Station House Surgery

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?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Station House Surgery on 5 May 2016. Overall, the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses.
- Risks to patients were assessed and well managed.
- Outcomes for patients who use services were good.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff were consistent and proactive in supporting patients to live healthier lives through a targeted approach to health promotion. Information was provided to patients to help them understand the care and treatment available
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice were involved in a care home project for the elderly with the three GP practices in Kendal. The aim was to provide high quality care to patients with advanced care planning, low admission rates to hospital, prescribing savings and deaths in a preferred place of care.
- The practice had a system in place for handling complaints and concerns and responded quickly to any complaints.
- Patients said they were able to get an appointment with a GP when they needed one, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure in place and staff felt supported by management. The practice sought feedback from staff and patients, which they acted on.
- Staff throughout the practice worked well together as a team and they received opportunities for development.
- The practice was aware of and complied with the requirements of the Duty of Candour.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

We found significant events were recorded, investigated and learned from. There was a system in place to manage patient safety alerts. Arrangements were in place to safeguard adults and children from abuse.

There were good procedures in place for monitoring and managing risks to patients and staff safety. Appropriate recruitment checks had been carried out for staff including Disclosure and Barring Service (DBS) checks. There were infection control arrangements in place and the practice was clean and hygienic. There were systems and processes in place for the safe management of medicines. There was enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. Staff worked with multidisciplinary teams.

The practice was supportive of further development for staff. They had received regular appraisals and training appropriate to their role.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data showed that patients rated the practice in line with local and national averages for being caring. Patients we spoke with and comment cards indicated that patients were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. There was a practice register of all people who were carers and they were being supported, for example, by offering health checks and referrals for social services support.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Summary of findings

They reviewed the needs of their local population and engaged with the clinical commissioning group (CCG) in an attempt to secure improvements to services where these were identified.

Services were planned and delivered to take into account the needs of different patient groups and to help to provide flexibility, choice and continuity of care. There were specialist clinics which included minor surgery and family planning advice. The practice had good facilities. Patients said they could make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day. The practice had a system in place for handling complaints and concerns and responded quickly to any complaints.

Are services well-led?

Good

The practice is rated as good for being well-led.

The leadership, governance and culture were used to drive and improve the delivery of high-quality person centred care. The practice had a clear vision with quality and safety as its top priority. They had good governance arrangements that supported improvement. They had clear processes to monitor all aspects of the service, identify any risks and areas for improvements. The provider was aware of and complied with the requirements of the Duty of Candour.

There was a virtual active patient participation group (PPG) and the practice had acted on feedback from the group to improve services. Staff had received inductions and regular performance reviews. They were given the opportunity for further development and an 'open house' event had been held for staff to give informal feedback for improvements in the practice.

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 was responsive to the needs of older people, including offering home visits. The practice had urgent appointment slots late morning put aside for the elderly as they felt they sometimes had difficulty attending early morning appointments. Fifteen minute appointments were also available for patients who required them. All patients had a named GP. Prescriptions could be sent to any local pharmacy electronically and the practice dispensed medication to those who were eligible for this service or delivered to their homes where appropriate. Elderly patients could be referred to additional organisations such as Age UK for additional support.

Patients who were at high risk of hospital admission or who had recently had contact with the out of hours service or had unplanned hospital admissions were referred to the local care co-ordinator. The role of the care co-ordinator is to support those patients over 75 who are identified as at the greatest risk of a hospital admission. So they maintain their independence and stay in their own homes longer when it is appropriate and safe to do so.

The practice were involved in a care home project for the elderly with the three GP practices in Kendal. There was a multi-disciplinary team involved including a nurse practitioner, community pharmacist and care coordinators. The aim was to provide high quality care to patients with advanced care planning, a high rate of deaths in preferred place of care (in the last year 90% were managed in the home), low admission rates to hospital and prescribing savings. The team working on the project had been nominated for an award by the British Medical Journal.

The practice maintained a palliative care register and end of life care plans were in place for those patients it was appropriate for. They offered immunisations for pneumonia and shingles to older people.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions.

