Temple Sowerby Medical Practice

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 Temple Sowerby Medical Practice on 26 November 2015. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the Duty of Candour.

We saw one area of outstanding practice:

- The practice had worked with local clergy to establish a non-denominational, confidential listening ear service for patients experiencing social isolation, loneliness and bereavement

However, there were also areas where the provider should make improvements:

Summary of findings

- The practice should implement a system of staff appraisals as soon as possible to ensure staff are provided with a formal opportunity to discuss training, learning and development requirements
- Review the process currently in place to identify topics for clinical audit and ensure these are fully comprehensive and carried out on a regular basis
- Consider installing a hearing loop in the practice
- Update the practice recruitment policy to reflect the need to see proof of qualifications (if appropriate) and photographic ID
- Strengthen the system currently in place for infection control audits to ensure they include details of action to be taken and a review of previous action points
- Consider replacing the carpet in consultation rooms with easy to clean flooring to reduce the risk of spread of infection

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.

Nationally reported data we looked at as part of our preparation for this inspection did not identify any risks relating to safety. Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. Risks to patients were assessed and well managed.

There was evidence of effective medicines management. The practice was clean and hygienic and good infection control arrangements were in place. However, the practice should give consideration to implementing a more robust system for carrying out infection control audits and to replacing the carpets in the consultation rooms with easy clean flooring to mitigate the risk of infection.

Effective staff recruitment practices were followed and there were enough staff to keep patients safe. Disclosure and Barring Service (DBS) checks had been completed for all staff that required them.

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. Arrangements had been made to support clinicians with their continuing professional development. There were systems in place to support multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the information and equipment they needed to deliver effective care and treatment and had received training appropriate to their roles.

Data from the Quality and Outcomes Framework showed patient outcomes were comparable to local Clinical Commissioning Group (CCG) and national averages. The practice used the Quality and Outcomes Framework (QOF) as one method of monitoring its effectiveness and had achieved 90.3% of the point's available (local CCG average 96.8% and national average 93.5%). Managers were aware of the areas where they needed to improve and were dedicated to improvement. Achievement rates for cervical screening, flu vaccination and the majority of childhood vaccinations were above local and national averages.

Summary of findings

There was evidence of clinical audit activity and improvements made as a result of this. However, there did not appear to be an effective system in place to ensure these were carried out on a regular basis, were two cycle audits or to determine the reason for the audit.

Staff had received inductions and were given the opportunity to undertake both mandatory and non-mandatory training. Not all of the staff had received an annual appraisal. The practice business manager told us that this was because the practice had recently undertook a smarter working review and had wanted to wait until staff were embedded in their new roles before implementing an appraisal system.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients said they were treated with compassion, dignity and respect and they felt involved in decisions about their care and treatment. Information for patients about the service was available. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Results from the National GP Patient Survey published in July 2015 were variable in respect of providing caring services with the practice scoring lower than the CCG and national averages in some areas and higher in others. For example, 85% of patients who responded to the survey said the last GP they saw or spoke to was good at listening to them (CCG average 91% and national average 87%) and 97% said the last nurse they saw or spoke to was good at listening to them (CCG average 94% and national average was 91%).

Results also indicated that 98% of respondents felt the nurse treated them with care and concern (CCG average 94% and national average of 90%). 83% of patients felt the GP treated them with care and concern (CCG average 89% and national average 85%).

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

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. Learning from complaints was shared with staff.

The practice's scores in relation to access in the National GP Patient Survey were above average. The most recent results (July 2015) showed that 79% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of

Summary of findings

65% and the national average of 65%. 90% of patients were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 88% and a national average of 85%.

The practice was able to demonstrate that it continually monitored the needs of its patients and responded appropriately. The practice had recently carried out a smarter working review which had included the re-organisation and improvement of the reception and dispensary areas and review of the way in which the practice dealt with referrals and secondary care communications.

