Dr Jonathan Smith

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a planned comprehensive inspection of Dr Jonathan Smith (Glenridding Health Centre) Medical Practice on 20 November 2014.

We rated the practice overall as good.

Our key findings were as follows:

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- There were good arrangements in place for infection control and the management of medicines.
- Patients told us they liked the way the open surgery operated and the access this gave them to a GP. This gave good continuity of care.
- The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services.

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

Importantly, the provider must:

- improve their approach to appraisal for staff to provide adequate support with their learning and development needs.

In addition the provider should:

- improve their approach to checking and recording information which confirms that staff members are of good character and have the skills and experience which are necessary for the work to be performed.
- consider their approach to obtaining written consent for some aspects of care and treatment, such as minor surgeries.
- make sure the lead GP for safeguarding undertakes children's safeguarding training to the highest level (level three), in line with national guidance.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well-managed. There were enough staff to keep people safe. The practice should consider their recruitment process to enable them to demonstrate that staff were suitable and fit for the role they had been employed to undertake.

We found the practice had in place good medicines management arrangements. There were arrangements in place to reduce the risk of the spread of infection. These would be further improved by some building work that was planned for the near future.

Are services effective?

Requires improvement

The practice is rated as requires improvement for effective as there were some areas where improvements should be made. Data showed patient outcomes were similar to the average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and routinely used. 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. However, staff were not receiving regular appraisals to allow the practice to identify their personal development needs. Staff worked well with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. Patients told us they liked the way the open surgery operated and the access

Summary of findings

this gave them to a GP. There was continuity of care, with routine and urgent appointments available the same day. The practice had a policy for handling any concerns or complaints people raised. The practice worked collaboratively with other agencies, regularly sharing information to ensure good, timely communication of changes in care and treatment.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

There was care planning in place for the most elderly and infirm. There were good communication mechanisms with other providers of care and treatment for frail older patients, including communication with district nurses. There were arrangements in place to support people when they reached the end of their life.

People with long term conditions

Good

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

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were in line with national and local averages for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had

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been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs of this age group. Patients told us they liked the way the open surgery operated and the access this gave them to a GP.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances, including patients who had a learning disability. Because of the small number of patients registered with the practice, they were able to identify and monitor those most at risk of experiencing poor or deteriorating health. The open access surgery was flexible to patient needs, allowing more time to be spent with the most vulnerable patients or those who may have difficulty communicating their needs.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The percentage of patients with physical and/or mental health conditions whose notes contained an offer of support and treatment within the preceding 15 months was 93.8%. 100% of patients diagnosed with dementia had their care reviewed in the previous 15 months.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. They carried out advance care planning for patients with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

CQC comment cards we received were positive about the emotional support provided by the practice and rated it well in this area. Some in particular, mentioned support given to patients suffering anxiety and the skill with which clinicians recognised the link between physical and mental health.

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What people who use the service say

We spoke with five patients during the inspection, including one member of the practice Patient Participation Group (PPG). The majority of patients were complementary about the services they received at the practice and told us the most important aspect of the service was that it was local and tailored to their needs. They told us it was an important part of their local community and were worried that its size may make it more vulnerable to closure. They told us this would have a big impact locally. Patients told us they particularly liked that there were open surgeries in the morning and afternoon, where they could attend and see clinical staff on the same day.

Many mentioned the good continuity of care they received, as they often received a consultation with the same GP each time they came.

They told us staff were friendly, and treated them with dignity and respect. They told us when they saw clinical staff, they felt they had enough time to discuss the reason for their visit and that staff explained things to them clearly in a way they could understand.

Patients told us due to the waiting room and reception area being very small, their conversations with staff could sometimes be overheard. However, they said staff made every effort to keep conversations confidential. They told us they found the premises to be clean and tidy.