Summary of findings

The IT manager co-ordinated the long term condition registers and the nurse administrator called the patients in for yearly review. Patients were seen for all conditions in one appointment where possible. Flexible appointments, including extended opening hours and home visits were available when needed.

The practice had introduced the 'year of care' approach for diabetic patients. The year of care project provides personalised care to patients to provide shared goals and action plans to enable them to self-manage their condition. Patients received their results prior to their appointment with their doctor. There was a protocol in place for the review of these patients. If patients are overdue a medication review this was highlighted on their prescription and if they still did not attend the dispenser would prompt the GP to take action.

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. There was a bi-monthly safeguarding meeting at the practice. Community health care staff, for example, health visitor and school nurse attended the meetings where possible. The IT manager carried out a monthly search for new children registered at the surgery and ensured that the health visitor knew about them.

Childhood immunisation rates for the vaccinations given were in line with CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 85% to 99%, compared to the CCG averages of 83% to 96% and for five year olds from 92% to 96% (with one exception for PVC booster at 63% out of 10 other vaccinations), compared to CCG averages of 73% to 98%.

The practice had a cervical screening programme. The practice's uptake for the cervical screening programme was 79.4%, which was below the national average of 81.8%; however the practice told us that the data for 2015/16 year, which was not yet published, had improved to 81%. The practice offered minor surgery which included intrauterine device (IUD), contraceptive coil fitting. They also offered contraceptive advice.

Appointments were available outside of school hours and the premises were suitable for children and babies. Ante natal clinics were offered twice weekly in the practice. There was also a baby and child immunisation clinic every Tuesday afternoon.

Summary of findings

Working age people (including those recently retired and students)

Good

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services which included appointment booking, test results and ordering repeat prescriptions. There was a full range of health promotion and screening that reflected the needs for this age group, this included travel vaccinations. Flexible appointments were available as well as extended opening hours. Phlebotomy was available until 5.30pm one evening a week.

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; all were made aware of their named GP through their care plan which was reviewed on at least an annual basis. The practice had produced letters specifically for patients with learning disabilities, for example, there was one for a reminder for their annual health check which was pictorial.

The practice had a dedicated mobile phone used by patients who had difficulty hearing which was held on reception so that they could communicate easily with the practice.

The practice provided services to a local care home for approximately 15 patients with autism. One of the GP partners was the practice lead for the care home.

The practice's computer system alerted GPs if a patient was a carer. There was a practice register of all people who were carers and were being supported, for example, by offering health checks and referral for social services support. There were 275 patients on the carer's register which is 2.59% of the practice population. Written information was available for carers to ensure they understood the various avenues of support available to them.

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 practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health. They carried out advanced care planning for patients with dementia. 84%

Summary of findings

of patients identified as living with dementia had received an annual review in 2014/15 (national average 84%). The practice also worked together with their carers to assess their needs. Staff had received dementia awareness training.

The practice maintained a register of patients experiencing poor mental health and recalled them for regular reviews. They told them how to access various support groups and voluntary organisations. Reception staff had attended a mental health awareness course. The community psychiatric nurse attended multi-disciplinary meetings every two months. Qualified counsellors held sessions weekly. Patients were referred to these services by their doctor.

Summary of findings

What people who use the service say

We spoke with six patients as part of our inspection, which included two members of the practice's patient participation group (PPG); we spoke with one of them by telephone.

All of the patients we spoke with were satisfied with the care they received from the practice. Words used to describe the practice included brilliant and good. They told us staff were friendly and helpful and they received a good service.

We reviewed 37 CQC comment cards completed by patients prior to the inspection. The cards completed were all overwhelmingly and wholly positive. Common words used to describe the practice included, excellent, caring, friendly and patients said they received a good service. Patients gave positive comments on the service they received from the dispensary staff who they described as a caring team.

