Alston Medical Practice

Quality Report

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Date of inspection visit: 06/05/2014
Date of publication: 13/08/2014

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.

Summary of findings

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Summary of findings

Overall summary

Alston Medical Practice provides primary medical services from Monday to Friday for patients in the Alston Moor area of Cumbria. It is a rural dispensing practice and is attached to the Ruth Lancaster James Community Hospital in the town of Alston. It is registered with the Care Quality Commission to provide the following regulated activities: treatment of disease, disorder and injury; diagnostics and screening procedures; family planning; maternity and midwifery services and surgical procedures.

We spoke with 20 patients, two members of the practice's Patient Participation Group (PPG) and six members of staff from the practice. We also spoke with carers and family members, as well as staff who worked in the community hospital and the local community pharmacist. We spoke with and interviewed the Practice Manager, two GP's, a Practice Nurse and staff carrying out reception and dispensing of medication duties.

All the patients we spoke with were very complimentary about the service they received. The results of a recent patient survey also showed they were consistently pleased with the service they received.

The staff team were fully committed to providing good care to their patients and there was a strong team-working ethic among the practice staff.

The provider worked well with other agencies and had developed a positive and effective working relationship with the local community pharmacy.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Overall, the service was safe. We saw the practice had clearly defined systems, processes and standard operating procedures (SOP). All of the staff we spoke with during the inspection were familiar with safeguarding procedures and were clear about their roles and responsibilities in this area. Equipment was available to enable staff to respond in the event of a medical emergency. Medicines were managed appropriately and patients had access to medicines when they required them. The practice was visibly clean and had infection control policies and procedures in place.

The service could take action to improve processes and procedures in relation to the recruitment of staff and the checking of professional registrations. Also, the storage of blank prescription forms did not adhere to guidance issued.

Are services effective?

Overall, the service was effective. We found care and treatment was delivered in line with recognised practice standards and guidelines. Patients were referred appropriately to other services, where there was a need to do so. The provider had developed a positive and effective working relationship with the local community pharmacy.

Are services caring?

Overall, the service was caring. All of the patients we spoke with said they were treated with respect and dignity by the practice staff at all times. Patient's also reported they felt involved in all decisions surrounding their care or treatment.

Are services responsive to people's needs?

Overall, the service was responsive. The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. Patients said they were satisfied with the appointment systems operated by the practice. The practice had a policy for handling any concerns or complaints people raised.

Are services well-led?

Overall, the service was well-led. Staff were aware of the need to get things right for patients and it was clear the care of patients was their priority. Feedback we received from patients showed they felt

Summary of findings

valued and well cared for by staff. There was an established management structure within the practice. Staff demonstrated an understanding of their areas of responsibility and reported feeling supported, motivated and valued by their peers.

The practice had a Patient Participation Group (PPG). It was felt the practice had tried to get a geographical as well as a demographical spread of patients to participate. Most of the patients we spoke with were not aware of this group.

Summary of findings

What people who use the service say

All 20 patients we spoke with were very complimentary about the service 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.

We reviewed 23 CQC comment cards completed by patients prior to the inspection. Their comments were complimentary about the practice, staff who worked there and the quality of service and care provided.

We also looked at the results of a practice survey completed in January 2014 that collected the views of patients who used the service. A total of 60 patients took part in the survey and they were very positive about the service they received.

Areas for improvement

Action the service COULD take to improve

- The service could take action to improve processes and procedures in relation to the recruitment of staff and the checking of professional registrations.
- The storage of blank prescription forms did not adhere to guidance.

Good practice

Our inspection team highlighted the following areas of good practice:

- The practice had developed positive working relationships with the local community pharmacy. The dispensary would attempt to serve the needs of the community pharmacy's patients on the day it closed half-day and the community pharmacy would do the same for the practice's patients on a Saturday when the practice was closed.

Alston Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP. The team included a second CQC inspector, a GP practice manager 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 Alston Medical Practice

Alston Medical Practice provides primary care for people living within the Alston Moor area. It is a rural dispensing practice and is attached to the Ruth Lancaster James Community Hospital in the town of Alston. The practice area covers all of Alston Moor which covers North to South approximately nine miles and from East to West eight miles. The service is responsible for providing primary care for nearly 2,300 patients and is open from Monday to Friday. Out of hours services are provided by Cumbria Health on Call (CHoC).