We reviewed 19 CQC comment cards completed by patients prior to the inspection. The comments made reflected those made by the patients we spoke with during the inspection. All were complimentary about the practice, staff who worked there and the quality of service and care provided. Phrases used to describe the practice included, could not be better; fantastic; wonderful; 10 out of 10; and, vital to the remote community. Two patients in particular praised the practices approach to understanding the interconnection between physical and mental health and support for those with poor mental health. Four patients commented on how well the practice diagnosed and supported them through referrals to hospitals and consultants.

The latest GP Patient Survey completed in 2013/14 showed the large majority of patients were satisfied with the services the practice offered. The following results were all better than the average for other local practices:

- 97% described their overall experience of this surgery as good
- 89% would recommend this surgery to someone new to the area
- 88% are satisfied with the surgery's opening hours
- 100% say the last appointment they got was convenient
- 92% find it easy to get through to this surgery by phone
- 94% were able to get an appointment to see or speak to someone the last time they tried
- 90% say the last GP they saw or spoke to was good at explaining tests and treatments
- 90% say the last GP they saw or spoke to was good at involving them in decisions about their care

These results were based on 89 surveys that were returned from a total of 267 sent out; a response rate of 33%.

Areas for improvement

Action the service MUST take to improve

- Must improve their approach to appraisal for staff to provide adequate support with their learning and development needs.

Action the service SHOULD take to improve

- The practice should improve their approach to checking and recording information which confirms that staff members are of good character and have the skills and experience which are necessary for the work to be performed.

Summary of findings

- The practice should consider their approach to obtaining written consent for some aspects of care and treatment, such as minor surgeries.
- The lead GP for safeguarding should undertake children's safeguarding training to the highest level (level three), in line with National guidance.

Dr Jonathan Smith

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 and a CQC pharmacy inspector.

Background to Dr Jonathan Smith

The Glenridding Health Centre is based in a very rural area and is situated on the edge of Lake Ullswater. It has a small practice population of just over 700 patients. This number fluctuates during the year, due to the local tourist trade. Many new patients register at the start of the tourist season when they come to work in local services, including hotels, catering and recreational services and then leave at the end of the season. These patients are often from a diverse range of nationalities that come to Glenridding and surrounding areas for work.

Dr Smith is the lead GP and registered provider of the service. There is also a female associate GP, a practice nurse, a practice manager, three dispenser / receptionists and a cleaner working at the practice. The practice is a training practice and therefore normally has a GP registrar. However, there was none allocated at the time of our inspection.

The practice is commissioned to provide services within a Personal Medical Services (PMS) agreement with NHS England. The practice provides primary medical care services to patients in the area around Glenridding, Ullswater, Troutbeck, Greystoke, Dacre, Stainton, Eamon Bridge and Penrith. Glenridding Health Centre is a dispensing practice. This means under certain criteria they can supply eligible patients with medicines directly.

All patient services are delivered from the ground floor. There are two consultation rooms, a treatment room and reception and waiting area. There are good access facilities for patients with physical disabilities and there is a disabled parking bay outside the building. There is a large National Trust car park to the rear of the building, which patients can use if they inform reception staff of their car registration on arrival.

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

Why we carried out this inspection

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

How we carried out this inspection

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

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

Detailed findings

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

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

We carried out an announced visit on 20 November 2014. During our visit we spoke with all staff who were working at the time of the inspection. This included the lead and associate GPs, the Practice Nurse, the Practice Manager and dispensing and reception staff. We also spoke with five patients who used the service. We reviewed 19 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, they used reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. There was no standard form within the practice to record these.

The GP told us that as the patients came from a small community, patient safety was an important consideration. They said that if anything went wrong, then they know they would have to see the patient, not only in the surgery, but also out and about in the community. They therefore prioritised getting things right, but were also open and transparent when things went wrong.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of five significant events that had occurred over the last 12 months and we were able to review a number of these.

There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. The staff we spoke with were aware of the system for raising significant events and felt encouraged to do so.

National patient safety alerts were disseminated by the practice manager to practice staff. These were distributed to staff members, and a copy was put on file in a folder for locum GPs to refer to. This file was also available for any staff member to refer to.

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. 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. Contact details were easily accessible.

