoke with told us they worked well together as a team. An example of this was their willingness to accept in-house referrals from each other without question or hesitation. This allowed patients to have access to the clinician who was best placed to treat their condition at short notice.

One of the nurses we spoke with told us about the work they did in partnership with a local nursing home; one of three care homes staff from the practice attended on a regular basis. They told us they had completed care plans with their patients to help them avoid admission to hospital, completed 'special patient forms' for use by out of hours providers and completed regular reviews of do not attempt resuscitation (DNACPR) orders with those patients who had them in place. They said they attended the nursing home on request, and this would typically be two or three times a week. This work helped to ensure some of the practice's most at risk patients received effective and appropriate care.

The practice held multidisciplinary team meetings to discuss the needs of high risk patients, for example, those with end of life care needs. These meetings were attended

Good

Are services effective?

(for example, treatment is effective)

by the practice's GPs and nurses along with district nurses, social workers, community psychiatric nurses, drug and alcohol workers and palliative care nurses among others. The practice felt this system worked well and remarked on the usefulness of the meetings as a means of sharing important information.

The practice was a member of a group of GP practices located in the area who met regularly to build relationships and share learning with the aim of improving patient care. The practice team felt this had been beneficial for both themselves and their patients.

Information Sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and the practice made referrals 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.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to co-ordinate, 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. Training had been delivered by an external provider and staff had also completed online learning modules. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. Clinical staff we spoke with 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 documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's formal written consent was obtained. Verbal consent was taken from patients for routine examinations. Patients we spoke with reported they felt involved in decisions about their care and treatment.

Health Promotion & Prevention

The practice offered all new patients a consultation. Clinicians completed the 'new patient assessment' which involved explaining the service to the patient, reviewing their notes and medical history, and the recording of basic information about the patient. For example, confirming any medicines they were currently taking. The patient's needs were assessed and where appropriate, they were placed into the relevant monitoring service. For example, children would be placed within the immunisation programme at the appropriate point.

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. We were told this worked well to prevent any patient groups from being overlooked. Processes were in place to ensure the regular screening of patients was completed, for example, cervical screening.

Medicine reviews were done in the presence of the patient. Some of the patients we spoke with told us they were on regular medicines. They confirmed they were asked to attend the practice to review their conditions and the effectiveness of their medicines.

There was a range of information on display within the practice reception areas. This included a number of health promotion and prevention leaflets, for example, on smoking cessation and alcohol consumption. The latest practice newsletter was also available for patients to take away with them.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

All of the 15 patients we spoke with said they were treated with respect and dignity by the practice staff at all times. Comments left by patients on CQC comment cards reflected this. Of the 53 CQC comment cards completed across all three sites, 33 patients made direct reference to the caring manner of the practice staff. Words used to describe the approach of staff included professional, helpful, friendly, supportive, caring and respectful.

We observed staff who worked in the reception area 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.

The reception area fronted directly onto the patient waiting areas; both at the main surgery in Kirkby Stephen and the branch surgery in Brough. We saw staff who worked in these areas made every effort to maintain people's privacy and confidentiality. Voices were lowered and personal information was only discussed when absolutely necessary. Phone calls from patients were taken by staff in areas where confidentiality could be maintained. Perspex screens separated these areas from the patient waiting areas.

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. This reduced the risk of personal conversations being 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

The patient survey information we reviewed 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 90% of practice respondents said the GP was good at involving them in care decisions and 90% felt the GP was good at explaining treatment and results. Both these results were better than the average results achieved by other practices in the local CCG area (77% and 84%) and nationally (75% and 82%).

Patients we spoke to on the day of our inspection 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 had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and supported these views.

One of the GPs we spoke with said they shared agreed guidelines with patients about their conditions and treatments for these. We saw they had some printed copies of these available for patients to take away, in addition to some electronically stored information.

Staff told us that translation services were available for patients who did not have English as a first language. This service was used infrequently by patients due to the small numbers of patients involved.

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, reassuring and supportive. Patients also commented they felt staff regularly went beyond the call of duty and exceeded their expectations. For example, when supporting patients and helping them to cope with long term health problems.

Notices in the patient waiting room also signposted people to a number of support groups and organisations. This included MIND for help with mental health issues and the

Good

Are services caring?

