Shap 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?	Outstanding
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Shap Medical Practice on 13 August 2015. Overall the practice is rated as good.

Specifically, we found the practice to be outstanding for providing responsive services and good for providing safe, effective, caring and well-led services. It was also good for providing services for the following population groups: 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).

Our key findings were as follows:

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Scores in relation to this were high in the National GP patient Survey (July 2015). 83% said the last GP they saw or spoke to was good at involving them in decisions about their care (national average 74%) and 75% said the last nurse they saw or spoke to was good at involving them in decisions about their care (national average 65%).
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- The practice scored very highly in relation to access in the National GP Patient Survey. The most recent results (July 2015) showed 90% (compared to 73% nationally and 78% locally) of respondents were able to get an appointment or speak to someone when necessary.
- The practice offered pre-bookable appointments on alternate Monday evenings with GPs and nurses, which improved access for patients who worked full time.
- 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 proactively sought feedback from staff and patients,

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which they acted on. For example, following suggestions from patients, a calibration service for patients own blood pressure monitors had recently been arranged.
- Information about services and how to complain was available and easy to understand.
- Staff retention was high and clinical and non-clinical staff worked effectively as a team.

We saw several areas of outstanding practice including:

- GPs preferred to see their own palliative care patients out of hours and carried out proactive visits at weekends and on evenings. Patients and their relatives were given the doctors personal telephone numbers so they could contact them at any time. A recent audit showed that over the past five years 43% of deaths occurred at the patient's own home, this was in comparison to 22% nationally and 23% locally (data taken from Public Health England).
- The practice made use of their IT facilities and premises to access support from community organisations. For example a 'TellyTalk' service at the practice enabled patients to contact Age UK, Citizens Advice or Carlisle Law Centre. (TellyTalk is a video conferencing facility which enables a patient visiting the practice to see, hear and speak to an officer based in various locations). Patients were able to use TellyTalk within the practice to access free information and advice.
- Due to the rural area covered by the practice, all of the doctors carried oxygen and defibrillators in their cars. All of the doctors had winter tyres for their vehicles so in the event of severe weather staff could still visit patients.

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.

The 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 good medicines management. Good infection control arrangements were in place and the practice was clean and hygienic. 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.

Data showed patient outcomes were above national averages. The practice used the Quality and Outcomes Framework (QOF) as one method of monitoring its effectiveness and had achieved 100% of the points available. This was above the local and national averages of 97.2% and 93.5% respectively.

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. Staff had received training appropriate to their roles. 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.

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. We also saw that staff treated patients with kindness and respect, and maintained privacy and confidentiality.

The practice scored highly on the National GP Patient Survey from July 2015. Results showed patients were happy with the care received. Over 90%, (92% and 91%) of patients said their GP and nurse respectively treated them with care and concern (compared to

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82% and 87% nationally). A high proportion of patients (94%) said the last GP they saw or spoke to was good at listening to them (compared to the national average of 87%) and 92% said the last nurse they saw or spoke to was good at listening to them (national average 78%).

A comprehensive system had been devised to support patients who were carers. The practice had implemented a 'Carers Identification Protocol' which set out the mechanisms in place for identifying carers and ensuring that they were offered a health check and referred for a Carers Assessment. There were good links with local support groups such as Eden Carers and Eden Young Carers.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services.

The practice scored very highly in relation to access in the National GP Patient Survey. The most recent results (July 2015) showed 90% (compared to 73% nationally and 78% locally) of respondents were able to get an appointment or speak to someone when necessary. All respondents said the appointment was at a convenient time for them (compared to the national and local averages of 94% and 92% respectively). The practice also scored highly on the ease of getting through on the telephone to make an appointment (93% of patients said this was easy or very easy, compared to the national average of 74% and a CCG average of 78%).

Patients were able to book longer appointments on request and pre-bookable appointments with a GP or a nurse were available on alternate Monday evenings. 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.

Staff preferred see their own palliative care patients out of hours and carried out proactive visits at weekends and on evenings. Patients and their relatives were given the doctors personal telephone numbers so they could contact them at any time. A recent audit showed that over the past five years 43% of deaths occurred at the patient's own home, this was in comparison to 22% nationally and 23% locally (data taken from Public Health England).

The practice made use of their facilities to support the community, for example the provision of a 'TellyTalk' service that enabled patients to contact Age UK, Citizens Advice or Carlisle Law Centre. (TellyTalk is a video conferencing facility which enables a patient visiting the practice to see, hear and speak to an officer based in

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various locations). Patients were able to use TellyTalk within the practice to access free information and advice. The practice had also arranged for an ultrasound scanning service to be provided at the practice. This was of benefit to patients given the lack of local public transport, as it meant patients did not have to travel to other locations for scans.

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. There was a clear and documented vision for the practice. 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. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as outstanding for the care of older people.

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 slightly above local clinical commissioning group (CCG) average (99.2%) and 2.9 points above the England average.

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 care plans. A register of housebound patients was maintained; clinical staff carried out home visits as necessary and arrangements were in place to deliver prescriptions to this group of patients.

The practice maintained a palliative care register and offered immunisations for pneumonia and shingles to older people. Staff preferred see their own palliative care patients out of hours and carried out proactive visits at weekends and on evenings. Patients and their relatives were given their doctor's personal telephone numbers so they could contact them at any time. A recent audit showed that over the past five years 43% of deaths occurred at the patient's own home, this was in comparison to 22% nationally and 23% locally (data taken from Public Health England).

People with long term conditions

Good

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

The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. Patients with long-term conditions such as hypertension and diabetes, were offered a structured annual review to check that their health and medication needs were being met, or more often where this was judged necessary by the GPs. A new system had been introduced where patients with several long-term conditions had all of their reviews carried out within the same appointment, this reduced the need to attend on several occasions.

Summary of findings

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.