The latest GP Patient Survey published in January 2016 showed that scores from patients were below or in line with national and local averages. The percentage of patients who described their overall experience as good was 76.4%, which was below the local clinical commissioning group (CCG) average of 88% and the national average of 85%. Other results from those who responded were as follows;

- The proportion of patients who would recommend their GP surgery – 68% (local CCG average 81%, national average 79%).
- 87% said the GP was good at listening to them compared to the local CCG average of 91% and national average of 89%.
- 89% said the GP gave them enough time compared to the local CCG average of 90% and national average of 87%.
- 89% said the nurse was good at listening to them compared to the local CCG average of 93% and national average of 91%.
- 94% said the nurse gave them enough time compared to the local CCG average of 94% and national average of 92%.
- 75% said they found it easy to get through to this surgery by phone compared to the local CCG average 80%, national average 73%.
- 64% described their experience of making an appointment as good compared to the local CCG average 78%, national average 73%.
- Percentage of patients who find the receptionists at this surgery helpful – 86% (local CCG average 91%, national average 87%).

These results were based on 117 surveys that were returned from a total of 238 sent out; a response rate of 49.2% and 1.1% of the overall practice population.

The practice said they believed that some patient's perception of being able to make an appointment was still poor which was why there were low scores for patient access. This was because they had previously run a patient demand led appointment system for all appointments. Following feedback from patients this system was changed to the current system and feedback from patients was now positive.

Station House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and a specialist advisor with experience of GP practice management and a CQC pharmacist specialist inspector.

Background to Station House Surgery

Station House Surgery provides Primary Medical Services to the town of Kendal and the surrounding areas. The practice provides services from one location, Station Road, Kendal, Cumbria, LA9 6SA. We visited this address as part of the inspection.

The surgery is located in the converted railway station building adjacent to Kendal railway station, with consulting areas for patients on the ground and first floors. There is parking for patients at the front of the building with dedicated disabled parking bays and staff parking at the rear. There is step free access at the front of the building and a lift to take patients to the first floor.

The practice has six GP partners and four salaried GPs. Six are female and four male. All of the salaried GPs and two of the partners work part time. The practice is a training practice who have GP trainees allocated to the practice (fully qualified doctors allocated to the practice as part of a three-year postgraduate general practice vocational training programme). There are four practice nurses and a research nurse. There are two assistant practitioners and a phlebotomist. There is a practice manager, patient services manager and IT manager. There are twelve administrative members of staff. There is a medicines manager who works in the dispensary with five dispensing staff, some of whom work part time.

The practice provides services to approximately 10,600 patients of all ages. The practice is commissioned to provide services within a General Medical Services (GMS) contract with NHS England.

The practice is open from 8am until 6.30pm Monday to Friday. There are extended opening hours Wednesday to Friday morning and on occasional Tuesday mornings from 7.30am.

Consulting times with the GPs and nurses range from 8.30am – 11:30am and 2pm – 5pm. On extended opening days consulting times run from 7:30am.

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

Information taken from Public Health England placed the area in which the practice was located in the ninth least deprived decile. In general, people living in more deprived areas tend to have greater need for health services. The average male life expectancy is 80 years and the female is 83. The average male life expectancy in the CCG area and nationally is 79. The average female life expectancy in the CCG area is 82 and nationally 83. The practice has a higher percentage of patients over the age of 40+ upwards to age 85+ and lower numbers of patients from birth to the age of 35, when compared to national averages. The percentage of patients reporting with a long-standing health condition is slightly higher than the national average (practice population is 57% compared to a national average of 54%). The proportion of patients who are in paid work or full-time employment or education is 68% compared to the CCG average of 59% and the national average of 62%

Detailed findings

Why we carried out this inspection

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

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

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?

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included the local clinical commissioning group (CCG) and NHS England.

The inspection team:

- Reviewed information available to us from other organisations, for example, NHS England.
- Reviewed information from CQC intelligent monitoring systems.
- Carried out an announced inspection visit on 5 May 2016.
- Spoke to staff and patients.
- Looked at documents and information about how the practice was managed.
- Reviewed patient survey information, including the NHS GP Patient Survey.

Reviewed a sample of the practice's policies and procedures.