The practice had integrated well with the local community. Managers were aware of the particular problems faced by patients who were from farming communities or those living in isolated and often deprived rural areas and had adapted services to meet their needs. For example, GPs had ensured they all had 4-wheel drive cars for home visiting purposes and were conscious of lambing and silage periods. A confidential listening ear service had been developed with the local vicar to support patients experiencing social isolation, loneliness or bereavement. Prescription and medication delivery services had been established. The practice patient participation group (PPG) had been proactive in setting up support groups for patients experiencing certain medical conditions.

Are services well-led?

Good

The practice is rated as good for providing well-led services.

The leadership, management and governance of the practice assured the delivery of person-centred care which met patients' needs. Staff understood their responsibilities in relation to the practice aims and objectives. There was a well-defined leadership structure in place with designated staff in lead roles. Staff said they felt supported by management. Team working within the practice between clinical and non-clinical staff was good.

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 they acted on. There was an active PPG which met on a regular basis and worked with the management team to monitor services and implement improvements.

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 the practice had good outcomes for conditions commonly found amongst older people. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with heart failure. This was above the local clinical commissioning group (CCG) average of 99.6% and the England average of 97.9%.

The practice offered proactive, personalised care to meet the needs of the older people in its population. For example, all patients over the age of 75 had a named GP and patients at high risk of hospital admission and those in vulnerable circumstances had comprehensive care plans.

The practice maintained a palliative care register and offered immunisations for pneumonia and shingles to older people.

As part of their elderly care initiative the practice had sent an annual health questionnaire to patients of 83 years of age with a view to pro-actively identifying patients with potential health issues. 17 (out of 19) questionnaires were returned and patients referred or signposted to relevant services where appropriate. The practice were planning to extend this questionnaire to patients aged 80 and over.

The practice had implemented a system to target early intervention at patients at risk of a fall.

People with long term conditions

Good

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

Longer appointments and home visits were available when needed. 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. For those people with the most complex needs, GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Practice nurses were supported in undertaking additional training to help them understand and care for patients with certain long term conditions, such as diabetes.

Nationally reported Quality and Outcomes Framework (QOF) data (2014/15) showed the practice had achieved good outcomes in

relation to some of the conditions commonly associated with this population group. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with asthma. This was 1.5 percentage points above the local CCG average and 2.6 points above the national average. However, performance in relation to diabetes was below average; the practice achieved 84.9% of the points available compared to 93.6% locally and 89.2% nationally.

The practice had empowered patients with long term conditions such as atrial fibrillation, blood pressure problems and those as risk of stroke and taking Warfarin (a blood thinning medication) to remotely monitor and self-manage their conditions. Patients with chronic obstructive pulmonary disease (COPD) were issued with a rescue pack of antibiotics and steroids in line with clinical guidance.

The practice reported that 1247 of their patients (28% of their patient list) had a long term condition

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

The practice had identified the needs of families, children and young people, and put plans in place to meet them. There were processes in place for the regular assessment of children's development. This included the early identification of problems and the timely follow up of these. Systems were in place for identifying and following-up children who were considered to be at-risk of harm or neglect. For example, the needs of all at-risk children were regularly reviewed at practice multidisciplinary meetings involving child care professionals such as health visitors.

Appointments were available outside of school hours and the premises were suitable for children and babies. Arrangements had been made for new babies to receive the immunisations they needed. Vaccination rates for 12 month and 24 month old babies and five year old children were in line with or above the national averages. For example, childhood immunisation rates for the vaccinations given to two year olds ranged from 78% to 95% (CCG averages ranged from 83% to 96%) and five year olds from 84% to 100% (CCG averages ranged from 73% to 98%).

The practice's uptake for the cervical screening programme was 88%, which was higher than the clinical commissioning group (CCG) average of 82%.

Pregnant women were able to access an antenatal clinic provided by healthcare staff attached to the practice.

Summary of findings

The practice had produced a young person's information sheet which gave young people information on their right to be seen alone, patient confidentiality and accessing various support organisations.

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 met. The practice was open from 8.30am to 1pm and 1.30pm to 6.30pm on a Monday to Friday. Appointments were available with a GP from 8.30am to 12 midday and from 2pm to 6.30pm. Nurse appointments were available from 9am to 12midday and 2pm to 6.30pm.