Macmillan service for support following bereavement. The practice had also developed links with a local organisation that provided support for its patients with caring responsibilities.

Support was provided to patients during times of bereavement. Families were offered a visit from a GP at these times for support and guidance. The practice manager said this would be the GP who had been involved with the patient and their family in order to maintain continuity of care. Staff were kept aware of patients and families who had been bereaved so they were prepared and ready to offer emotional support. The practice also offered details of bereavement services and had developed a bereavement protocol and pack to help patients and families during these times. Staff we spoke with in the practice recognised the importance of being sensitive to people's wishes.

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 CQC comment cards all said they felt the practice was meeting their needs. This included being able to access repeat medicines at short notice when this was required.

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. For example, the practice had identified its highest risk patients and had developed holistic care plans to meet their needs. This included patients who were housebound and those who lived in local nursing and care homes.

The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. Staff we spoke with, including GPs and the practice manager, told us the practice had made a conscious decision to continue to provide services from three sites. This included the two rural branch surgeries in Brough and Tebay. Feedback we received from patients, both verbally on the day and from those patients who completed CQC comment cards, showed this was highly valued and appreciated. This helped to ensure the needs of patients could be met without the need to travel to the main surgery in Kirkby Stephen.

We were told there had been very little turnover of staff in recent years which enabled good continuity of care and accessibility to appointments with a GP or nurse of choice. For example, patients could access appointments face-to-face in the practice, receive a telephone call back from a clinician or be visited at home. Longer appointments were available for people who needed them.

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.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, opening times provided late appointments each week and appointments were also available on a Saturday morning. This helped to improve access for those patients who worked full time. The practice had access to telephone translation services if required, for those patients whose first language was not English.

The premises and services had been adapted to meet the needs of people with disabilities. All of the treatment and consulting rooms could be accessed by those with mobility difficulties. The patient toilet could be accessed by patients with disabilities and parking for these patients was provided in the main surgery car park close to the entrance. An induction loop system was in place for patients who experienced hearing difficulties. The practice manager said a power assisted door was due to be installed at the main Kirkby Stephen site by the buildings' owners, NHS Property Services.

The practice had male and female GPs, which gave patients the ability to choose to see a male or female GP if they had a preference.

Access to the service

Nearly all of the patients we spoke with and those who filled out CQC comment cards said they were satisfied with the appointment systems operated by the practice. They said they could see a doctor on the same day if required and could see another doctor quickly if there was a wait to see the doctor of their choice. This was reflected in the results of the most recent national GP Patient Survey (2013/14). This showed 86% of patients who responded were able to get an appointment to see or speak to someone the last time they tried and 98% said the last appointment they received was convenient. These results were based on the responses of 132 patients and were in line with the weighted CCG (local area) averages.

We saw that as a result of patient feedback in 2013, the practice had reviewed their appointment system and introduced a new process in February 2014. Patients who asked for an urgent, same day appointment were called back by a GP or nurse practitioner. This was to establish if their need was urgent and if so, to ensure they could be seen the same day. A small number of the patients we spoke with or who filled out CQC comment cards said they didn't like the new appointments system; however similar numbers of patients said they preferred the new system. The practice manager said the new system was being reviewed on an on-going basis. They had engaged with the local community about the changes made and had

Good

Are services responsive to people's needs?

(for example, to feedback?)

attended a number of meetings locally with patients who used the practice. This was to help their patients understand the reasons behind the changes and to listen and respond to any concerns raised. We spoke with a member of the practice's patient group ('The Patient Voice') who confirmed the pro-active role the practice manager had taken. They said patients had appreciated the approach taken and felt re-assured any questions or issues raised had been resolved.

Patients could make their appointments in different ways, either by telephone, face to face or online, via the practice website. Routine appointments were 15 minutes long (most practices offer 10 minute routine appointments) and every appointment made available could be booked online. This included appointments released for booking in advance, appointments released at shorter notice and appointments with both GPs and nurses.

Appointments were available from 8.30am to 6.30pm on weekdays and appointments were also available with a GP or nurse on a Saturday morning. The Saturday morning surgery was particularly useful to patients with work commitments. This was confirmed by patients we spoke with who worked during the week. We were also told the practice were considering an evening clinic one night a week and also to extend one of the clinics at the Tebay branch to include a nurse or health care assistant.