Good

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. The practice manager was responsible for their collation. They maintained a schedule of these, there had been 26 in the last 12 months. Significant events would be discussed at a dedicated meeting every two months or if necessary when the GPs met for coffee on a morning in the practice. We reviewed safety records, incident reports and minutes of meetings where these were discussed

Staff we spoke with were aware of the significant event process and actions they needed to take if they were involved in an incident. They received feedback on significant events through the practice meetings process. The incident recording form supported the recording of notifiable incidents under the Duty of Candour. (The Duty of Candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

A significant event was raised due to the management of a patient's medication. Following an investigation of the incident the practice found that a more consistent approach to this type of medication could be implemented across the practice. One of the GPs then wrote a protocol for staff to follow for the prescribing of medication used to treat anxiety and insomnia.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance and national safety alerts. The practice manager and patient safety manager managed the dissemination of national patient safety alerts between them. We saw a folder with copies of all the alerts received, there was a notation on each of them of what action was taken, by who and when.

Overview of safety systems and processes

The practice could demonstrate its safe track record through having systems in place for safeguarding, health and safety, including infection control and staffing.

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There were safeguarding packs in each consulting room and at reception for staff, these included a flow chart to follow, a practice safeguarding incident form and local contacts and telephone numbers. One of the GP partners was the lead for safeguarding adults and children. Patient records were tagged with alerts for staff if there were any safeguarding issues they needed to be aware of. There was a bi-monthly safeguarding meeting at the practice. Community health care staff, for example, health visitor and school nurse attended the meetings where possible. The IT manager carried out a monthly search for new children registered at the surgery and ensured that the health visitor knew about them. Staff demonstrated they understood their responsibilities and had all received safeguarding children training relevant to their role and safeguarding adults training. The safeguarding lead had received level three safeguarding children training.
- There was a notice displayed in the waiting area, advising patients that they could request a chaperone, if required. Only clinical staff carried out chaperoning. They had all received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy, patients commented positively on the cleanliness of the practice. One of the practice nurses was the infection control lead. Staff had received infection control training appropriate to their role. There were infection control policies, including a needle stick injury policy. Regular infection control and hand hygiene audits had been carried out and where actions were raised these had been addressed. We saw a comprehensive cleaning schedule for domestic cleaning at the practice.
- We saw the practice had a recruitment policy which was updated regularly. Recruitment checks were carried out. We sampled recruitment checks for both staff and GPs and saw that checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the

appropriate professional body and the appropriate DBS checks. There were risk assessments in place for those staff which did not require a DBS. We saw that the clinical staff had medical indemnity insurance.

Medicines Management

The arrangements for managing medicines, including emergency drugs, in the practice were satisfactory.

- The practice operated a Doctor Dispensing Service for patients that did not live near a pharmacy. Systems were in place for reviewing and re-authorising repeat prescriptions, providing assurance that prescribed medicines reflected patients' current clinical needs. Blank prescription forms were handled in accordance with national guidance and kept securely at all times. A process was in place to ensure prescriptions were signed before medicines were handed out to patients and for monitoring prescriptions that had not been collected.
- All members of staff involved in the dispensing process had received appropriate training. The written dispensary procedures were kept under review and competency checks were completed with dispensary staff to help ensure the quality of the dispensing service. Mentorship was provided to trainee dispensing staff to support them to complete certificated dispenser training.
- Any medicines incidents or 'near misses' were recorded for learning and the practice had a system in place to assess the quality of the dispensing process. The medicines manager also worked with the local CCG (Clinical Commissioning group) to monitor prescribing practice at the surgery in response to local and national recommendations.
- Processes were in place to check medicines were within their expiry dates and this was routinely recorded. 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 these were managed. There were also appropriate arrangements in place for the destruction of controlled drugs.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patients and staff safety. There was a health and safety policy in place. The practice used a contractor who gave them advice on health and safety and assisted them in carrying out a health and safety risk assessment. This was monitored and actions raised had been carried out. There was a fire safety risk assessment which was reviewed every 18 months. There were two members of staff trained as fire wardens and all staff had received fire safety training. We saw records of regular fire evacuation drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. There was a legionella and asbestos risk assessment in place for the building.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The GPs had a protocol for covering each other's absences. The nurse administration member of staff monitored the rota for nurses and the administration staff covered each other's absences. Several of them were part time, including the GPs which meant they could cover each other's leave.

Arrangements to deal with emergencies and major incidents

All staff received basic life support training and there were emergency medicines available in the practice. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location.