Nationally reported QOF data (2013/14) showed the practice had achieved good outcomes in relation to 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 diabetes. This was 7.2 percentage points above the local CCG average and 9.9 points above the national average.

The practice had developed a pulse check template, which was to be used during long term condition reviews and opportunistically by the nurses, with the aim of aiding work on atrial fibrillation and stroke prevention. This template had been recognised across the area as good practice and was to be rolled out to other practices.

Staff preferred see their own palliative care patients, which included people with long term conditions, out of hours and carried out proactive visits at weekends and on evenings.

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 the local CCG area.

Pregnant women were able to access an antenatal clinic provided by healthcare staff attached to the practice. The practice had obtained 100% of the QOF points available to them for providing recommended maternity services and carrying out specified child health surveillance interventions. Nationally reported QOF data (2013/14) showed antenatal care and screening were offered in line

with current local guidelines. The data also showed that child development checks were offered at intervals consistent with national guidelines. Cervical screening rates (83.8%) were above the national average (81.9%).

The practice provided a sexual health service and had effective arrangements in place for chlamydia screening. The screening uptake was recognised by other practices in the locality as high. These practices subsequently adopted the same approach to encourage screening.

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 and flexible. The practice offered some online services as well as a full range of health promotion and screening which reflected the needs for this age group.

Patients could order repeat prescriptions and book appointments on-line. The practice was open every evening except Thursday until 6.30pm. Appointments were also available on alternate Mondays between 6.30pm and 7.00pm.These extended opening hours were particularly useful to patients with work commitments. During a recent trial the practice was open on Easter Monday. Staff reported this was successful and they were considering whether to open on future bank holidays.

The practice wrote to local HGV drivers to let them know that they would make every attempt to accommodate them at times that were convenient to them, either early on a Monday morning or on a Friday evening.

Additional services were provided such as health checks for the over 45s and travel vaccinations.

Staff preferred see their own palliative care patients, which included working age people, out of hours and carried out proactive visits at weekends and on evenings.

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.

Summary of findings

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. The practice offered longer appointments for people with a learning disability, 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 implemented a 'Carers Identification Protocol' which set out the mechanisms in place for identifying carers and ensuring that they were offered a health check and referred for a Carers Assessment. There were good links with local support groups such as Eden Carers and Eden Young Carers.

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 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. Staff were aware of those patients with memory problems who lived alone, they contacted them to remind them about their appointment dates and times. Patients experiencing poor mental health were sign posted to various support groups and third sector organisations.

Nationally reported QOF data (2013/14) showed the practice had achieved good outcomes in relation to patients experiencing poor mental health. For example, the practice had obtained 100% of the QOF points available to them for providing recommended care and treatment for patients with poor mental health. This was 8.8 percentage points above the local CCG average and 9.6 points above the England average. The practice kept a register of patients with mental health needs which was used to ensure they received relevant checks and tests.

Summary of findings

What people who use the service say

We spoke with nine patients during our inspection. We spoke with people from different age groups, who had varying levels of contact and had been registered with the practice for different lengths of time.

We reviewed 27 CQC comment cards which had been completed by patients prior to our inspection.

Patients were very complimentary about the practice, the staff who worked there and the quality of service and care provided. They told us the staff were very caring and helpful. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. Patients were happy with the appointments system, although some felt they waited too long to be called in for their appointment.

The latest National GP Patient Survey published in July 2015 showed the large majority of patients were satisfied with the services the practice offered. The results were either in line with or above the national averages:

- GP Patient Survey score for opening hours – 81% (national average 75%);
- Percentage of patients rating their ability to get through on the telephone as very easy or easy – 90% (national average 71%);
- Percentage of patients rating their experience of making an appointment as good or very good – 93% (national average 74%);
- Percentage of patients rating their practice as good or very good – 98% (national average 85%);
- The proportion of patients who would recommend their GP surgery – 97% (national average 78%).

Outstanding practice

GPs preferred to see their own palliative care patients out of hours and carried out proactive visits at weekends and on evenings. Patients and their relatives were given the doctors personal telephone numbers so they could contact them at any time. A recent audit showed that over the past five years 43% of deaths occurred at the patient's own home, this was in comparison to 22% nationally and 23% locally (data taken from Public Health England).

The practice made use of their IT facilities and premises to access support from community organisations. For example a 'TellyTalk' service at the practice enabled patients to contact Age UK, Citizens Advice or Carlisle Law Centre. (TellyTalk is a video conferencing facility which enables a patient visiting the practice to see, hear and speak to an officer based in various locations). Patients were able to use TellyTalk within the practice to access free information and advice.

Due to the rural area covered by the practice, all of the doctors carried oxygen and defibrillators in their cars. All of the doctors had winter tyres for their vehicles and a tractor was available so in the event of severe weather staff could still visit patients.

Shap Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team included a GP specialist advisor, a practice nurse and a further CQC inspector.

Background to Shap Medical Practice

Shap Medical Practice is registered with the Care Quality Commission to provide primary care services. It is located in the Shap area of Penrith in Cumbria.

The practice provides services to around 2,800 patients from three locations:

- Peggy Nut Croft, Shap, Penrith, Cumbria, CA10 3LW
- The Market Hall, Orton, Penrith, Cumbria, CA10 3RL
- The Health Centre, Tebay, Penrith, Cumbria, CA10 3SP.

We visited the main surgery at Shap and the branch surgery at Orton as part of the inspection.

The practice has three GP partners (two female and one male), two practice nurses (both female), a healthcare assistant, a practice manager, a dispensary manager and seven staff who carry out reception, administrative and dispensing duties.

The practice is part of Cumbria clinical commissioning group (CCG) and is within an area of relatively low levels of deprivation. The practice population is made up of a higher than average proportion of patients over the age 65 (22.4% compared to the national average of 16.7%).