The lead GP was the designated lead for safeguarding of vulnerable adults and children. Both the lead GP and practice nurse had been trained to level two in the safeguarding of children and young people. The practice did not have a lead GP who had undertaken training to the appropriate level (level three) in this area, in line with National guidance. The lead GP told us that he attended regular multi-disciplinary primary care meetings, where safeguarding within the area and themes from the local safeguarding board were discussed.

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.

A chaperone policy was in place and this service was advertised in the reception and waiting area. The practice manager told us normally a GP or nurse acted as a chaperone when required. Historically, non-clinical staff had also acted as chaperones if no clinical staff were available. However, they told us they had not had to do this for some considerable time. The non-clinical staff we spoke with told us they had not received any training on the role of chaperone and were unclear about how they would carry out this role. They told us they would stand outside the curtain, so they could hear, but not see the examination. To reduce the risk of abuse occurring it is important that chaperones should place themselves inside the screened-off area as opposed to outside of the curtains/screen. If they are placed outside the screened area then they are not technically acting as a chaperone. The practice manager told us that non-clinical staff would no longer be asked to undertake the role of chaperone.

Medicines management

We found the practice had in place good arrangements for the management of medicines. We checked vaccines stored in the refrigerator and found they were stored securely and were only accessible to authorised staff. Maximum and minimum temperatures of the refrigerator

was checked and recorded every day when the surgery was open. This ensured that the vaccines were fit for use. Vaccines were administered by the practice nurse using directions that had been produced in line with legal requirements and national guidance. We saw copies of directions that were signed by the nurse who used them.

Medicines storage in the dispensary was secure. Processes were in place to check medicines were within their expiry date and suitable for use. We checked a sample of medicines and they were all within their expiry date.

There was a good double-checking system for medicines dispensed for patients. Prescriptions were checked and signed by the GP before patients received their medicines. The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

We saw processes in place for checking medicines stored in the Emergency Medicines bags to ensure no expired stock was kept. Blank prescription forms were handled in accordance with national guidance and were kept securely.

We saw that regular audit was done to improve the way medicines were managed. For example, audits of dispensing processes were carried out to identify and manage concerns. The practice manager told us that standard operating procedures were reviewed if concerns were raised. We also saw that clinical audits, as required by the Clinical Commissioning Group, were undertaken, for example, to assess the prescribing of medicines for chronic lung disease. Action plans to improve prescribing were agreed to promote safe and effective use.

There were protocols for medicines management that were followed in practice and covered all required areas, for example, the generation of repeat prescriptions by staff. Protocols were regularly updated and staff were familiar with them. There was a safe system in place for updating patients' repeat prescribing records following hospital discharge. Systems were also in place to ensure patients received a regular review of their medicines. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

There was a system in place for the management of high risk medicines that included regular monitoring in line with national guidance.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by practice staff. Controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. Controlled drugs that were dispensed for patients were double-checked by a GP and this was recorded in the Controlled Drugs register. Appropriate arrangements were in place to ensure that dispensed controlled drugs were picked up safely by patients or their representatives. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

We saw records showing members of staff involved in the dispensing process were experienced and had regular checks of their competence.

Cleanliness and 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.

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 and staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy for needle stick injuries. All instruments were single use to reduce the risk of the spread of infection.

There was major building work planned for the practice to commence January 2015. This included improvements to the building and facilities to in terms of infection control. For example, the plans included the installation of new clinical sinks and elbow operated taps to reduce the risk of the spread of infection. Also new flooring and seating which could be more easily washed. The practice manager told us that an audit of infection control was planned to take place following the completion of this work, as the building work would address many of the outstanding concerns.

Good

Are services safe?

There was one patient and staff toilet. 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.

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.

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

Equipment

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

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date.

Staffing and recruitment

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

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. However, for two staff recruited within the last two years there were some gaps in documented evidence. For example, for one staff member the practice manager was able to verbally tell us the past working history for the staff member. However, there was no application form or curriculum vitae (CV) on file. For another staff member there was no formal record that references had been sought. However, the practice manager showed us very brief notes of a telephone conversation that they told us they had made to the previous employer. We saw that the practice had checked proof of identification, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service for each staff member.