The practice has two GP's, a GP registrar, two practice nurses, a practice manager and staff who carry out dispensing and reception duties.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

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?

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. This did not highlight any significant areas of risk across the five key question areas. As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. We also spoke with two members of the practice's Patient Participation Group (PPG).

We carried out an announced visit on 06 May 2014. The inspection team spent eight hours inspecting the service and visited the provider's surgery in Alston. We spoke with 20 patients and six members of staff from the practice. We also spoke with carers and family members, as well as staff who worked in the cottage hospital physically attached to the practice and the local community pharmacist. We

Detailed findings

spoke with and interviewed the Practice Manager, two GP's, a Practice Nurse and staff carrying out reception and dispensing of medication duties. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the provider maintained in relation to the provision of services.

Are services safe?

Summary of findings

Overall, the service was safe. We saw the practice had clearly defined systems, processes and standard operating procedures (SOP). All of the staff we spoke with during the inspection were familiar with safeguarding procedures and were clear about their roles and responsibilities in this area. Equipment was available to enable staff to respond in the event of a medical emergency. Medicines were managed appropriately and patients had access to medicines when they required them. The practice was visibly clean and had infection control policies and procedures in place.

The service could take action to improve processes and procedures in relation to the recruitment of staff and the checking of professional registrations. Also, the storage of blank prescription forms did not adhere to guidance issued.

Our findings

Safe patient care

The 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; their comments included "Made to feel at ease (by the staff)."

We spoke with a practice nurse who told us they were aware of a patient safety incident that had occurred recently. They said following the incident, the practice manager had arranged a meeting to discuss what had occurred, learning for staff and measures taken to prevent such incidents from happening again. This meant patients, including those in vulnerable circumstances, could be confident of safe patient care.

We saw the practice had clearly defined systems, processes and standard operating procedures (SOP). The purpose of these was to minimise the risk of errors being made and to ensure national and professional guidance was adhered to. We reviewed the practice's SOP and found they were appropriate. This meant the safety of people who used the service was promoted.

Learning from incidents

We spoke with a range of staff about how the practice learnt if things went wrong or when there were near misses. They told us there had been one incident where an out of date medicine had been supplied. There had also been two minor events in the last 12 months relating to the administration and communication of anticoagulant (prevention of blood clotting) medicine monitoring. Staff told us meetings had taken place to discuss these events and changes in practice had been implemented regarding the monitoring of medication expiry dates. Staff who worked in the dispensary described the monthly check that is now completed on the expiry dates of all medicines held within the dispensary.

We asked to see records the provider maintained around the review of incidents, including minutes of meetings held, investigations completed and how any lessons learned had been shared. We found records were not always available. This was an area the practice had already identified for improvement. One of the GP's we spoke with described the

Are services safe?

'pressing need' to set up regular adverse events practice meetings. This demonstrated the provider had learnt from the recent medicine supply error and planned to take steps to improve its incident review processes.

We spoke with a member of staff who worked in the dispensary. They described how they had responded to a medicine alert from the Medicines and Healthcare products Regulatory Agency (MHRA). An issue had been identified with a supplier of a thyroid hormone medicine. The member of staff said in response to the concerns highlighted they had moved all of the practice's patients onto an alternative brand of the medicine within four hours of receiving the alert. This meant the provider actively learned and responded to safety alerts from external bodies.

Safeguarding

Staff we spoke with during the inspection were familiar with safeguarding procedures. They all described clearly what action they would take in the event of a safeguarding matter coming to their attention. They were clear about their roles and responsibilities in this area. They were also able to give examples of what constitutes abuse and the signs of abuse they looked for when dealing with patients on a daily basis. Staff told us the provider had a whistle blowing policy and they wouldn't hesitate to use it if they suspected people were at risk. This meant patients were cared for by staff who protected them from the risk of abuse.