The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group. The practice also offered a travel vaccination service.

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 those with a learning disability. Patients with learning disabilities were invited to attend the practice for annual health checks. Longer appointments for people with a learning disability were available, if required.

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

Good arrangements were in place to support patients who were carers. The practice had systems in place for identifying carers and ensuring that they were offered a health check and referred for a carer's assessment.

The practice also regularly hosted a representative from Eden Health and Wellbeing Hub who was able to provide advice and information to patients on matters such as benefits, money advice, social, leisure, work and learning opportunities and support available to assist people in staying independent, such as meals on wheels services.

Summary of findings

The practice had set up a confidential non-denomination specific listening ear service, for people experiencing social isolation, loneliness and bereavement with local clergy.

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).

At 89% the percentage of patients diagnosed with dementia whose care had been reviewed in a face to face meeting in the last 12 months was higher than the national average of 84%.

The practice worked closely with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. Care plans were in place for patients with dementia. Patients experiencing poor mental health were sign posted to various support groups and third sector organisations. The practice kept a register of patients with mental health needs which was used to ensure they received relevant checks and tests.

The practice used a stress cycle analysis tool to diagnose patients experiencing stress related symptoms, look at alternatives to prescribing antidepressants and encourage patients to be resilient to stress.

Summary of findings

What people who use the service say

The results of the national GP patient survey published on 2 July 2015 showed the practice was performing in line with local and national averages. 250 survey forms were distributed and 126 were returned, a response rate of 50.4%. This represented 2.8% of the practice's patient list.

- 93.8% found it easy to get through to this surgery by phone compared to a CCG average of 80.3% and a national average of 73.3%.
- 89.6% were able to get an appointment to see or speak to someone the last time they tried (CCG average 87.8%, national average 85.2%).
- 86.9% described the overall experience of their GP surgery as fairly good or very good (CCG average 88%, national average 84.8%).
- 79.9% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 79.9%, national average 77.5%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received eight comment cards which were all positive about the standard of care received. Words used to describe the practice and its staff included supportive, efficient, attentive, re-assuring, friendly and amazing. The only negative comment included on a comment card was in relation to dissatisfaction with the waiting time for an appointment to see a practice nurse.

We spoke with five patients during the inspection, two of whom were members of the practice patient participation group. All five patients said they were happy with the care they received and thought staff were approachable, committed and caring. The results of the practice patient experience survey 2014/15 found that 90% of patients rated the practice as either good, very good or excellent.

Areas for improvement

Action the service SHOULD take to improve

- The practice should implement a system of staff appraisals as soon as possible to ensure staff are provided with a formal opportunity to discuss training, learning and development requirements
- Review the process currently in place to identify topics for clinical audit and ensure these are fully comprehensive and carried out on a regular basis
- Consider installing a hearing loop in the practice
- Update the practice recruitment policy to reflect the need to see proof of qualifications (if appropriate) and photographic ID
- Strengthen the system currently in place for infection control audits to ensure they include details of action to be taken and a review of previous action points
- Consider replacing the carpet in consultation rooms with easy to clean flooring to reduce the risk of spread of infection

Outstanding practice

- The practice had worked with local clergy to establish a non-denominational, confidential listening ear service for patients experiencing social isolation, loneliness and bereavement

Temple Sowerby Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector**.** The team included a GP specialist adviser, a pharmacist specialist advisor and a second CQC inspector.

Background to Temple Sowerby Medical Practice

The practice is located in the village of Temple Sowerby, to the east of Penrith in the Eden Valley. The practice provides care and treatment to 4,467 patients from Temple Sowerby, Penrith, Appleby and the surrounding areas. It is part of the NHS Cumbria Clinical Commissioning Group (CCG) and operates on a General Medical Services (GMS) contract. The practice is a rural dispensing practice and can dispense medication to all of their patients, with the exception of those residing in Penrith and Appleby.