The practice is located in a purpose built two storey building. All patient facilities are on the ground floor. There is on-site parking, disabled parking, a disabled WC, wheelchair and step-free access.

Surgery opening times at Shap are between 8:30am to 6:30pm every weekday except Thursdays, when the practice is open until 1:00pm. The branch surgery at Orton is open on Tuesdays between 9:15am and 10.30am and on Thursdays between 4:00pm and 5:45pm. The branch surgery at Tebay is open between 11.30am and 12.15pm each Wednesday. The practice recently introduced extended hours with a doctor and nurse available alternate Mondays between 6.30pm and 7.00pm. Patients can book appointments in person, on-line or by telephone.

The practice provides services to patients of all ages based on a General Medical Services (GMS) contract agreement for general practice.

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

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.

Detailed findings

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)

As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. This included the local clinical commissioning group (CCG).

We carried out an announced visit on 13 August 2015. We spoke with nine patients and nine members of staff from the practice. We spoke with and interviewed three GPs, a practice nurse, the practice manager, the healthcare assistant and three staff carrying out reception, administrative and dispensing duties. All of the GP partners made themselves available to us on the day of the inspection. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 27 CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Safe track record

The practice had a good track record for maintaining patient safety.

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how the practice operated. Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards reflected this. We (CQC) had not received any safeguarding concerns regarding patients who used the practice. We met with the local clinical commissioning group (CCG) before we inspected the practice and they did not raise any concerns with us.

As part of our planning we looked at a range of information available about the practice. This included information from the Quality and Outcomes Framework (QOF) and the National Patient Survey. The latest information available to us indicated there were no areas of concern in relation to patient safety.

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibility to raise concerns, and how to report incidents and near misses

We saw that records were kept of significant events and incidents. We reviewed a sample of the reports completed by practice staff during the previous 12 months, and the minutes of meetings where these were discussed. The records looked at showed the practice had managed such events consistently and appropriately during the period concerned and this provided evidence of a safe track record for the practice.

Learning and improvement from safety incidents

The practice was open and transparent when there were near misses or when things went wrong. There was a comprehensive system in place for reporting, recording and monitoring significant events. We spoke with the GPs and the practice manager about the arrangements in place. They told us that all staff had responsibility for reporting significant or critical events. Staff were aware of the system for raising issues to be considered and felt encouraged to do so. The practice also reported significant events to the local clinical commissioning group (CCG), using the safeguarding incident risk management system (SIRMS).

Records of those incidents were kept on the practice computer system and made available to us. We found details of the event, steps taken, specific action required and learning outcomes and action points were noted.

There was evidence that significant events were discussed at staff meetings to ensure learning was disseminated and implemented. We saw there had been a significant event in relation to the delayed dispensing of a medicine. We saw evidence that a thorough investigation had taken place. This had identified some key learning points, which had been shared with the relevant staff. The event had been discussed within the practice and protocols were revised to prevent the incident from happening again. The changes were implemented and the practice told us they would be reviewed at a later date to confirm they remained effective. A yearly review of significant events took place which involved all practice staff.

We discussed the process for dealing with safety alerts with the practice manager and some of the clinical staff. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. Arrangements had been made which ensured national patient safety alerts were disseminated by the practice manager to all of the GPs. This enabled the clinical staff to decide what action should be taken to ensure continuing patient safety, and mitigate risks. Any alerts were discussed at the monthly clinical meetings to ensure staff were aware of any necessary action. We saw minutes confirming these discussions had taken place.

Reliable safety systems and processes including safeguarding

The practice had effective systems in place to manage and review risks to vulnerable children, young people and adults. Safeguarding policies and procedures were in place. These provided staff with information about safeguarding legislation and how to identify, report and deal with suspected abuse. Information about how to report safeguarding concerns and contact the relevant agencies was easily accessible.

Good

Are services safe?

There were identified members of staff with clear roles to oversee safeguarding within the practice. Staff we spoke with said they knew which of the GP partners was the safeguarding lead. The GP was responsible for ensuring staff were aware of any safeguarding cases or concerns.

There was a system on the practice's electronic records to highlight vulnerable patients. Children and vulnerable adults who were assessed as being at risk were identified using READ codes. These codes alerted clinicians to their potential vulnerability (clinicians use READ codes to record patient findings and any procedures carried out). The clinicians discussed ongoing and new safeguarding issues with local health visitors at monthly meetings.

Staff we spoke with had a good knowledge and understanding of the safeguarding procedures and what action should be taken if abuse was witnessed or suspected.

We saw records which confirmed all relevant staff had attended training on safeguarding children. All of the GPs had completed child protection training to level three. This is the recommended level of training for GPs who may be involved in treating children or young people where there are safeguarding concerns. The practice nurses had completed level two which is more relevant to the work they carry out. The administration and reception staff had attended level one training sessions. This was confirmed by the staff we spoke with.

The practice had a chaperone policy. We saw posters on display in the consultation rooms to inform patients of their right to request a chaperone. A practice nurse or a member of the administration team undertook this role. Staff we spoke with had received training, were clear about the requirements of the role and had undergone Disclosure and Barring Service (DBS) checks.

An up to date whistleblowing policy was in place. Staff we spoke with were all able to explain how, and to who, they would report any such concerns. They were all confident that concerns would be acted upon.

Medicines management

There were clear systems in place to manage medicines. We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. We saw medicines were in date and good systems to check expiry dates were implemented.

There was a clear policy for ensuring medicines were kept at the required temperatures (for example, some vaccines needed to be stored in a refrigerator). The policy described the action to take in the event of a potential failure of the refrigerator. Staff confirmed the procedure was to check the refrigerator temperature every day to ensure the vaccines were stored at the correct temperature. We saw records of the daily temperature recordings, which showed that the correct temperatures for storage were maintained.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a designated safe, access to them was restricted and the key was held securely.