We saw the provider had separate safeguarding policies and procedures in place to protect children and adults. The staff we spoke were aware of how to access these. Staff also said they had attended safeguarding training and / or completed online training and we saw evidence to confirm this. We saw the practice had a system in place to monitor people who were vulnerable, and staff were aware and responsive to the needs of these patients.

The practice manager told us regular practice safeguarding meetings were held and we saw evidence to support this. The team with responsibility for attending these meetings included a GP, a school nurse, the practice manager, practice nurses, a health visitor and a midwife. This meant the provider worked with other healthcare professionals within the community in order to maintain the safety of their patients.

Monitoring safety and responding to risk

Feedback from patients who completed comment cards indicated they would always be seen by a clinician on the day if their need was urgent. One patient commented "If it is urgent they will always see you, even if an appointment is not available."

Appropriate staffing levels and skill-mix were provided by the practice during the hours the service was open. This included GP's, a practice nurse, reception and dispensary staff. The practice also had a GP Registrar and used two regular locum GP's. Staff we spoke with were flexible in the tasks they carried out. This meant they were able to respond to areas in the practice that were particularly busy. For example, within the reception or the dispensary.

There was a defibrillator and oxygen available for use in a medical emergency and we saw evidence the equipment was checked daily to ensure it was in working condition. All of the staff we spoke with knew how to react in urgent or emergency situations.

Medicines management

There were up to date medicines management policies and staff we spoke with were familiar with them. One of the practice's GP's had medical accountability for medicines management. The practice also had a medicines manager and an appointed pharmacist who were funded by the local Clinical Commissioning Group (CCG). This service was initiated by the previous commissioner of services (the Primary Care Trust (PCT)), and was a Cumbria-wide initiative.

Staff who worked in the dispensary told us medicines requiring cold storage were placed in the practice's medicines fridges immediately upon receipt and 'booked in'. We saw this put into practice when a delivery of medicines was received. The temperatures of the two medicine's fridges in the practice were monitored daily to ensure they remained within specified limits. This meant the practice had suitable arrangements in place for the storage of temperature-critical medicines, including vaccines.

We looked at how controlled drugs were managed. Controlled drugs were medicines that required extra checks and special storage arrangements because of their

potential for misuse. The records showed the controlled drugs were stored, recorded and checked safely. We checked a sample of the controlled drugs stored and the number of tablets stored matched the records maintained.

There was a clear audit trail for the authorisation and review of repeat prescriptions. The dispenser checked the practice's computerised records to see if the items ordered were authorised for repeat. If not, they sent a request through to the GP electronically, who then reviewed the items requested and authorised or declined the request. Only then would the dispenser issue the prescription or advise the patient of the next course of action they should take (e.g. arrange to see their GP). There was also a clear audit trail for the management of information received from other services. For example, hospital discharge letters that included information about medicines prescribed were scanned into the practice's computer system and sent to the GP for review and authorisation. The medicines were only dispensed following authorisation by the GP and we saw evidence to confirm this.

The practice had specific dispensing software with bar code technology to provide real time checking of the quality of medicine dispensing. The dispenser would call up on their screen the prescription they were dispensing, collect the medicine and scan the bar code into the system. If the medicine scanned didn't match the medicine prescribed for dispensing, the system flagged up an error message on the screen and would not print the patient specific medicine label with directions for use on. This prevented medicines that hadn't been prescribed from being dispensed. The staff in the dispensary said if the bar code wasn't recognised but the medicine was correct, a secondary check by a trained colleague would be sought. This meant patients could be confident they would receive the correct medicines, based on their prescription.

We saw appropriate arrangements were in place to obtain out of stock medicines. This included attempts to source medicines from pharmacies in the community. The staff in the dispensary said "We do anything we can to help them (the patients)." Arrangements were also in place to maintain stock levels within the dispensary. This included deliveries twice daily and the ability to automate re-orders of commonly used medicines. This meant the practice was attempting to ensure patients had access to medicines when they needed them.

Staff who worked within the dispensary showed us FP10 prescription forms were stored in a room that was locked. Although the room was secure, storage arrangements for blank FP10 prescription forms did not adhere to guidance issued by NHS Protect. NHS Protect leads on work to identify and tackle crime across the health service. The aim is to protect NHS staff and resources from activities that would otherwise undermine their effectiveness and their ability to meet the needs of patients and professionals. The guidance stated "As a minimum, prescription forms should be kept in a locked cabinet within a lockable room or area." Prescription forms used for the prescribing of controlled drugs were stored in line with guidance.