The practice provides services from the following address, which we visited during this inspection:

Temple Sowerby Medical Practice, Linden Park, Temple Sowerby, Penrith, Cumbria, CA10 1RW

The practice is located in a modern purpose built two storey building which was erected in 2004. All reception and consultation rooms are fully accessible. If patients with mobility problems need to access the upper floor of the building a lift is in operation. On-site parking is available, which includes disabled parking bays.

The practice is open between 8.30am to 1.00pm and 1.30pm to 6.30pm on a Monday to Friday. Appointments with a GP are available form 8.30am to 12 midday and from 2pm to 6.30pm. Nurse appointments are available from 9am to 12 midday and from 2pm to 6.30pm. The service for patients requiring urgent medical attention out-of-hours is provided by the NHS 111 service and Cumbria Health on Call Limited (ChoC).

Temple Sowerby Medical Practice offers a range of services and clinic appointments including chronic disease management clinics, new patient health checks, children's clinics, immunisations, cervical screening, travel advice, contraception and minor surgery. The practice consists of:

- Two GP partners (both female)
- One salaried GP (female)
- Two practice nurses
- One healthcare assistant
- Seven non-clinical staff including a business manager, general manager and reception/administration/ secretarial staff
- Four dispensing team staff consisting of a dispensing manager, two dispensers and a dispensing assistant

The area in which the practice is located is in the eighth (out of ten) most deprived decile. In general people living in more deprived areas tend to have greater need for health services.

The practice's age distribution profile showed higher percentages of patients aged over 45 than the national average. Average life expectancy for the male practice population was 79 (national average 79) and for the female population 82 (national average 83).

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. The 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 that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 26 November 2015. During our visit we spoke with a mix of clinical and non-clinical staff including GPs, practice nurses, the business manager, the general manager, the dispensing manager and administration and reception staff. We spoke to five patients, two of whom were members of the practice patient participation group (PPG) and observed how staff communicated with patients who visited or telephoned the practice on the day of our inspection. We reviewed eight Care Quality Commission (CQC) comment cards that had been completed by patients. We also looked at the records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff were well aware of their roles and responsibilities in reporting and recording significant events. The practice had an up to date significant event policy and reporting form
- Significant events were analysed and reviewed as a standing agenda item at monthly practice meetings.

We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, a prescription incorrectly issued to a patient with the same name as another patient lead to an alert being placed on the patients' records to alert staff of the need to be extra vigilant. Another, where the dispensary refrigerator was accidentally turned off, led to the practice purchasing a cover for the electricity socket to ensure this did not happen again.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults 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 was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs were trained to Safeguarding level three.
- A notice in the waiting room advised patients that chaperones were available if required. Staff who acted as chaperones were all clinically trained and had 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). Other staff members were in the process of having DBS checks.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy and a comprehensive cleaning schedule was in place. The practice nurse was the infection control clinical lead and had undertaken an Infection Prevention and Control Practitioner Course delivered by the Royal College of Nursing (RCN). There was an infection control protocol in place and staff had received up to date training. Infection control audits were undertaken but did not identify actions to be taken. For example, a check carried out in October 2015 stated that the carpet in one of the consulting rooms was stained by the use of a spillage kit but there was no note of the action that was to be taken to address this.
- An effective system was in place for the collection and disposal of clinical and other waste. However, although dated, sharps bins were not signed on construction
- GP consultation rooms were carpeted yet we were told that these rooms were used to take blood and other samples. This could present a risk in respect of the spread of infection
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice carried out regular medicines audits, with the support of the local CCG pharmacy team, to ensure prescribing was in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. A Patient Group Direction allows registered health care professinals, such as nurses, to supply and administer specified medicines, such as vaccines, without a patient having to see a doctor
- We reviewed two personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification,

references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. However, the practice recruitment policy needs updating to ensure its includes the need to seek proof of qualifications (where appropriate) and photographic ID

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available and staff were aware of their roles and responsibilities in relation to this. The practice had up to date fire risk assessments but accepted they needed to carry out more regular fire 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. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. All part time clinical staff were contracted to provide cover for sickness and unexpected leave at short notice and they all knew and were able to cover each other's duties. Regular locum GPs were used to try and ensure continuity of care for patients. An effective locum induction pack was in operation.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care 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 keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed the practice had achieved 90.3% of the total number of points available to them compared with the local CCG average of 96.8% and national average of 93.5%. At 9.1% their clinical exception rate (the QOF scheme includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect) was below the local CCG average of 10.1% and national average of 9.2%. This suggests that the practice operated an effective patient recall system, where staff was focussed on following patients up and contacting non-attenders.