The practice employed sufficient numbers of suitably qualified, skilled and experienced staff for the purposes of carrying on the regulated activities. There were arrangements in place to ensure cover for staff absences.

Monitoring safety and responding to risk

Feedback from patients we spoke with and those who completed CQC comment cards indicated they would always be seen by a clinician on the same day during open surgery.

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.

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, dealing with emergencies and equipment. The practice also had a health and safety policy. We saw evidence the practice had sought professional health and safety advice to refine this policy.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to emergency medicines, oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). All staff we spoke with knew the location of this equipment.

The practice had emergency response plans in place. These identified the action to take during disruption due to

Good

Are services safe?

unforeseen changes in staffing levels or loss of essential supplies or facilities. There were also arrangements to use the community hospital to ensure continued access to services in the event of the practice premises being unavailable due to an emergency.

There were appropriate arrangements in place to ensure that staff knew what to do in the event of a fire in the practice.

Requires improvement

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 the nurse 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 diabetes were invited into the practice to have their medicines reviewed for effectiveness.

Staff had access to the necessary medical equipment for assessment of patients and were skilled in its use; for example, blood pressure monitoring equipment and an electrocardiogram (ECG) machine.

We reviewed the most recent Quality and Outcomes Framework (QOF) results for the practice for the year 2012 / 2013. The QOF is part of the General Medical Services (GMS) contract for general practices. Practices are rewarded for the provision of quality care. The data for some indicators was not published because of the small numbers of patients counted within the indicators. This was to maintain patient confidentiality and to ensure analysis was undertaken only where this was statistically meaningful. We saw where indicators were published they were in line with the average of other practices.

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 filled in 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

The practice had a system in place for completing clinical audit cycles. For example, the practice had undertaken an audit of Ear, Nose and Throat (ENT) referrals. This was a repeat audit cycle, where the practice was able to demonstrate the changes since the initial audits had been carried out.

We reviewed a range of data available to us prior to the inspection relating to health outcomes for patients. This demonstrated that the practice was performing the same as, or better than, average when compared to other practices in England.

For example, QOF data showed the percentage of patients with physical and/or mental health conditions whose notes contain an offer of support and treatment within the preceding 15 months was in line with national averages at 93.8%. 100% of patients diagnosed with dementia had their care reviewed in the previous 15 months.

Due to the small number of patients registered with the practice, they were able to identify and monitor those most at risk of experiencing poor or deteriorating health. For example, they were able to tell us about the very small number of frail elderly patients, patients with a learning disability and patients with poor mental health. They told us because they served a small community they could get to know patients really well and could identify anything that was out of the ordinary for a patient and react quickly. The practice had a process in place for identifying and monitoring those patients who may need more support with their health. For example, those on end of life care or patients who had recently been discharged from hospital.

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 evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had processes in place that covered child health and family support. This included a programme of routine health and development reviews. These were to allow them to assess growth and development of young children, identify risk factors and opportunities for improving health.

The practice had systems in place to identify patients, families and children who were most at risk or vulnerable. For example, practice staff told us that they had a register of patients who had a learning disability and also those with poor mental health. They also told us that annual

health checks were carried out for patients on these registers. QOF data confirmed that registers were in place and that patients were having their health needs assessed on a regular basis.

Effective staffing

Staff employed to work within the practice were appropriately qualified and competent to carry out their roles safely and effectively. This included the clinical and non-clinical staff. We reviewed staff training records for a selection of staff, and we saw that they had attended mandatory training, such as annual basic life support. A new e-learning system had been implemented across the clinical commissioning group (CCG) in Cumbria. We saw practice staff were making progress with relevant online e-learning training to support them to undertake their job role. This included areas such as infection control, health and safety and information governance.

The nurse in the practice was registered with the Nursing and Midwifery Council (NMC). To maintain their registration nurses must undertake regular training and updating of their skills. We saw evidence to support this took place in the nurse staff file.