Cleanliness and infection control

We saw the practice was visibly clean and the staff we spoke with reported they had completed infection control training. The practice had a range of policies and procedures relating to infection control. These included staff washing their hands, use of antibacterial hand gel and 'bare below the elbow' dress code.

The practice had a several infection control leads. The practice nurse told us they were one of those and they knew how to access the infection control policies.

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 general and clinical waste.

The practice manager explained the premises were leased from Cumbria Partnership and all fixtures and fittings were supplied and maintained by them. The cleaning of the premises was also provided by the Partnership. There was a daily cleaning schedule for the premises and we saw audits were carried out to ensure the cleaning was taking place.

Staffing and recruitment

The practice manager stated the practice hadn't recruited any new members of staff since 2010/11. We saw the practice had a recruitment policy, however the practice manager said it needed updating. Information as specified within Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 was not available to be viewed for all staff employed within the practice. For example, the practice had employed two locum GP's as a long standing arrangement. Both had formerly been GP partners elsewhere. The practice held copies of all Locum GP's professional registrations. The practice had verified

Are services safe?

these staff held valid police checks (called Disclosure and Barring Service or DBS checks), however they did not keep copies of these on file. There were also no references on file for these staff.

The practice employed sufficient numbers of suitably qualified, skilled and experienced staff for the purposes of carrying on the regulated activities. We asked the practice manager how they ensured staff were registered with the relevant professional bodies. For example, did they routinely check the practice nurses were registered with the Nursing and Midwifery Council (NMC). The practice manager said they knew they could check this information on line, but were unable to provide evidence of having done so. The practice manager checked this information during the inspection and showed us the practice nurses were registered with the NMC. We also spoke with a practice nurse who was able to show us details of their registration online.

Dealing with Emergencies

The provider had emergency response plans in place. We saw there were 'panic buttons' in place within all rooms in the practice. This allowed staff to raise the alarm quickly to alert other staff to the need to deal with an emergency situation. Equipment for dealing with medical emergencies was seen to be available within the practice, including emergency medicines.

We spoke with one of the GP's about how they maintained safe patient care during visits to patients at home. They were able to describe how they had successfully resuscitated a patient who was severely ill at home.

Equipment

The provider had a range of equipment in place. This included medicine fridges, a defibrillator, oxygen, sharps boxes (for the safe disposal of needles), an electrocardiogram (ECG) machine and fire extinguishers. We saw regular checks of the equipment took place to ensure it was in working condition.

The practice had a total of three fire extinguishers on the premises. One of these had been advised to be replaced by the fire service in November 2012. We saw the extinguisher continued to be out of date and available for use. We spoke with the practice manager about this and they said fire safety checks, including fire extinguishers, were overseen by the Cumbria Partnership NHS Trust, who owned the premises. The practice manager informed us after the inspection the extinguisher had been replaced.

Are services effective?

(for example, treatment is effective)

Summary of findings

Overall, the service was effective. We found care and treatment was delivered in line with recognised practice standards and guidelines. Patients were referred appropriately to other services, where there was a need to do so. The provider had developed a positive and effective working relationship with the local community pharmacy.

Our findings

Promoting best practice

We found care and treatment was delivered in line with recognised practice standards and guidelines. For example, we spoke with a practice nurse who told us they used National Institute for Health and Care Excellence (NICE) guidelines. They showed us how they accessed and used current standards and best practice for managing conditions such as hypertension and diabetes.

GPs and other clinical staff were able to perform appropriate skilled examinations with consideration for the patient. Staff had access to the necessary equipment and were skilled in its use. For example, one GP was skilled in and responsible for very minor surgery and cryotherapy within the practice.

Patients were referred appropriately to other services, where there was a need to do so. For example, there were no specific practice clinics to offer advice on smoking cessation, although advice would be offered during nurse and GP consultations. Patients were referred to the local community pharmacist in Alston who offered smoking cessation advice. The practice also had two sets of guidelines in use for the two week cancer referral service. These had been produced in West Cumbria and were found to be comprehensive.