The practice had a business continuity plan in place for major incidents such as building damage which had been tested recently by an incident at the practice. The plan included emergency contact numbers for staff and was updated on a regular basis.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. Any new guidance was disseminated by the GP or nurse for the clinical area and placed on the practice intranet. There was a rolling programme of multi-disciplinary clinical meetings at the practice. This information was used to develop how care and treatment was delivered to meet patient needs.

The practice were active members of opportunities for NHS research. They employed a nurse for this purpose who had a dedicated supervising doctor. They were currently active in four research studies. For example two were regarding patients with high blood pressure. One was to encourage patients to self- monitor blood pressure and the other a study of medication to reduce this which was taken on an evening rather than a morning which is the usual advice given. They were also to sign up for another four studies.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). The QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures. The results are published annually. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients.

The latest publicly available data from 2014/15 showed the practice had achieved 94.9% of the total number of points available to them, with a clinical exception reporting rate of 5.4%. The QOF score achieved by the practice in 2014/15 was above the England average of 94.8% and below the local clinical commissioning group (CCG) average of 96.8%. The clinical exception rate was below the England average of 9.2% and the CCG average of 10.1%, the practice had the seventh lowest clinical exception rate in the last year in the CCG area.

The data showed:

- Performance for asthma related indicators was better than the national average (100% compared to 97.4% nationally).
- Performance for diabetes related indicators was above the national average (95.7% compared to 89.2% nationally).
- Performance for The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness in the preceding twelve months was 83.4% which was lower than the national average of 89.9%.
- Performance for mental health related indicators was below the national average (69.5% compared to 92.8% nationally).
- Performance for dementia indicators was below the national average (92.7% compared to 94.5% nationally).

We discussed the lower QOF scores with the practice management team. They told us that there had been issues in the 2014/15 reporting year with staffing at the practice, which meant that they had not time to focus on QOF as they should have. They had since recruited four salaried GPs which they hoped gave them more resources to focus on performance. They were able to confirm that they had demonstrated improvement with their scores for the 2015/16 QOF year. Performance for COPD indicators had improved, for example, the percentage of patients with COPD who had a review undertaken including an assessment of breathlessness in the preceding twelve months was now 98% compared to the previous year of 83.4%.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. We saw examples of five full completed audits which had been carried out in the last year. This included audits regarding the management of atrial fibrillation, renal function and alendronic acid, prescribing interactions with hydroxyzine, minor surgery and use of rescue steroids in COPD.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

Good

Are services effective?

(for example, treatment is effective)

- The practice had a comprehensive induction programme for newly appointed members of staff which covered such topics as fire safety, health and safety and responsibilities of their job role. There was also an up to date locum induction pack at the practice.
- The learning needs of non-clinical staff were identified through a system of appraisals and informal meetings. Staff development was discussed at appraisal. One of the reception staff was being supported to study a national vocational qualification (NVQ) in business administration. The practice manager had been supported to undertake training on pensions, finances and understanding leadership. Staff had access to appropriate training to meet those learning needs and to cover the scope of their work. All staff where appropriate had received an appraisal within the last twelve months. They told us they felt supported in carrying out their duties. The practice nurses were appraised by one of the GP partners and the practice manager.
- All GPs in the practice had received their 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.) The salaried GPs had quarterly meetings with their mentors (a GP partner) and when they had been in post a year they were to receive an in house appraisal.
- Staff received training that included: fire safety, basic life support, dementia training, customer service, safeguarding adults, equality and diversity and information governance awareness. All staff had received safeguarding children training appropriate to their role. Two members of staff who had recently started to work at the practice had not received their full training, this was planned to be rolled out over twelve months. We saw their induction covered information regarding safeguarding, health and safety and fire procedures. Clinicians and practice nurses had completed training relevant to their role.
- The practice is a training practice that has GP trainees allocated to the practice (fully qualified doctors allocated to the practice as part of a three-year postgraduate general practice vocational training programme).
- The practice had obtained funding and had supported two existing members of staff to train as assistant practitioners. This enabled them to carry out additional duties such as phlebotomy, wound care, sexual health clinics and contraception advice and health promotion. One was a specialist in chronic disease management and carried out foot checks for patients with diabetes, the other a specialist in hypertension and they also did a 'one stop shop' for patients with irregular blood pressure and pulse and they could carry out ECG). The practice nurses were also encouraged to develop further one of them had completed their prescribing qualification with another due to commence the same course in September 2016.