- Performance for diabetes related indicators was lower than the local CCG and national averages (84.9% compared to the CCG average of 93.6% and national average of 89.2%). For example, the percentage of patients on the diabetes register with a record of a foot examination and risk classification in the preceding 12 months was 84.7% (national average 88.4%)
- The percentage of patients with hypertension having regular blood pressure tests was higher than average (100% compared with a CCG average of 98.9% and national average of 97.8%)
- Performance for mental health related indicators was lower than average (92.3% compared with a CCG average of 95.4% and national average of 92.8%).

The practice was able to demonstrate that it had carried out some clinical audit activity to help improve patient outcomes; however, there did not appear to be an effective system in place to ensure these were carried out on a regular basis, were two cycle audits or to determine the reason for the audit. We did see evidence of some single cycle audits, including one used to determine whether patients at risk of developing oesophageal cancer were being monitored appropriately and management of the condition was in line with current NICE guidelines. The audit identified 18 patients of which three were offered further surveillance.

The practice had a palliative care register and held monthly multi-disciplinary palliative care meetings discuss the care and support needs of palliative care patients and their families.

Effective staffing

The staff team included medical, nursing, dispensing, managerial and administrative staff. The partnership consisted of two GP partners. We reviewed staff training records and found that staff had received a range of mandatory and additional training. This included basic life support, health and safety, infection control, information governance, safeguarding and appropriate clinical based training for clinical staff.

The GPs were up to date with their yearly continuing professional development requirements and had been revalidated (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 practice nurses reported they were supported in seeking and attending continual professional development and training courses.

Not all of the staff had received an annual appraisal. The practice business manager told us that this was because the practice had recently undertook a smarter working review and had wanted to wait until staff were embedded in their new roles before carrying out whole staff group appraisals. The intention was that an appraisal schedule would be implemented in the near future. However, our interviews with staff confirmed that the practice was proactive in identifying and providing training and funding for relevant courses and personal development

Good

Are services effective?

(for example, treatment is effective)

opportunities. Four non-clinical staff members had been given the opportunity to undertake an NVQ level 2 in business management. The practice dispensers had undertaken NVQs in pharmacy service skills.

We looked at staff cover arrangements and identified that there were sufficient GPs on duty when the practice was open. Holiday, study leave and sickness were covered in house whenever possible. When the practice did have to use a locum GP they tend to use a regular locum who were aware of practice policies and procedures and known to the patients. An effective locum induction pack was in operation. For a variety of reasons the practice had used locum GPs regularly but felt that this would improve since they had appointed a salaried GP. They were also actively trying to recruit another salaried GP or partner.

Coordinating patient care and information sharing

The information needed 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 investigation and test results. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment. A flowchart system was in operation to assess whether a patient required referral to an Independent Mental Capacity Advocate (IMCA).

Patients were supported to express their views and were involved in making decisions about their care and treatment. Of the 126 patients who participated in the National GP Patient Survey published in July 2015, 83.6% reported the last GP they visited had been good at involving them in decisions about their care. This compares to a national average of 81.4% and local clinical commissioning group average of 85.3%. The same survey revealed that 91.9% of patients felt the last nurse they had seen had been good at involving them in decision about their care compared with a national average of 84.8% and local CCG average of 88.3%.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. These included patients requiring palliative care, carers and those with a long-term and mental health condition or learning disability.

The practice's uptake for the cervical screening programme was 87.8%, which was higher than the national average of 81.9%.