The GPs in the practice were registered with the General Medical Council (GMC) and were also required to undertake regular training and updating of their skills. GPs were up to date with their yearly continuing professional development requirements and all either had been through the revalidation process or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council.)

We asked to see appraisal records for two staff members. Neither staff member had received an appraisal within the last year. The nurse who had worked at the practice just over one year had not had an appraisal whilst working at the practice. We were concerned this meant staff did not have the opportunity to formally discuss their work, identify their learning needs and create and agree a personal development plan to ensure they kept their knowledge and skills up to date. The Practice Manager and GP told us as they were a small practice with a low numbers of staff, they could have informal discussions with staff about personal development. However, none of these were documented.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Correspondence relating to patient care, such as test results, letters from the local hospital (including discharge summaries) and out-of-hours providers were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning 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.

The practice had joint working arrangements with another practice to offer a service for long-acting reversible contraception such as intrauterine devices or coils, which the practice did not offer itself.

The practice held multidisciplinary team meetings once a month to discuss the needs of high risk patients, for example, those with end of life care needs. These meetings were attended by district nurses, social workers and palliative care nurses. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice also attended a twice yearly referral support group to review referrals to hospital and consultants.

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).

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we

Requires improvement

Are services effective?

(for example, treatment is effective)

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).

Verbal consent was taken from patients for routine examinations and other treatments. Patients we spoke with reported they felt involved in decisions about their care and treatment.

We spoke with the GP about instances where they obtained written consent to treatment. They told us they were aware of their responsibility to obtain written consent for higher risk treatments, such as when performing minor surgeries. However, they told us because they know the patients so well; they have sometimes performed these without obtaining formal written consent. It is considered good practice to obtain written consent for minor surgeries. This is so that everyone involved understands what was explained and agreed.

Health promotion and 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 medications 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 offered, for example, cervical screening. However, the practice told us that take up rates for cervical screening had increased and then declined. They thought this might be because in a small community, patients get to know clinicians and this might make them more reluctant to undergo an intimate examination. They thought the increase had occurred when the new nurse was appointed and then declined as patients got to know them. They were investigating ways to address this.

Medicine reviews were done in the presence of the patient. Some of the patients we spoke with told us they were prescribed 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 area. This included a number of health promotion and prevention leaflets, for example, on smoking cessation and alcohol consumption. A registered healthcare charity had been given the opportunity to put on a display within the practice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with five patients during the inspection, including one member of the practice Patient Participation Group (PPG). All patients we spoke with told us staff were friendly, and treated them with dignity and respect. They told us when they saw clinical staff, they felt they had enough time to discuss the reason for their visit and that staff explained things to them clearly in a way they could understand. Many mentioned the continuity of care they received, as they often got to see the same GP each time they came.

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was considerate, understanding and caring, while remaining respectful and professional. The practice was running an open clinic for all patients on the day of our inspection. We saw only two or three patients waiting at any one time. Patients were seen a short time after arrival and waiting was kept to a minimum. Patients were greeted by clinical staff when it was their turn to see the doctor or nurse. We noted that although patients did not pre-book appointments, they were often greeted by name as staff knew people well.

Patients told us because the waiting room and reception area was very small, sometimes their conversations with staff could be overheard. But they told us staff made every effort to keep conversations confidential.

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. 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.

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 93% said the last GP they saw or spoke to was good at giving them enough time and 95% that the last GP they saw or spoke to was good at listening to them. 90% said the last GP they saw or spoke to was good at explaining tests and treatments. Overall, 90% said the last GP they saw or spoke to was good at involving them in decisions about their care. These results were in line with other practices in the Cumbria Clinical Commissioning Group (CCG).

Patients we spoke with 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 told us 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.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The majority of patients we spoke with and the CQC comment cards we received were positive about the emotional support provided by the practice and rated it well in this area. Some in particular, mentioned support given to patients suffering anxiety and the skill with which clinicians recognised the link between physical and mental health.