A GP within the practice was the mental health lead for the Eden Valley locality. There was a practice- attached mental health care co-ordinator; an initiative the practice was attempting to spread across the Eden Valley locality. This meant patients could be confident their mental health needs would be assessed and diagnosed effectively and their care and treatment planned effectively.

Management, monitoring and improving outcomes for people

Two audits had been completed around patients attending accident and emergency (A+E) and the Minor Injuries Unit (MIU). Monitoring the number of avoidable attendances for patients was a focus of this work. There had been a reduction of 13% when comparing data from 2013 to 2012, with the biggest reduction in attendances being among patients over 75 years of age. We saw action plans were in place to further improve this outcome area for patients. This showed the practice had completed work on monitoring and improving outcomes for people.

Are services effective?

(for example, treatment is effective)

We saw audits of prescribing patterns and data had been completed. This work was done in line with the General Medical Services (GMS) Quality and Outcomes Framework (QOF). Areas audited included the prescribing of non-steroidal anti-inflammatory drugs (NSAIDs), antibiotic prescribing and the prescribing of an anticonvulsant medicine. It was evident that improvements in performance in line with QOF targets had been made within most of these areas. Staff we spoke with said there was no other current audit or monitoring of performance activity in progress at the time of inspection.

Staffing

Staff employed to work within the practice were appropriately qualified and competent to carry out their roles safely and effectively. This included staff who worked within the dispensary, whose competency was regularly checked and signed off by clinical staff.

The practice was designated as a training practice for GP Registrars and one of the GP's was the designated trainer for the practice. They told us about a week-long induction programme for GP Registrars which involved sitting in with GP partners, but the main focus was on understanding the practice as an organisation.

Staff we spoke with told us about training and professional development available to them. This included time allowed to maintain their current skills and the opportunity to learn new ones. They confirmed they had received appraisals and had identified learning and development plans as part of this process.

Working with other services

It was evident the practice regularly engaged with other health and social care providers and other bodies to co-ordinate care to meet patient's needs. Both GP's were funded to provide in-hours supervision and care at the cottage hospital physically attached to the practice. The hospital had six inpatient beds and was usually used by patients as 'step-down' care provision from Carlisle hospital inpatient care. Other GP's could occasionally refer patients to the cottage hospital, in which case, as with the hospital referral, a doctor to doctor phone consultation took place before admission.

Staff who worked in the dispensary spoke of an arrangement they had with the local community pharmacy. A reciprocal arrangement was in place between the practice and the community pharmacy. The dispensary would attempt to serve the needs of the community pharmacy's patients on the day it closed half-day and the community pharmacy would do the same for the practice's patients on a Saturday when the practice was closed. We spoke with the community pharmacist and they confirmed the positive working arrangement and how it worked well for both parties in putting patients first.

Other professionals who the practice had good working relationships and co-ordinated care with included dieticians, a podiatrist, opticians, physiotherapists, digitised x-ray facilities and an elderly care consultant who visited the practice on a fortnightly basis. This demonstrated how the practice enabled multi-disciplinary working with other services.

Health, promotion and prevention

The two practice nurses played leading roles with regards to health promotion and prevention within the practice. We asked a practice nurse how they registered new patients. They told us the person would register with the practice first, then be asked to attend for a health check. This included making an appointment to see their children, if they had any.

The practice nurse told us how the risks, benefits and alternative options were discussed with patients when their long term conditions required a review. They told us how they monitored and reviewed the care and their treatment.

The practice nurse said they were responsible for recalling, monitoring and health education for people with long term conditions and these included conditions such as asthma, diabetes, hypertension, and coronary heart disease; they also carried out cervical smears. We were told blood tests and screening checks were carried out on these people twice a year. Where people failed to attend, we were told the reception staff would offer another appointment. Where a person then failed to attend the GP would make an assessment as to the action they would take. They would decide the most appropriate action and whether a visit to the person's home would be needed. This meant people could be confident their long term conditions were being managed effectively.

We saw there was a practice newsletter in the reception area that informed people about health promotion issues, including optical and hearing aid clinics. The nurse told us

Are services effective?