Childhood immunisation rates were generally better or comparable with local CCG averages. For example, childhood immunisation rates for the vaccinations given to two year olds ranged from 77.5% to 95% (compared with the CCG range of 83.3% to 96%). For five year olds this ranged from 83.7% to 100% (compared to CCG range of 72.5% to 97.9%).

Flu vaccination rates were above average. For the over 65s this was 77.9% (national average 73.2%), and for at risk groups 71.7% (national average 52.3%).

Patients had access to appropriate health assessments and checks. These included health checks for new patients and

Good

Are services effective?

(for example, treatment is effective)

NHS health checks for people aged 40–74. Appropriate follow-ups for 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 and that people were treated with dignity and respect.

- 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.
- Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

We received eight completed CQC comment cards of which seven were very complementary about the practice. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. The only negative comment received was in relation to being able to get an appointment with a nurse within an acceptable timescale. However, the same comment card also stated that the patient had received great care at the practice. We also spoke with five patients during our inspection. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the National GP Patient Survey showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. The practice was in line with local and national averages for the majority of its satisfaction scores on consultations with doctors and nurses. For example:

- 95% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 83% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and the national average of 85%.
- 99% 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%.
- 98% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 94% and the national average of 90%.
- 97% patients said they found the receptionists at the practice helpful compared to the CCG average of 90% and the national average of 87%.

The practice had worked with their patient participation group (PPG) to set up a prescription and emergency medicine delivery service for housebound and elderly patients. The practice had also been instrumental in setting up a confidential non-denomination listening ear service with local clergy for patients experiencing social isolation, loneliness or bereavement. Due to the success of this initiative it was now being rolled out across the area.

Care planning and involvement in decisions about care and treatment

Patients told us 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 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 85% said the GP was good at listening to them compared to the CCG average of 91% and the national average of 87%.
- 85% said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 89% 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%.
- 84% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and the national average of 82%.

Good

Are services caring?

- 97% said the last nurse they spoke to was good listening to them compared to the CCG average of 94% and the national average of 91%.
- 97% said the nurse gave them enough time compared to the CCG average of 94% and the national average of 92%.

The practice had access to a translation service for patients who did not have English as a first language. The practice did not have a hearing loop. Patients with a learning disability were routinely offered longer appointments and were also invited into the practice when registering as a means of getting to know the staff and premises.

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.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified approximately 35 patients (0.7% of the practice list) as carers. Carer's were routinely signposted to Eden Carers Association. The practice also regularly hosted a representative from Eden Health and Wellbeing Hub who was able to provide advice and information to patients on matters such as benefits, money advice, social, leisure, work and learning opportunities and support available to assist people in staying independent, such as meals on wheels services.

Staff told us that contact was routinely made with families who had suffered bereavement and patients signposted to relevant support services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had reviewed the needs of its local population planned services accordingly. Services took account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care.

- There were longer appointments available for anyone who needed them. Patients with a learning disability were routinely offered a longer appointment.
- Home visits were available for older patients, housebound patients and patients who would benefit from these.
- The appointment system operated by the practice ensured that patients could generally get a same day appointment following triage by a GP. Requests for pre bookable appointments with a named GP could usually be facilitated within an acceptable timescale
- The practice was able to demonstate that it had considered the needs of, and integrated well with the local community recognising the particular needs of socially isolated patients living in a widespread rural area
- There were disabled facilities and translation services available. The practice did not have a hearing loop
- All patient facilities were easily accessible to patients with a mobility issue.
- The practice offered online services such as being able to book an appointment or request a repeat prescription
- The practice had been proactive in setting up a confidential listening service with local clergy
- The practice had worked with their PPG to set up an emergency prescription and medication delivery service
- The practice had empowered some of their patients with atrial fibrillation, blood pressure conditions and those at risk of stroke and taking Warfarin to remotely monitor and self-manage their conditions.
- Practice GP's were pro-active in the early assessment of patients who may be at risk of a fall. Patients were then referred into a pre-falls service based at Penrith hospital for a physiotherapy consultation which could result in the prescribing of a social activity such as Pilates to improve flexibility and core strength
- The practice hosted a counsellor from Cumbria Drug & Alcohol Services on a weekly basis. One of the practice GPs had received training to enable them to deliver a drug reduction programme.