Notices in the patient waiting room also signposted people to a number of support groups and organisations.

Support was provided to patients during times of bereavement. Within a small community the clinical staff were aware of those receiving end of life care. We spoke with the GP about how they offered bespoke support for families based on the knowledge they had of patients'

Good

Are services caring?

wishes and preferences. Staff were kept aware of patients who had been bereaved so they were prepared and ready to offer emotional support. The practice also offered details of bereavement services. Staff we spoke with in the practice recognised the importance of being sensitive to people's wishes at these times.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice operated an open surgery to see a GP. This allowed patients to turn up at the practice without an appointment and see a GP on the same day. The patients we spoke with and those who filled out CQC comment cards told us in particular they liked the way the open surgery operated and the access this gave them to a GP. Patients emphasised the location of the practice was important to them and this made it easier to access health care within their local community.

The majority of patients we spoke with and all those who filled out CQC comment cards said they felt the practice was meeting their needs.

We found that the practice understood the needs of the practice population and systems were in place to address identified need. Practice staff told us that because they delivered services in rural areas, they felt they could get to know their practice population well. When we asked about those most at risk of poor access to primary care, the practice were able to tell us who these patients were and what action they had taken to reduce the barriers for them to access care and treatment. This enabled good continuity of care and accessibility of appointments with a GP of choice. Patients had choice over whether to see the male or female GP.

As there were no set appointment times, the GP told us this meant they spent as much time as was needed with each patient. This gave flexibility over the time patients could spend with a GP, with patients with more complex needs or who needed support with communication, able to spend longer with the GP. There was also access to home visits and telephone consultations

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

The practice had a Patient Participation Group (PPG). We spoke with one member of the group who told us the practice was responsive and listened to what the group had to say. They told us the practice had changed its opening hours to allow a small number of bookable appointments earlier or later in the day as a result of feedback from the PPG. We saw these were advertised in the practice waiting room. They told us the PPG had worked with the practice to identify and arrange other community healthcare services, such as the chiropodist and hearing aid clinic to be delivered from the practice. This increased the range of services available to the local community.

They also told us the practice had looked into promoting the health improvement agenda by trying to arrange access to gym facilities for those over the age of 65. However, as they had been unable to identify a physiotherapist or other appropriate healthcare professional to support this safely, these plans had been put on hold.

Tackling inequity and promoting equality

The practice had recognised the needs of the different groups in the planning of its services. The practice had made arrangements so that people with physical disabilities were able to access the service. All consultation and treatment rooms were based on the ground floor making access easier for patients in a wheel chair or with physical disabilities. There was a bell at the reception where patients could indicate they needed support to access the building. A large parking space for people with a disability was provided outside the practice. A portable induction loop system was in place for patients who experienced difficulties with their hearing.

Opening times had been extended to provide appointments outside normal working hours each week. This helped to improve access for those patients who worked full time.

We saw evidence that the practice provided staff with e-learning training on equality and diversity to help them understand the diverse needs of patients.

The practice also had access to telephone translation and interpreter services if required, for those patients whose first language was not English. Staff told us they most frequently used these services during tourist season when workers from other countries came to the area for work. These patients were registered with the practice for the duration of their stay to ensure good access to healthcare. They told us they maintained good relationships with local employers, who would recommend their services to staff.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

The practice was open from 9:30am until 11am and 4pm and 5:30pm Monday, Tuesday, Thursday and Friday. On a Wednesday the practice was open 9:30am to 11am. It offered an open surgery during these times. There was also a small number of pre-bookable appointments for those patients who wished to see a doctor outside normal working hours.

During core hours, when the practice was closed, the GP was contactable by mobile phone. The main phone number was diverted to the GPs mobile, so patients could access them in case of an emergency. The NHS GP Patient Survey found that 88% of patients surveyed were satisfied with the surgery opening times. They also found it easy to get through to this surgery by phone (92%) and were able to get an appointment to see or speak to someone the last time they tried (94%). 100% of patients surveyed said the last appointment they got was convenient.