Due to the rural location and the lack of pharmacy in the village, there was a dispensary within the practice. Patients were therefore able to obtain their medicines either straight after their consultation, or within a day if stocks were not held on site. Staff had access to written procedures to support the safe dispensing of medicines and these were up to date.

Vaccines were administered by nurses using patient group directions (PGDs) and patient specific directions (PSDs). These are specific guidance on the administration of medicines authorising nurses to administer them. We saw up-to-date copies of directions were held by each of the nurses.

There were systems in place to ensure GPs regularly monitored patients' medicines and re-issuing of medicines was closely monitored, with patients invited to book a 'medication review', where required. A part time pharmacist worked with the practice to monitor medicines and provide advice and support to both staff and patients. They carried out monitoring of medicines issued to patients on discharge from hospital, and contacted any' at-risk' patients to ensure they understood what the medicines were for and advise them of any side effects.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice.

Good

Are services safe?

The protocol covered, for example, how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

All prescriptions were reviewed and authorised by a GP before they were given to the patient. We saw records of blank prescription form serial numbers were made on receipt into the practice. Blank prescriptions were securely stored at all times.

Cleanliness and infection control

We saw the practice was clean, tidy and well maintained. Patients we spoke with told us they were happy with the cleanliness of the facilities. Comments from patients who completed CQC comment cards reflected this.

One of the practice nurses was the nominated clinical infection control lead. The practice manager was the non-clinical lead. We saw there was an up to date infection prevention and control policy and detailed guidance for staff about specific issues. For example hand washing and the safe use and disposal of sharp items. Regular infection control audits were carried out. All of the staff we spoke with about infection control said they knew how to access the practice's infection control procedures. All staff had attended training courses on infection control, clinical staff were trained every year and non-clinical staff every three years.

The risk of the spread of infection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment (PPE) such as aprons and gloves were available for staff to use. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels. The treatment rooms had flooring that was impermeable, and easy to clean. The privacy curtains in the consultation rooms were changed every six months or more frequently if necessary. We saw records were maintained so staff knew when they were due to be changed. However, the curtains at the branch surgery had been due to be changed in the previous month. We observed they were clean and the GP on duty told us they would be changed immediately.

The practice employed an external company to carry out cleaning duties. We looked at records and saw they completed cleaning schedules, on a daily, weekly, monthly and annual basis. The practice manager carried out regular checks on the cleanliness of the building.

We saw there were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We looked at some of the practice's clinical waste and sharps bins located in the consultation rooms. All of the clinical waste bins we saw had the appropriately coloured bin liners in place and all of the sharps bins we saw had been signed and dated as required. There were spillage kits (these are specialist kits to clear any spillages of blood or other bodily fluid) located throughout the building.

The practice had processes in place for the management, testing and investigation of legionella (bacteria found in the environment which can contaminate water systems in buildings). We saw the practice carried out regular checks to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment; for example, weighing scales and blood pressure monitoring equipment. Fire extinguishers were serviced regularly. The practice maintained records showing when the next service was due.

Staffing and recruitment

The practice had an up to date recruitment policy in place that set out the standards they followed when recruiting staff.

We looked at a sample of three personnel files. We saw that pre-employment checks, such as obtaining a full work history, evidence of identity and references had been carried out, prior to staff starting work.

The practice manager and all staff that were in direct contact with patients had been subject to DBS checks. The GPs had undergone DBS checks as part of their application

to be included on the National Medical Performers' List. All performers are required to register for the online DBS update service which enables NHS England to carry out status checks on their certificate.

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There were arrangements in place for members of non-clinical staff to cover each other's annual leave. Locums provided cover for the clinical staff's annual leave.

Staff we spoke with were flexible in the tasks they carried out. This demonstrated they were able to respond to areas in the practice that were particularly busy. For example, by working on the front reception desk receiving patients or by answering the telephones. Staff told us there was always enough staff on duty to maintain the smooth running of the practice and ensure patients were kept safe.

We asked the practice manager how they assured themselves that GPs and nurses employed continued to be registered to practise with the relevant professional bodies (for GPs this is the General Medical Council (GMC) and for nurses this is the Nursing and Midwifery Council (NMC)). They told us they routinely checked with the GMC and NMC to assure themselves of the continuing registration of staff. Records of these checks were maintained. Clinical staff and the practice manager had medical indemnity insurance policies in place; we saw certificates to confirm this.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff and patients to see.

The practice manager showed us a number of risk assessments which had been developed and undertaken; including a fire risk assessment. Risk assessments of this type helped to ensure the practice was aware of any potential risks to patients, staff and visitors and planned mitigating action to reduce the probability of harm.

There were systems in place to manage and monitor health and safety. The fire alarms and emergency lights were regularly tested. There were annual fire evacuation drills. We saw records confirming these checks had been carried out.

There were clear lines of accountability for all aspects of patient care and treatment. The GPs each had lead roles such as safeguarding and infection control. Each clinical lead had systems for monitoring their areas of responsibility.

Appropriate staffing levels and skill-mix were provided by the practice during the hours the service was open.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). The defibrillator was accessible and staff carried out regular checks on the battery and the associated equipment. All staff we spoke with regarding emergency procedures knew the location of this equipment. In addition to the equipment held in the practice, all of the doctors carried oxygen and defibrillators in their cars.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. All of the emergency medicines we checked were in date.

Staff attended annual fire safety training. Most staff within the practice worked part-time therefore several members of the team were designated fire wardens.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk. Copies of the plan were held off site, so contact details were available if the building was not accessible.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could describe the rationale for their treatment approaches. They were familiar with best practice guidance from the National Institute for Health and Care Excellence (NICE). For example, the GPs showed us how they routinely referred to NICE guidelines when carrying out clinical audits. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs and these were reviewed when appropriate.