Access to the service

The practice was open from 8.30am to 1pm and 1.30pm until 6.30pm Monday to Friday. Appointments with GPs were available from 8.30am to 12 midday and from 2pm until 6.30pm. Nurse appointments started at 9am.

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

- 85% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and the national average of 75%.
- 94% patients said they could get through easily to the surgery by phone compared to the CCG average of 80% and the national average of 73%.
- 80% patients described their experience of making an appointment as good compared to the CCG average of 79% and the national average of 73%.
- 79% patients said they usually waited less than 15 minutes their appointment time compared to the CCG average of 65% and the national average of 65%.
- 90% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 88% and a national average of 85%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available in the practice to advice patients how to make complaints. The practice website did not include any guidance on how to make a complaint

We looked at ten complaints that the practice had received during the period May 2014 to the date of our inspection.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We found that these had been satisfactorily handled, dealt with in a timely way and apologies issued when necessary. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, we saw evidence of staff receiving additional training following receipt of complaints concerning staff attitude and of changes to the telephone system following receipt of a complaint about a delay in being able to get through to the surgery on the phone.

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 supported their locality motto which stated that patients should be able to plan their care with people who work together to understand them and their carer(s) and allow them to control and bring together services to achieve the outcomes that are important to them.

The practice had a mission statement. This was:

'We, as a practice, will strive to be successful in delivering the best possible high quality general practice care for our patients. This quality will be evident through the practice showing it is reliable, responsive and empathetic. We will strive to care for our colleagues with equal enthusiasm'.

The practice did not have a specific business plan but had identified their priorities for 2016. This included a number of objectives, including:

- Conducting telephone triage and patient satisfaction surveys
- Reviewing and monitoring impact of changes made as a result of the smarter working review
- Carrying out an audit of patients who routinely did not attend for appointments
- Exploring the possibility of sharing back office functions with other practices
- Recruiting additional doctors

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

The practice did not have an effective system in place to ensure two cycle clinical audits were carried out on a regular basis. However, the practice were aware of this stating this had been due to time constraints as a result of a reduction in the number of GP partners from five to two over the last five years. They were now planning to implement a timetable for audit activity.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritise safe, high quality and compassionate care. The partners were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.

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

When there were unexpected or unintended safety incidents:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- They kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings. Whole team staff meetings were held on a monthly basis, clinical and business meetings on a fortnightly basis.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so and felt supported if they did.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

Are services well-led?

Good

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received.
- There was an active PPG which met on a quarterly basis. They had been instrumental in introducing a support group for patients with stomas. Due to the success of this group they had decided to expand the number of support groups offered to include patients receiving statin medication, those with chronic obstructive pulmonary disease, those with fragile skin and older people. Members of the PPG that we spoke with stated that they felt able to submit proposals for improvements to the practice management team and felt confident that these would be considered

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. For example, the practice had carried out a working smarter review which had included the re-organisation of the reception and dispensary areas and review of the way in which the practice dealt with referrals and secondary care communications.

The practice team was forward thinking and part of local pilot schemes and initiatives to improve outcomes for patients in the area. This included:

- The practice was involved in the Eden Health and Social Care Community pilot whose aim was to develop close working relationships between social services and allied healthcare professionals
- The practice had been one of the lead practices in the establishment of 1st Care Cumbria, a 34 practice GP federation aimed at improving collaborative working, sharing of best practice and developing greater strength in bidding for enhanced service contracts with the aim of ensuring primary care services are available locally.
- As part of their involvement with 1st Care Cumbria the practice had agreed to be a Primary Care Home rapid trialling site. This initiative is aimed at creating access to multi-disciplinary services locally in general practices, integrating primary and community care and reducing the number of non-urgent admissions to hospital.

The practice was also in the process of establishing a GPwSI (GP with special interest) gynaecological clinic and in obtaining the services of a visiting eye specialist.