(for example, treatment is effective)

the practice gave smoking cessation advice, however following the initial consultation with the GP, the local community pharmacist now provided the service. The practice also offered a cervical screening service.

We were told the annual flu vaccines continued to be offered to people including those in vulnerable groups. For example, people who suffered from asthma and other long term conditions. Where these people had visited the practice for another appointment, the nurse said they were offered the vaccine so they would not have to make another appointment.

Are services caring?

Summary of findings

Overall, the service was caring. All of the patients we spoke with said they were treated with respect and dignity by the practice staff at all times. Patient's also reported they felt involved in all decisions surrounding their care or treatment.

Our findings

Respect, dignity, compassion and empathy

All of the patients we spoke with said they were treated with respect and dignity by the practice staff at all times. Comments left by patients on comment cards we received reflected this. Comments included "Staff are always friendly and courteous"; "Made to feel welcome and cared for"; "All the staff are helpful, friendly and concerned" and "I can say without question that Alston Medical Practice is the best, most caring, most professional and thorough I have had experience of."

We observed staff who worked in reception, the dispensary and other clinical staff as they received and interacted with patients. Their approach was seen to be considerate, understanding and caring, while remaining respectful and professional. This was clearly appreciated by the patients who attended the practice. The reception and dispensary both fronted directly onto the patient waiting area. 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 and with the patient's agreement. The staff who worked in reception said they used non-identifiable patient reference numbers when transferring telephone calls from patients within the practice. This demonstrated the practice had made respecting patients' rights, including to privacy and dignity a priority.

People's privacy, dignity and right to confidentiality were maintained. For example, the practice offered a chaperone service and a private room was made available when people wanted to talk in confidence with the reception staff. We saw information about the chaperone service offered was clearly displayed in the waiting area. We were told a counsellor visited the practice on a regular basis and was available for people who had suffered bereavement to speak with. Information was also displayed to reflect the practice's intolerance of disrespectful, discriminatory or abusive behaviour.

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

Are services caring?

The practice provided services for people who cared for others (carers). This included working with a local organisation and maintaining a practice register of carers that people could ask to be added to. The practice also offered carers the opportunity to book double appointments if this was required. One patient who filled in a comment card stated "I am a full time carer to my (relative) who is xx years old. The office, pharmacy, nursing staff and doctors have provided not only a professional and efficient service to myself as a carer, but also to my (relative)." This demonstrated staff who dealt with people who cared for others were aware of their circumstances and would take account of that, including understanding the complications it could mean.

Involvement in decisions and consent

Patient's we spoke with reported they felt involved in all decisions surrounding their care or treatment. They went on to explain a full explanation was given to them by their clinician about their treatment or medication and they were given options to consider. One patient told us they "Had a choice of hospital" to attend for an operation they required. Comments left by patients on comment cards we received reflected this. Comments included "(I am) listened to and responded with good care and treatment"; "My needs have been responded to with care and treatment"; "Everyone (the staff) is always willing to do extra to make things happen and resolve health problems" and "Doctor listened to everything I said, then gave me everything I needed for a speedy recovery."

We spoke with a practice nurse who told us consent was obtained from patients in line with national guidance. This included consent for the sharing of information between professionals. They also said they would use the Gillick competency of children and young people when needed, however there had not been an occasion this had been required yet. Gillick competence is used 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. A GP within the practice was also the mental health lead for the Eden Valley locality and both GP's we spoke with reported awareness of mental capacity requirements. This meant patients were supported to make informed decisions and to provide informed consent.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Overall, the service was responsive. The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. Patients said they were satisfied with the appointment systems operated by the practice. The practice had a policy for handling any concerns or complaints people raised.

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. For example, patients could access appointments face to face in the practice, receive a telephone consultation or be visited at home. Patients could also make appointments with the GP of their choice and this could be either with a male or female doctor. This meant the practice was attempting to meet patient's individual preferences.

Patients we spoke with and those who filled out comment cards all said they felt the practice was meeting their needs. This included being able to see the GP of their choice and being able to access repeat medication at short notice when this was required.