GPs and nurses led in specialist clinical areas such as diabetes and asthma. GP leads had overall responsibility for ensuring the disease or condition was managed effectively in line with best practice. Nursing staff were jointly responsible with GPs for ensuring the day-to-day management of a disease or condition was in line with practice protocols and guidance. Clinical staff we spoke with said they would not hesitate to ask for or provide colleagues with advice and support. Staff had access to the necessary equipment and were skilled in its use; for example, blood pressure monitoring equipment.

We spoke with staff about how the practice helped people with long term conditions manage their health. They told us patients were booked in for recall appointments annually, or more frequently if their condition required this. This ensured patients had routine tests, such as blood tests to monitor their condition. A new system had been introduced where patients with several long-term conditions had all of their reviews carried out within the same appointment; this reduced the need to attend on several occasions.

Patients we spoke with said they felt well supported by the GPs with regards to decision making and choices about their treatment. This was reflected in the comments left by patients who filled in CQC comment cards.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs and nurses showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of a patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff from across the practice had roles in the monitoring and improvement of outcomes for patients. These included data input, clinical review scheduling and medicines management. The information staff entered and collected was then used by the practice staff to support the practice to carry out clinical audits and other monitoring activity.

The practice's prescribing rates were similar to national figures. For example, prescribing of hypnotics (medicines regularly prescribed for insomnia and other sleep disorders) and antibiotics were in line with national averages. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as asthma and that the latest prescribing guidance was being used.

The practice had a system in place for completing clinical audit cycles, which led to improvements in clinical care. We saw a number of clinical audits had recently been carried out. The results and any necessary actions were discussed at the clinical team meetings. This included an audit of the frequency of blood tests in patients with chronic kidney disease. An initial audit was carried out which showed that the frequency of monitoring was higher than necessary. Action was taken and the monitoring arrangements were amended. A further audit cycle was carried out and this showed an improvement, in that the frequency was in line with national (NICE) guidelines.

The practice used the information they collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. The Quality and Outcomes Framework 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. We saw the practice had achieved a score of 100% of the points available to them for providing recommended treatments for the most commonly found clinical conditions. This was above both the local clinical commissioning group (CCG) and England averages (94.9% and 93.5% respectively). Specific examples to demonstrate this included:

Good

Are services effective?

(for example, treatment is effective)

- Performance for depression related indicators was above the national average (100% compared to the national average of 86.3%).
- Performance for asthma related indicators was above the national average (100% compared to the national average of 97.2%).
- Performance for hypertension (high blood pressure) related indicators was above the national average (100% compared to the national average of 88.4%).

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of these patients and their families.

The practice also participated in local prescribing benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included clinical and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support. Protected learning time (PLT) sessions were held monthly. Some were in house training and others were sessions provided by the CCG, for example, training on diabetes management across Cumbria.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation (every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with NHS England).

Other staff undertook annual appraisals which identified learning needs from which action plans were documented. Nursing staff were appraised by a GP and the practice manager. The practice manager appraised the administrative and support staff and a GP carried out the practice manager's own appraisal. Staff interviews confirmed that the practice was supportive in providing training and funding for relevant courses.

We saw the practice had an induction programme to be used when staff joined the practice. This covered individual areas of responsibility and general logistical information about how the practice operated.

Nursing staff had defined duties they were expected to carry out and were able to demonstrate they were trained to fulfil these duties. For example, the practice nurse said they carried out cervical smears and had been trained (with the support of the practice) to do so. Both of the nurses (as well as two doctors) had completed a Certificate in Diabetes course. Following this one of the nurses had carried out an audit which resulted in a new policy on diabetes being adopted within the practice, to ensure care and treatment followed best practice guidelines.

Working with colleagues and other services

The practice had positive working relationships and had forged close links with other health and social care providers, to co-ordinate care and meet patients' needs.

The practice held multidisciplinary team (MDT) meetings to discuss the needs of high risk patients, for example, those with end of life care needs. These meetings were attended by a range of healthcare professionals including district nurses, palliative care nurses and health visitors and decisions about care planning were recorded. The practice maintained lists of patients who had learning disabilities, those at high risk of unplanned admissions and patients diagnosed as living with dementia. These and other at risk patients were reviewed and discussed at the MDT meetings. Separate clinical meetings were held by GPs and nurses. One of the GPs liaised with the nursing team to relay any information; however, the practice recognised that joint meetings may improve communication.

Staff recognised the importance of care co-ordination and liaised in with other services, including the community psychiatric nurse, counselling and drug and alcohol services.

The practice had been part of a CCG pilot across the Upper Eden area and worked with other practices to develop 'Primary Care Communities'. This involved contacting a group of at risk patients and assessing their health needs. If one of those patients was admitted to hospital, staff liaised with an external team and support was arranged on their discharge, for example, someone being at home for them or supplying groceries for when they returned. This pilot was then rolled out across the whole Eden locality.

Good

Are services effective?

(for example, treatment is effective)

We found effective end of life care arrangements were in place. The practice maintained a palliative care register. We saw there were procedures in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out-of-hours provider and the ambulance service.

Information sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, for example, through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use and patients welcomed the ability to choose their own appointment dates and times.

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

Regular meetings were held throughout the practice. Information about risks and significant events were shared openly at meetings. Patient specific issues were also discussed to enable continuity of care.

Correspondence from other services such as blood results and letters from the local hospital including discharge summaries, was received both electronically and by post. Staff we spoke with were clear about their responsibilities for reading and taking action to address any issues arising from communications from other care providers. They understood their roles and how the practice's systems worked.

Consent to care and treatment

Before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes.

We found that staff were aware of the Mental Capacity Act (MCA) 2005 and the Children Acts 1989 and 2004 and their duties in fulfilling it. One of the GPs had recently held some training sessions for practice staff on the MCA. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. They also demonstrated an understanding of Gillick competencies (Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge).