Consultations were provided face to face at the practice, advice given over the telephone, or by means of a home visit by the GP. This helped to ensure people had access to the right care at the right time. There was both a male and female GP in the practice; therefore patients had choice over the gender of doctor they wished to see. We found appointments were available to meet people's needs and individual preferences.

Information was available to patients about appointments and repeat prescriptions on the practice website and in the practice itself. This demonstrated patients were provided with information on how to access services. Repeat prescriptions could be requested in the practice, via email or online.

Out of hours enquiries were redirected to the Cumbria contracted out of hour's provider, Cumbria Health on Call Ltd (CHOC). Contact details for the out of hours service was also displayed in the window of the practice for any patient who turned up at the practice when it was closed.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

Staff we spoke with were aware of the practice's policy and knew how to respond in the event of a patient raising a complaint or concern with them directly. We asked to see a summary of all the complaints the practice and branches had received this year. They had received one complaint in the year. We reviewed this and found the complaint had been recorded and fully investigated. We found the practice listened and learned from the complaint. We saw that contact had been made with the patient and an agreed plan put in place to address their concerns.

Only one of the five 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. They had attended the practice for this reason. In addition, none of the 19 CQC comment cards completed by patients indicated they had felt the need to complain.

Are services well-led?

Good

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

Our findings

Vision and strategy

The lead GP and practice staff told us they had a vision to deliver high quality care in a rural setting. They told us how important it was to staff that they could meet the needs of their local community. There was an established management structure within the practice. The practice manager, GPs and staff we spoke with were clear on their roles and responsibilities. All of them demonstrated an understanding of their area of responsibility and each took an active role in ensuring a high level of service was provided on a daily basis.

Staff described their aim was to provide patients with an effective, high quality service. It was evident there was a strong team-working ethic among the practice staff. The practice manager and other staff told us about how important team work was to them and that they all took pride in their work.

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, and saw these were reviewed regularly and were up-to-date.

The practice held weekly governance meetings to discuss quality audits, serious and significant events, complaints, patient feedback, performance data and other information relating to the quality of the service. We saw notes that demonstrated the practice routinely reviewed data and information to improve quality of service and outcomes for patients. The size of the practice meant information could be disseminated to the small number of staff working at the practice quickly and easily. However, these mechanisms were largely informal and were not documented.

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

Leadership, openness and transparency

We spoke with five members of practice staff and they were all clear about their own roles and responsibilities. We found that there were good levels of staff satisfaction and staff talked about the importance of the local service they offered. Staff told us it was important to them that they offered good quality healthcare in a local setting and that they were integral to the community.

Staff told us they felt confident about raising any issues and felt that if incidents did occur these would be investigated and dealt with in a proportionate manner.

We spoke with the practice manager and GP about how the practice planned for the future. They told us about the planned building work and how this would help them to continue to provide a good quality services but within premises which were up to modern standards. They told us about the risks and challenges this had posed and how they were working with the estates team to address these. We found practice staff were open in their approach and shared with us the benefits and challenges of delivering healthcare in a small rural community.

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

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

The PPG member we spoke with gave examples of the areas the group had been asked to comment and provide ideas for. This had included reviewing the opening hours of the practice.

We spoke with the practice manager about how the practice had used feedback from patients to improve the service offered. They told us they had a number of mechanisms for collecting and analysing feedback from patients. This included the patient participation group, patient complaints and compliments and patient surveys. Overall, evidence from these demonstrated that patients were generally satisfied with the service provided by the practice.

Management lead through learning and improvement

We saw practice staff met on a regular basis. Notes from the meetings showed the team discussed clinical care, audit results, significant events and areas for improvement. Staff

Are services well-led?

Good

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

from the practice also attended the Clinical Commissioning Group CCG protected learning time (PLT) initiative. This provided staff with dedicated time for learning and development.

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

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: The provider did not have in place suitable arrangements to ensure that staff employed within the practice were suitably supported in relation to their responsibilities as staff were not receiving regular opportunities for appraisal. Regulation 23 (1)