Coordinating patient care and information sharing

The practice had effective and well established systems to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services. There were regular multi-disciplinary team meetings. This included the bi-monthly gold standards meetings where all new cancer diagnosis and reviews of patients were carried out and the palliative care register maintained.

Patients who were at high risk of hospital admission or who had recently had contact with the out of hours service or had unplanned hospital admissions were referred to the local care co-ordinator. They were employed by the local CCG. The role of the care co-ordinator is to support those patients over 75 who are identified as at the greatest risk of a hospital admission so they maintain their independence and stay in their own homes longer when it is appropriate and safe to do so.

The practice had advanced care plans in place for 2% of the patient population who were at highest risk of hospital admission. Emergency admissions were reviewed within 48 hours and where appropriate follow ups consultations were carried out.

Good

Are services effective?

(for example, treatment is effective)

The practice had designed a wound care assessment sheet for patients with ulcers or pressure sores on their skin to ensure that there was a plan in place to manage this care.

The IT manager co-ordinated the long term condition registers and the nurse administrator called the patients in for yearly review. Patients were seen for all conditions in one appointment where possible. The practice had introduced the 'year of care' approach for diabetic patients. The year of care project provides personalised care to patients to provide shared goals and action plans to enable them to self-manage their condition. They received their results prior to their appointment with their doctor. There was a protocol in place for the review of these patients. If patients are overdue a medication review this is highlighted on their prescription and if they still do not attend the dispenser will prompt the GP to take action.

The GPs had a buddy system if the doctor was away from the practice for the following up of information from other health care providers, such as hospitals.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements, including the Mental Capacity Act 2005. Clinical staff had received training on this. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.

The practice had a cervical screening programme. The practice's uptake for the cervical screening programme was 79.4%, which was below the national average of 81.8%; however the practice told us that the data for 2015/16 year, which was not yet published, had improved to 81%. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were in line with CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 85% to 99%, compared to the CCG averages of 83% to 96% and for five year olds from 92% to 96% (with one exception for PVC booster at 63% out of 10 other vaccinations), compared to CCG averages of 73% to 98%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients with the assistant practitioners or the GP or nurse if appropriate. Follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed throughout the inspection that members of staff were courteous and very helpful to patients; both attending at the reception desk and on the telephone. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We reviewed 37 CQC comment cards completed by patients prior to the inspection. The cards completed were all overwhelmingly and wholly positive. Common words used to describe the practice included, excellent, caring, friendly and patients said they received a good service. Patients gave positive comments on the service they received from the dispensary staff who they described as a caring team.

We spoke with six patients as part of our inspection, which included two members of the practice's patient participation group (PPG); we spoke with one of them by telephone. All of the patients we spoke with were satisfied with the care they received from the practice. Words used to describe the practice included brilliant and good. They told us staff were friendly and helpful and they received a good service.

Results from the national GP patient survey published in January 2016 showed the practice was in line with local and national satisfaction scores on consultations with doctors and nurses. For example:

- 98% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 97% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and the national average of 97%.
- 86% said they found the receptionists at the practice helpful compared to the CCG average of 91% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us that 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 available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey we reviewed showed scores were broadly in line with local and national averages regarding patients' involvement in planning and making decisions about their care and treatment. For example:

- 87% said the GP was good at listening to them compared to the CCG average of 91% and the national average of 89%.
- 89% said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 88% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and the national average of 86%.
- 89% said the last nurse they spoke to was good listening to them compared to the CCG average of 93% and the national average of 91%.
- 94% said the nurse gave them enough time compared to the CCG average of 94% and the national average of 92%.

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

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. This included information regarding safeguarding, stop smoking advice, cancer care and information regarding NHS health checks.

The practice's computer system alerted GPs if a patient was a carer. There was a practice register of all people who were carers and were being supported, for example, by offering health checks and referral for social services support. There

Good

Are services caring?

were 275 patients on the carer's register which is 2.59% of the practice population. Written information was available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, depending upon the families wishes the GP would telephone or visit to offer support.