There was a practice policy for recording consent for specific interventions. For example, verbal consent was taken from patients for routine examinations and verbal and implied consent for the measurement of blood pressure. Written consent was obtained for any minor surgical procedures.

Health promotion and prevention

The practice identified people who needed ongoing support and were proactive in offering this. This included carers, those receiving end of life care and those at risk of developing a long term condition. For example, there was a register of all patients with asthma. Nationally reported QOF data (2013/14) showed that the practice had obtained 100% of the points available to them for providing recommended clinical care and treatment to such patients. The data indicated that 87.8% of patients on the register had received an asthma review in the previous 12 months. This was 12.5 percentage points above the local CCG average and 12.3 points above the England average.

The QOF data showed the practice obtained 100% of the points available to them for providing cervical screening to women. This was 0.4 percentage points above the local CCG and 2.5 points above the England averages. The practice had procedures in place for the management of cervical screening. The proportion of patients eligible for screening who had been tested was 83.8%, this was above the local and the national averages (82.8% and 81.9% respectively).

We found patients with long-term conditions were recalled to check on their health and review their medicines for effectiveness. The practice's electronic system was used to flag when patients were due for review. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively. Staff said this worked well and helped to prevent any patient groups from being overlooked.

Good

Are services effective?

(for example, treatment is effective)

New patients were offered a 'new patient check', to ascertain details of their past medical histories, social factors including occupation and lifestyle, medications and measurements of risk factors (e.g. smoking, alcohol intake, blood pressure, height and weight).

The practice offered a full range of immunisations for babies and children, as well as travel and flu vaccinations, in line with current national guidance. Vaccination rates for 12 month and 24 month old babies and five year old children were in line with other practices in the local CCG area. All of the patients on the long-term conditions registers were offered annual flu vaccinations. Dedicated clinics were held on Saturday mornings to encourage working people to attend. National data showed that 90% of the eligible population had received the flu vaccine during 2014; this was the third highest across the CCG, and well above the national average of 73%.

Patients were encouraged to take an interest in their health and to take action to improve and maintain it.

There was a range of information on display within the waiting room. This included a number of health promotion and prevention leaflets. The practice's website included links to a range of patient information, including for family health, long term conditions and minor illnesses.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients we spoke with said they were treated with respect and dignity by the practice staff. Comments left by patients on Care Quality Commission (CQC) comment cards reflected this. Of the 27 CQC comment cards completed, 14 patients made direct reference to the caring and respectful manner of the practice staff. Words used to describe the approach of staff included helpful, kind, courteous, caring, pleasant, respectful and considerate.

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was considerate and caring, while remaining respectful and professional. This was clearly appreciated by the patients who attended the practice. We saw that any questions asked or issues raised by patients were handled appropriately and the staff involved remained polite and courteous at all times.

We reviewed the most recent data available for the practice regarding patient satisfaction. This included information from the national GP survey (July 2015). The scores in relation to patients' last appointment with doctors and nurses were all well above the national averages:

- 92% of patients said the GP treated them with care and concern (82% nationally)
- 91% of patients said the nurse treated them with care and concern (compared to 87% nationally)
- 78% of patients said they had confidence and trust in their GP (compared to 63% nationally)
- 77% of patients said they had confidence and trust in their nurse (compared to 62% nationally).

Staff were familiar with the steps they needed to take to protect people's dignity. Consultations took place in purposely designed consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. We noted that consultation and treatment room doors were closed during consultations and conversations taking place in those rooms could not be overheard.

The reception area opened directly onto the patient waiting area. We saw staff who worked in this area made every effort to maintain patients' privacy and confidentiality. Staff were aware of how to protect patients' confidential information. There was a room available if patients wanted to speak to the receptionist privately.

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

The practice had policies in place to ensure patients and other people were protected from disrespectful, discriminatory or abusive behaviour. The staff we spoke with were able to describe how they put this into practice.

Care planning and involvement in decisions about care and treatment

Patients told us they felt they had been involved in decisions about their care and treatment. They said the clinical staff gave them time to ask questions and responded in a way they could understand. Patients were satisfied with the level of information they had been given.

The results of the National GP Patient Survey from July 2015 showed most patients felt involved in their care and treatment. The scores were well above the national averages:

- 94% said the last GP they saw or spoke to was good at listening to them (national average 87%)
- 83% said the last GP they saw or spoke to was good at involving them in decisions about their care (national average 74%)
- 92% said the last nurse they saw or spoke to was good at listening to them (national average 78%)
- 75% said the last nurse they saw or spoke to was good at involving them in decisions about their care (national average 65%).

We saw that access to interpreting services was available to patients, should they require it. Staff we spoke with said the practice did not have many patients whose first language was not English. They said when a patient requested the use of an interpreter, a telephone service was available, or they could book an interpreter to accompany the patient. There was also the facility to request translation of documents should it be necessary to provide written information for patients.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

All of the patients we spoke with on the day of our visit told us staff responded compassionately when they needed help and provided support when required. For example, patients commented that staff were caring and took time to help and support them.

Most of the staff had worked at the practice for many years so there was good continuity of care for patients. Staff knew patients well which meant they were able to provide a more personalised service. For example, reception staff were aware of those patients with memory problems who lived alone, they contacted them to remind them about their appointment dates and times.

Support was provided to patients during times of bereavement. Staff told us that if families had suffered bereavement, one of the GPs carried out a home visit at a convenient time for the family. Clinical staff referred patients struggling with loss and bereavement to support groups who provided these types of services.

We saw there was a variety of information on display throughout the practice. This included a patient information leaflet, which contained details about the practice and the services on offer. Notices in the patient waiting areas signposted patients to a number of support groups and organisations. The practice's website provided detailed information on health, conditions and diseases. There was a separate section for teenagers which covered a variety of topics relevant to young people. The website was regularly updated and included links to support organisations.