As part of the practice's family planning service, a GP at the practice used to fit intrauterine contraceptive devices (IUCD's) for patients. This responsibility was passed to a new partner, who subsequently retired. This service was now provided, by arrangement, by a GP practice 20 miles away. This meant the practice had made arrangements to ensure the needs of their patients would continue to be met in this area.

The practice worked with other agencies to make sure that patients' needs continued to be met. GP's used the 'Choose and Book' system to access hospital appointments for their patients. The patients we spoke with and comments received on comment cards showed that people were offered a choice of hospitals to attend. This meant patients were supported to choose other services in line with their preferences.

We saw patients received support from the practice following discharge from hospitals or following the return of test results. This included through the timely provision of post-operative medicines and follow-up appointments with a GP or nurse as required.

Access to the service

Patients we spoke with and those who filled out comment cards all said they were satisfied with the appointment systems operated by the practice. One patient said "You can always get an appointment here" and other comments included "Appointments available in reasonable timescales

Are services responsive to people's needs?

(for example, to feedback?)

and if it is urgent, they will always see you – even if an appointment is not available"; "Appointments immediately" and "I can always get an appointment when I want one."

Patients could make appointments in a number of ways. They could call in to the practice, request an appointment over the telephone, or book an appointment online after registering to use this service. The practice was open Monday to Friday and the opening hours were clearly displayed, both within the practice and on the practice's website and practice leaflet. Out of hours enquiries were redirected to the provider's contracted out of hour's provider, Cumbria Health on Call (CHoC). We spoke with two members of the practice's Patient Participation Group (PPG), one of whom said early discussions had taken place regarding the practice extending its opening hours. This showed the practice was monitoring its appointments system and service provision in order to continue to meet the needs of its patients.

Consultations were provided face to face at the practice, over the telephone, or by means of a home visit by a GP. This helped to ensure people had access to the right care at the right time.

An antenatal and well-baby clinic was also held on a Wednesday afternoon. This was an open access clinic where no appointment was needed.

Concerns and complaints

The practice had a policy for handling any concerns or complaints people raised. Staff spoken with were aware of the practice's policy and knew how to respond in the event of a patient raising a concern or complaint with them directly. We were told a 'comments box' was normally in place in the waiting area, however this had not been put back in place following some recent refurbishment work and was not present on the day of the inspection.

We saw information on how patients could raise concerns or complaints was displayed on the window in reception at the bottom of the 'Alston Medical Practice – Practice Charter' poster. Information was also provided within the practice leaflet. Although information was available, most of the patients we spoke with said they were unaware of how they would raise any concerns or complaints they had with the practice.

The practice had received one formal complaint within the last 12 months. We reviewed this and found the complaint had been acknowledged on receipt, investigated and resolved in conjunction and to the satisfaction of the complainant. As a result of the complaint, some of the practice's Standard Operating Procedures (SOP) had been reviewed and updated. This demonstrated the practice listened, learned and made improvements to the services it provided as a result of feedback and complaints.

Are services well-led?

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

Summary of findings

Overall, the service was well-led. Staff were aware of the need to get things right for patients and it was clear the care of patients was their priority. Feedback we received from patients showed they felt valued and well cared for by staff. There was an established management structure within the practice. Staff demonstrated an understanding of their areas of responsibility and reported feeling supported, motivated and valued by their peers.

The practice had a Patient Participation Group (PPG). It was felt the practice had tried to get a geographical as well as a demographical spread of patients to participate. Most of the patients we spoke with were not aware of this group.

Our findings

Leadership and culture

Staff we spoke with regularly referred to the vision of 'joined up services' within the local community of Alston Moor, and the role the practice saw for itself. This was described to us as 'a virtual campus of integrated services spanning health and social care.' The practice manager said "To be viable we need to work together" and referred to the links the practice had with the cottage hospital, the local community pharmacy and residential home. Staff were aware of the need to get things right for the patients and it was clear the care of patients was their priority. Feedback we received from patients showed they felt valued and well cared for by the staff.

There was an established management structure within the practice. Staff demonstrated an understanding of their areas of responsibility and took an active role in ensuring that a high level of service was provided on a daily basis. It was evident there was a strong team-working ethic among the practice staff. Several of the staff we spoke with told us about how they 'mucked in' and helped colleagues during busy periods or when the need arose. Staff reported feeling supported, motivated and valued by their peers.