Information was available to patients about appointments on the practice website. This included how to arrange appointments and home visits and how to book appointments through the website. Consultations were provided face-to-face at the practice, 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 also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The practice's contracted out of hours provider was Cumbria Health on Call (CHoC).

The practice, including the two branch surgeries, was situated at ground level and all services for patients were provided from there. We saw that the waiting areas at the two sites we visited in Kirkby Stephen and Brough were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

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.

We saw the practice had received 13 complaints (six formal complaints, seven informal) and three compliments during 2014 to date. In 2013 they received nine complaints (four formal, five informal) and two compliments. These had been reviewed as part of the practice's formal annual review of complaints. 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. Positive feedback from patients was also shared and celebrated among the staff.

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 saw the practice had a 'suggestion boxes' in place for patients to use at both of the sites we visited (the main surgery in Kirkby Stephen and the branch surgery in Brough).

None of the 15 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, only one of the 53 CQC comment cards completed by patients indicated they had felt the need to complain. They went on to state that other than their complaint, they were satisfied with the services provided.

The practice had responded to feedback provided by patients regarding the running of childhood immunisation clinics. Patients had said they felt the times the clinics were run were not always suitable, so in response the practice had made changes in order to meet the needs of their patients.

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

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. This was documented within the practice's statement of purpose. It stated the practice's aims and objectives included 'To deliver general medical services to the patients registered in the Upper Eden area and to patients who present for immediately necessary treatment and as temporary residents. To promote and support the health of the community of Upper Eden. Patients will be treated with consideration, respect and support in their care and treatment'. The practice manager and GPs spoke of how they wanted the practice to become the 'health hub' for the community of Upper Eden. It was evident in discussions we had with staff throughout the day that it was a shared vision and was fully embedded.

The staff we spoke with, including clinical and non-clinical staff, all knew the provision of high quality care for patients was the practice's main priority. They also knew what their responsibilities were in relation to this and how they played their part in delivering this for patients.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared drive on any computer within the practice. We looked at a sample of these policies and procedures. All of the policies and procedures we looked at had been reviewed regularly and were up-to-date.

The practice held regular governance meetings where matters such as performance, quality and risks were discussed. There was a timetabled schedule of meetings for 2014 and we saw records to confirm these meetings had been held. The following meetings were held on a regular basis: referral meetings, significant event meetings, prescribing meetings, GP meetings and business meetings. Focused team meetings were also held regularly, including for nurses, reception staff and dispensary staff. This helped to ensure that information was shared at the appropriate levels and in a timely manner.

The practice had comprehensive assurance systems and performance measures, which were reported and monitored. These included the use of their electronic patient records system, Report Analysis Intelligence Delivering Results (RAIDR - a bespoke intelligence tool for health professionals), the Productive General Practice programme and the Quality and Outcomes Framework (QOF). The QOF data for this practice showed it was performing in line with the averages of the local Clinical Commissioning Group (CCG) and across England as a whole. Performance in these areas was monitored by the practice manager and GPs, supported by the administrative staff. Many of the QOF areas, for example diabetes or epilepsy, had clinical leads allocated to them. This included a lead GP, nurse and administrative support. We saw that QOF data was regularly discussed at team meetings. Lead GPs had also been allocated to many of the additional and enhanced services the practice provided. Examples included for contraception, cervical screening and minor surgery. The Productive General Practice programme had already delivered some positive outcomes, including a review of the practice's treatment rooms and the development of standard operating procedures (SOP's) for the administrative staff.

There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify where action was needed. The practice had completed a number of clinical audits throughout 2014, for example on blood pressure, cancer and emergency admissions. The results of these audits demonstrated outcomes for patients had improved.

There were robust arrangements for identifying, recording and managing risks, issues and mitigating actions. Incident reporting was encouraged and was reviewed frequently at all levels across the practice.

The practice manager and GPs told us forward planning was discussed regularly. The practice manager spoke of a number of individual plans for improvement, for example, building improvements for the main surgery in Kirkby Stephen. There was also an appreciation of the need to change. For example, to work with staff to build on the practice's vision and develop a five year plan.