A comprehensive system had been devised to support patients who were carers. The practice had implemented a 'Carers Identification Protocol' which set out the mechanisms in place for identifying carers and ensuring that they were offered a health check and referred for a Carers Assessment. There were good links with local support groups such as Eden Carers and Eden Young Carers.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Services were tailored to meet the needs of the local community. The patients we spoke with and those who completed comments cards were positive about the practice, felt the practice was meeting their needs and appreciated the services provided by the branch surgeries. We found that the practice worked collaboratively with other agencies to support patient care, for example, attending regular multi-disciplinary meetings, safeguarding meetings and mental health team meetings.

The practice engaged regularly with the local clinical commissioning group (CCG) and other practices in the Eden locality to discuss local needs and service improvements. For example, the practice worked with Primary Care Communities, an integrated health and social care team that ensured patients discharged from hospital were provided with support when required.

The Quality and Outcomes Framework (QOF) data (2013/14) showed the practice had obtained 100% of the points available to them for providing recommended care and treatment to patients needing palliative care (this was in line with the local average and 3.3 percentage points above the national average). The practice kept a register of patients who were in need of palliative care and their IT system alerted clinical staff about those who were receiving this care. QOF data showed that multi-disciplinary team (MDT) meetings took place at least every three months, to discuss and review the needs of each patient on this register. Staff told us these meetings included relevant healthcare professionals involved in supporting patients with palliative care needs, such as community nurses. Staff preferred see their own palliative care patients out of hours and carried out proactive visits at weekends and on evenings. Patients and their relatives were given the doctors personal telephone numbers so they could contact them at any time. A recent audit showed that over the past five years 43% of deaths occurred at the patient's own home, this was in comparison to 22% nationally and 23% locally (data taken from Public Health England).

The practice had identified the needs of families, children and young people, and put plans in place to meet them. Pregnant women were able to access an antenatal clinic provided by healthcare staff attached to the practice. The practice had obtained 100% of the QOF points available to them for providing recommended maternity services and carrying out specified child health surveillance interventions.

The practice had identified the needs of those with mental health issues and put plans in place to meet them, for example the practice offered longer appointments when required and met regularly with the Community Psychiatric Nurse's (CPN's). The practice had obtained 100% of the QOF points available to them for this service; this was 8.8% above the CCG average and 9.9% above the England average.

The practice made use of their facilities to support the community, for example the provision of a 'TellyTalk' service that enabled patients to contact Age UK, Citizens Advice or Carlisle Law Centre. (TellyTalk is a video conferencing facility which enables a patient visiting the practice to see, hear and speak to an officer based in various locations). Patients were able to use TellyTalk within the practice to access free information and advice. The practice had also arranged for an ultrasound scanning service to be provided at the practice. This was of benefit to patients given the lack of local public transport, as it meant patients did not have to travel to other locations for scans.

A review of the retinal screening service showed that the practice had a high DNA (did not attend) rate. Patients had difficulty accessing the clinic, due to the lack of local public transport. Arrangements were therefore made to host the clinic at the practice. The uptake from patients increased from 55% to over 80%.

A Patient Participation Group (PPG) had been established to help staff engage with a cross section of the practice population and obtain patient views. A PPG is made up of practice staff and patients that are representative of the practice population. The main aim of a PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice.

We spoke with two members of the PPG; they explained their role and how the group worked with the practice. The representatives told us the PPG had a good working relationship with the practice, and felt that the GPs listened to them and were very receptive to their ideas. We found the practice regularly implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from (PPG) and patient

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

surveys. Examples included the provision of an NHS Optician in the practice, a volunteer prescription delivery service and a newly introduced calibration service for patients own blood pressure monitors. The practice had also responded to concerns raised by the PPG about appointments running late and initiated work to review records to ensure patients were booked appropriate length appointments. Staff demonstrated how the clinical system had been used to support this work.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients where necessary. Registers were maintained, for example for those patients who were housebound or who had a learning disability, and systems were in place to ensure those patients were offered appropriate care and support. For instance, the practice undertook annual health checks for patients with learning disabilities that included 30 minutes with a Nurse and 30 minutes with a Doctor, the same staff were used each year to provide continuity of care.

The majority of the practice population were English speaking patients but access to translation services were available if they were needed

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence. The practice had two mobile induction loops available throughout the practice. The practice further supported patients who were hard of hearing by facilitating a hearing aid cleaning and maintenance clinic.

There was a system for flagging vulnerability and high risk in individual patient records, we saw evidence that this was used well and was responsive to individual circumstances, for example ensuring dementia patients had the support required to attend appointments.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice accepted any patient who lived within their practice boundary irrespective of ethnicity, culture, religion or sexual preference.

Access to the service

Patients could access appointments and services in a way and a time that suited them. Patients were able to book appointments either by calling into the practice, on the telephone or using the on-line system. Face to face consultations and home visits were available to suit individual needs and preferences.

The surgery at Shap was open between 8:30am to 6:30pm every weekday except Thursdays, when it was open until 1:00pm. The branch surgery at Orton was open on Tuesdays between 9:15am and 10.30am and on Thursdays between 4:00pm and 5:45pm. The branch surgery at Tebay was open between 11.30am and 12.15pm each Wednesday.

The practice recently introduced extended hours with a doctor and nurse available alternate Mondays between 6.30pm and 7.00pm, additional sessions were also made available close to bank holidays to ensure sufficient appointments were available to meet demand.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through their website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent. Routine appointments were available for booking eight weeks in advance.

We looked at the practice's appointments system in real-time on the afternoon of the inspection. The next available routine appointment with a doctor was on the same day at a branch and the following morning in the main surgery, the next available nurse appointment was within two working days. Urgent, on the day, appointments were available for patients each day. Staff told us there

were no limits to these appointments and that all patients would be seen in an emergency. Patients we spoke to confirmed this, none had encountered any difficulties when making appointments.