The practice showed us numerous thank you cards and acknowledgements from the local paper from families of patients who had been bereaved thanking the practice for their care and support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the population and acted on them in the planning and delivery of their services. The practice had close links with the local community through the different multi-disciplinary meetings and groups the practice attended.

The practice worked with the local clinical commissioning group (CCG) to improve outcomes for patients in the area. The practice met with the other practices in the locality, three monthly and there were locality leaning events four to six times per year.

The practice were involved in a care home project for the elderly with the three GP practices in Kendal. The CCG gave support to this project. There was a multi-disciplinary team involved including a nurse practitioner, community pharmacist and care coordinator. The aim was to provide high quality care to patients with advanced care planning, deaths in preferred place of care (in the last year 90% were managed in the home), low admission rates to hospital and prescribing savings. The team working on the project had been nominated for an award by the British Medical Journal.

The practice provided services to a local care home for approximately 15 patients with autism. One of the GP partners was the practice lead for the care home.

Services were planned and delivered to take into account the needs of different patient groups and to help to provide flexibility, choice and continuity of care. For example;

- The practice offered extended opening hours Wednesday to Friday morning and on occasional Tuesday mornings from 7.30am.
- Telephone consultations were available if required.
- Booking appointments with GPs and requesting repeat prescriptions was available online.
- Home visits were available for housebound patients or those who could not come to the surgery.
- All patients had a named GP to ensure continuity of care as far as possible.
- The practice had urgent appointment slots late morning put aside for the elderly as they felt they sometimes had difficulty attending early morning appointments. Fifteen minute appointments were also available for patients who required them (GPs usually have 10 minute appointment slots).
- Specialist Clinics were provided including minor surgery, IUD (also known as coil) fitting and removal service, contraceptive implants, family planning advice, joint injections and testing and dosing for anticoagulation. The practice monitored disease modifying anti-rheumatic Medication (DMARDS). The practice offered travel vaccinations. A phlebotomy service was offered one evening a week until 5.30pm. Qualified counsellors held sessions weekly. Patients were referred to these services by their doctor.
- There were disabled facilities, including a lift to access the first floor, hearing loop and translation services available.
- The practice had a dedicated mobile phone used by patients who had difficulty hearing which was held on reception so that they could communicate easily with the practice.
- Ante natal clinics were offered in the practice twice weekly. There was also a baby and child immunisation clinic every Tuesday afternoon.
- The practice had produced letters specifically for patients with learning disabilities, for example, there was one for a reminder for their annual health check which was pictorial.
- Public Wifi was available for patients in the surgery.
- There was no signage outside of the surgery on the main road to sign post visitors to the practice. The building was not visible from the main busy road which the building was located in. The management team told us they wanted to obtain signage put had problems with this due to the building being listed.

Access to the service

The practice was open from 8am until 6.30pm Monday to Friday. There was extended opening hours on a Wednesday to Friday mornings and on the occasional Tuesday morning from 7.30am.

Consulting times with the GPs and nurses range from 8.30am – 11:30am and 2pm – 5pm. On extended opening days consulting times run from 7:30am.

Good

Are services responsive to people's needs?

(for example, to feedback?)

There was a GP telephone triage system in operation for urgent on the day appointments. Half of the GP daily appointments were for urgent consultations and half were for routine. A further GP session per week had been added recently and changes to opening hours implemented to improve patient access to appointments.

Patients we spoke with said they did not have difficulty obtaining an appointment to see a GP. We looked at the practice's appointments system in real-time on the afternoon of the inspection. There were routine appointments to see a GP the following week, six working days later.

Results from the National GP Patient Survey showed that patient's satisfaction with how they could access care and treatment was mostly lower than local and national averages. For example;

- 73.8% of patients were satisfied with the practice's opening hours compared to the local CCG average of 82.4% and national average of 78.3%.
- 75.2% patients said they could get through easily to the surgery by phone compared to the local CCG average of 80.1% and national average of 73.3%.
- 63.8% patients described their experience of making an appointment as good compared to the local CCG average of 78% and national average of 73.3%.