Leadership, openness and transparency

The practice had a clear leadership structure which had named members of staff in lead roles. For example, there were lead GPs in areas such as infection control and safeguarding and lead nurses for the management of specific long term conditions such as heart disease and chronic kidney disease. We spoke with staff throughout the practice, both clinical and non-clinical; they were all clear

Are services well-led?

Outstanding ☆

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

about their own roles and responsibilities. They also knew who the nominated leads were across the practice. We found there were high levels of staff satisfaction. Staff were openly proud of the organisation as a place to work and spoke highly of the open and honest culture. There were consistently high levels of staff engagement.

Staff we spoke with and records we saw showed that staff meetings were held regularly. Staff we spoke with said they felt actively encouraged to raise any concerns and suggestions for improvement they had.

We found the practice leadership promoted continuous improvement at all levels and staff were accountable for delivering this. There was a clear approach to seeking out and embedding new ways of providing care and treatment. Examples included work completed on care planning for the practice's most at risk patients and the implementation of the new appointments system to help ensure patients whose needs were urgent were seen quickly.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff. The practice manager told us staff had access to all of the practice's policies online. Staff we spoke with knew where to find these policies if required.

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 regularly attended staff 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 and engaged in the practice to improve outcomes for both staff and patients.

The practice had a patient group called 'The Patient Voice' which at the time of the inspection contained 116 members. The practice had taken the decision not to establish a traditional patient participation group (PPG) as they felt that it would limit numbers and may not reach out to their more rural or appeal to their younger patients. Instead 'The Patient Voice' was a group of patients who had said they were interested in being involved in issues that affected patient care. They were contacted and asked for views on a variety of issues about the practice. For example, about changing the practice phones so that when patients received a call from the practice, the number showed.

'The Patient Voice' contained representatives from various population groups and was actively trying to increase representation from the younger population. The practice manager helped with and oversaw the running of the group. The practice utilised the findings and recommendations from their own patient survey to establish the group. This survey was conducted in August 2013 and a copy was available on the practice's website. The findings of the survey were mainly positive and some areas for improvement were highlighted, particularly regarding access to appointments.

As a result, the practice decided to develop a survey for all patients asking them for their comments regarding their experience when making an appointment. Every patient who attended the practice during one week was given a questionnaire and a total of 212 forms were received back. As part of the survey patients were also asked if they would be interested in being contacted regarding issues that affected patient care. In total, 112 patients agreed to be contacted and this formed the basis of 'The Patient Voice' group. Patients have continued to join the group since, and the practice said they were still looking to develop the group further. The findings from the practice's patient survey on appointments were used to inform the changes introduced in February 2014.

Feedback from patients was encouraged and we saw the practice shared this feedback regularly with staff. This included when there were lessons to learn from patients who had raised complaints or concerns and also when patients had complemented the practice and the staff who worked there.

The practice were able to demonstrate they acted on feedback from external agencies. Our inspection in May 2014 highlighted some areas where improvements should be made. We followed up those areas as part of this comprehensive inspection and found the practice had made the improvements required.

Are services well-led?

Outstanding ☆

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

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.

Management lead through learning & improvement

Staff we spoke with said 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 very supportive of training and development opportunities. For example, we spoke with a nurse who had joined the practice in the last six months. They told us they had been supported well by the practice and the senior nursing staff since joining the practice. They said updates to training on immunisations and cervical screening had already been provided and they knew further training on the management of long term conditions was planned.

The practice had completed thorough reviews of significant events and other incidents and shared these with staff via meetings. Staff meeting minutes showed these events were discussed, with actions taken to reduce the risk of them happening again. Staff we spoke with consistently referred to the open and honest culture within the practice and the leadership's desire to learn and improve outcomes for patients. The practice manager said incident reporting was encouraged within a 'no blame culture', and was seen as a learning event and opportunity to improve by all of the practice management.

The practice manager met regularly with other practice managers in the area and shared learning and experiences from these meetings with colleagues. GPs met with colleagues at locality and CCG meetings. They also attended learning events and shared information from these with the other GPs in the practice. We spoke with nurses who said a member of the practice's nursing team attended a practice nurse's forum that had been established in the last few months. This was used to share good practice across GP practices in the area. Information was brought back into the practice and shared with the nursing team verbally and via email.