The practice manager said they were aware of the need to make progress with succession planning and was looking into pursuing an apprenticeship to complement the administrative staff employed by the practice. This meant the provider showed an understanding of the current and future leadership needs of the practice.

Governance arrangements

Staff were aware of what they could and couldn't make decisions on. For example, staff who worked within the dispensary demonstrated to us they were aware of what they could and couldn't do with regards to the issue of repeat prescriptions. We also found GP had clearly defined lead roles within the practice, for example for family planning or GP training.

GP's from the practice sat on various local clinical groups. This included a local clinical reference group who met regularly and reviewed clinical issues. A GP also sat on the Local Medical Committee (LMC). The LMC represents the

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views of GPs to any other appropriate organisation or agency. This showed the practice participated in joint working arrangements and had representation on external bodies.

Systems to monitor and improve quality and improvement

We saw some audit activity had taken place within the practice during the last 12 months, mainly within the area of prescribing. Full clinical audits had been undertaken by the medicines manager and pharmacist attached to the practice. The audit and re-audit of prescribing patterns had resulted in improvements in the quality of prescribing within the practice for various medicines groups.

Audits had also been completed for a sample of cancer patients (on the referral process and care received) and on the number of patients attending Accident and Emergency (A+E) unnecessarily during practice hours. Plans for improvement had been produced. A further audit of A+E attendances had been completed and the results showed improvements had been made.

We spoke with a GP who told us an audit on depression had been completed some years ago, however there had been no recent clinically led audit activity within the practice.

Patient experience and involvement

The practice had a Patient Participation Group (PPG). We spoke with two current members of the group and were told it was formed in November 2013. Membership of the group was by invitation from the practice. It was felt the practice had tried to get a geographical as well as a demographical spread of patients to participate. Most of the patients we spoke with were not aware of the group.

One of the first priorities of the group was to complete the practice's patient survey. The survey was carried out in February 2014 and sampled 60 patients' views over five days. The results were published on the practice's website in March 2014. Most of the feedback from patients was very positive and was reflected by patients we spoke with during the inspection. A negative comment was raised and investigated by the practice. This showed the practice took notice of and acted upon feedback from people who used the service. It was decided a formal action plan was not required due to the positive findings of the survey.

Other comments from members of the PPG reflected the positive comments we received from patients. Examples included "Access to appointments is unbelievably good", "I've never seen anything work quite as well as this place" and "They make it special for you – you don't have any barriers (to care)." This showed patients were satisfied with their experience of using the practice and the services it provided.

Staff engagement and involvement

Staff told us they had meetings on a regular basis, although these were mostly informal and were used to discuss relevant issues at the time. These meetings were not minuted and this was confirmed by the practice manager. Staff told us they were encouraged and supported to raise issues by their peers and were confident these would be listened to and acted upon.

The practice manager told us "I'm very proud of the team here" and said they operated an open door policy and staff were able to speak with them at any time. The staff we spoke with confirmed this and told us they felt well supported and appreciated by the whole practice team.

Learning and improvement

GP's were allowed up to two weeks study leave; however both GP's said they had been unable to use all their allocation due to practice commitments. The GP's attended day courses and also accessed online educational resources as part of their learning and development. Staff from the practice also attended the Clinical Commissioning Group (CCG) protected time education initiative. This provided GP practice staff with protected time for learning and development once every two to three months. This meant systems were in place to enable learning and to improve performance.

Identification and management of risk

One of the GP's we spoke with told us about a risk they had identified. They felt the practice needed to set up regular practice meetings to discuss adverse events. They felt this was an area the practice could improve in. Both of the GP's within the practice felt regular practice meetings had been allowed to lapse due to workload pressures.

Risks relating to the supply of medicines from the dispensary within the practice were managed with a comprehensive set of Standard Operating Procedures (SOP). Competency checks were also completed on a

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regular basis on staff that worked in the dispensary and were signed off by a clinician. Other controls, including bar code scanning technology, were in place to ensure the correct supply of medicines to patients.