The practice said they believed that some patient's perception of being able to make an appointment was still poor. This was because they had previously run a patient demand led appointment system for all appointments. Following feedback from patients this system was changed to the current system and feedback from patients was now positive.

Listening and learning from concerns and complaints

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

We saw the practice had received 11 formal complaints in the last 12 months and these had been investigated in line with their complaints procedure. Where mistakes had been made, it was noted the practice had apologised formally to patients and taken action to ensure they were not repeated. Complaints and lessons to be learned from them were discussed at clinical meetings. The practice carried out an annual review of complaints to establish if there were any patterns or trends to the complaints.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice's mission statement was to be an effective and efficient family practice working as a well-trained highly motivated team, maintaining and constantly reviewing the provision of care, for the benefit of their patients' health and quality of life. Staff we spoke with talked about patients being their main priority. They also knew what their responsibilities were in relation to this and how they played their part in delivering this for patients.

The practice had an afternoon planned in the future for the staff to spend time on the ethos of the mission statement to be delivered by an outside company. The practice had a practice development plan. They also had quarterly practice development meetings.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities, the GP partners were involved in the day to day running of the practice. There were three non-clinical managers in the practice who had clear roles. There was the practice manager, patient service manager and IT manager.
- There were clinical leads for areas such as safeguarding, long term conditions and learning disabilities.
- Practice specific policies were implemented and were available to all staff.
- Managers had a comprehensive understanding of the performance of the practice.
- A programme of continuous clinical audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. The partners were visible in the practice. Staff told us that they were approachable and always took the time to listen to all members of staff. The GPs worked together as a team, doctors helped each other when they were busy and had a daily catch up over coffee which usually included the nurses.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents.

There were meetings held at the practice every week involving the GPs. These would alternate between clinical meetings, gold standard meetings, QOF meetings and business meetings. We saw examples of minutes from these meetings. The salaried GPs had weekly meetings. Staff meetings were weekly and minutes were disseminated to those who could not attend. The GP partners and non-clinical managers had meetings every week to discuss staffing any issues.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients. They had gathered feedback from patients through a patient survey and formal and informal complaints received and the virtual practice participation group (PPG). The group had 28 to 30 patients who they could contact for information and feedback. NHS health checks had been introduced for the over 40s as a result of feedback from the PPG. There was a PPG action plan; one of the actions was to assist the patient services manager devise a questionnaire for all patients about access to appointments.

Following feedback from the PPG, complaints and general feedback from patients the practice changed a new appointment system they had introduced in May 2014 which was not working. They consulted with patients and the PPG to find a more suitable appointment system. Complaints reduced and feedback from this change was positive. The practice was still seeking to improve further and had an action plan in place to address low scores on NHS choices and in the National GP Patient Survey for making appointments. A patient questionnaire was planned. A further GP session per week had been added and changes to opening hours implemented to improve

Are services well-led?

Good

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

patient access to appointments. There was a launch of a change of corporate image planned for the practice which included a press release to the local press regarding the appointment system.

The practice had also gathered feedback from staff. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. The managers at the practice had held an informal 'open house' meeting with staff to gain ideas from them as to how they could improve. The practice produced a staff newsletter every month.

Continuous improvement

Several experienced staff had retired within the last two years. However, the practice were successful in recruiting four new salaried GPs into the practice within the last year. This was a new way of working for the practice as they had only had GP partners in the past. They set up a full induction programme and mentorship for the new GPs.

Staff had been given opportunities to develop, for example, existing staff had progressed to the role of assistant practitioner and had been encouraged and supported to study at a local university to obtain the qualification required to carry out this role. This benefitted the practice in terms of them being able to carry out more varied tasks and services they were able to deliver. One of the assistant practitioners was invited to give a talk at a local training session to other practices on the benefits and what it was like to work as an assistant practitioner. They also provided mentoring support to another practice for newly qualified assistant practitioners.

The practice created the role of nurse administrator. Their role was to support the nursing staff. They did all of the administration work relating to chronic disease management, which enabled the nurses to have more clinical time with patients.

The practice were aware that their premises was becoming too small. They maximised the usage of their consulting rooms and space available to them but had also submitted a business case to NHS England to secure funding to enable them to expand within the existing building.