The practice scored very highly in relation to access in the National GP Patient Survey. The most recent results (July 2015) showed 90% (compared to 73% nationally and 78% locally) of respondents were able to get an appointment or speak to someone when necessary. All respondents said the appointment was at a convenient time for them (compared to the national and local averages of 94% and 92% respectively). The practice also scored highly on the ease of getting through on the telephone to make an appointment (93% of patients said this was easy or very easy, compared to the national average of 74% and a CCG average of 78%).

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. Patients had a preferred GP. Home visits were made each day if required to those patients who needed one. Patient notes on the clinical system ensured additional needs were identified and allowed for longer appointments or additional support to be provided if required. For example, patients with mental health conditions were booked appointments at times that were less stressful and steps were taken to ensure patients with dementia were able to attend with a relative or carer.

The practice provided a home visit service reflecting the needs of an elderly and rural community with pockets of deprivation. Doctors all carried their own on-call bag, as well as a defibrillator and oxygen. This meant if they were called to a rural area some distance from the practice they would have the appropriate equipment available without having to return to the practice. All of the doctors carried winter tyres for their vehicles so in the event of severe weather staff could still visit patients.

Telephone consultations were bookable by patients and were used by the practice proactively, for example phoning patients following high-risk discharges. Several patients told us how staff phoned them just to check how they were.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its 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 to help patients understand the complaints system; this information was available at reception and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a formal complaint about the practice.

We looked at the two informal complaints received in the last 12 months; no formal complaints had been received. The practice handled both of these satisfactorily, responses were made in a timely manner and there was openness and transparency with dealing with the complaint.

Complaints were discussed formally and informally at regular meetings. The practice reviewed complaints annually to detect themes or trends. We looked at the report from the 2014/2015 review. Improvements had been made as a result of the complaints, for example a change to referral policy.

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 had a documented vision; this was: 'to deliver high quality patient centered family medicine, prioritising continuity of care from the cradle to the grave.' Practice staff took pride in being a 'family practice'.

We spoke with a variety of practice staff including the practice manager, GPs, the practice nurse and some of the practice's administrative and support staff. They all knew and shared the practice's aims and objectives and knew what their responsibilities were in relation to these.

Practice business meetings were held every month. These meetings were used to review any changes that needed to be made to take account of contractual changes in the GP contract, to reaffirm what the practice did well, what its priorities were, and what changes needed to be made to make further improvements to patient outcomes. The practice did not have a formal business plan which set out future aims; the practice manager told us this was something they were working on, as part of their work on succession planning.

Governance arrangements

Arrangements for assessing, monitoring and addressing risks were in place. For example, the practice had a business continuity plan to help ensure the service could be maintained in the event of foreseeable emergencies. The practice had a number of policies and procedures in place to govern activity. These were available to staff via the shared drive on the computer system. The policies and procedures had been reviewed regularly and were up-to-date. Risk assessments had been carried out where risks were identified and actions to mitigate these risks had been put into place. For example, we saw a fire risk assessment was in place and the fire alarms within the building were tested every Thursday.

There was a management team in place to oversee the practice. The practice used a variety of systems to monitor performance, including prescribing data and Quality and Outcomes Framework (QOF). Comparative data was analysed to compare performance against other local practices. The practice had achieved an overall QOF score of 100% of the maximum points available in 2013/2014; this achievement was above both the local clinical commissioning group (CCG) and the national averages (94.9% and 93.5% respectively). We saw that QOF data was discussed at practice business meetings and actions were taken to maintain or improve outcomes. For example, reminders were sent to patients if they failed to respond to the request to attend the practice for reviews of their long-term conditions.

The practice had carried out a number of completed clinical audit cycles, which it used to monitor quality and systems to identify where action should be taken.

Arrangements were in place which supported the identification, promotion and sharing of good practice. For example, a system was in place which ensured significant events were discussed within the practice team. Staff were encouraged and supported to learn lessons where patient outcomes were not of the standard the practice expected. We found that staff felt comfortable to challenge existing arrangements and looked to continuously improve the service being offered.

The practice held regular meetings for staff. These included management meetings between the practice manager and clinicians, clinical meetings, primary health care team meetings and monthly administrative staff meetings. We looked at minutes from some of these meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

There was a well-established management team with clear allocation of responsibilities. For example, one of the GP partners was the safeguarding lead. The practice manager was responsible for the application of the practice's human resource policies and procedures. We spoke with staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. There were good levels of staff engagement and there was a real sense of team working across all of the staff, both clinical and non-clinical.

We saw that there was strong leadership within the practice and the GPs were visible and accessible. We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings and through individual appraisals.

We found there were good levels of staff satisfaction across the practice. Staff told us they had the opportunity and were happy to raise issues at meetings.

Are services well-led?

Good

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

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

The practice had made arrangements to seek and act on feedback from patients and staff. There were suggestion boxes in the waiting rooms and there was a patient participation group (PPG) open to all patients. The PPG contained representatives from some of the key population groups. Staff from the practice always attended to support the group. We spoke with two members of the PPG and they felt the practice supported them fully with their work and took on board and acted on any concerns they raised. This included the introduction of a hearing aid cleaning and maintenance service, which was implemented following a suggestion from the PPG.

NHS England guidance stated that from 1 December 2014, all GP practices must implement the NHS Friends and Family Test (FFT), (the FFT is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience that can be used to improve services. It is a continuous feedback loop between patients and practices). We saw the practice had introduced the FFT, there were questionnaires available in the waiting room and instructions for patients on how to give feedback. FFT feedback was routinely reviewed. The latest results showed that 98% of respondents were extremely likely or likely to recommend the practice.

The practice gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff we spoke with told us their regular meetings provided them with an opportunity to share information, changes or action points. Staff retention was high and they felt involved and engaged in the running of the practice.

The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of the policy, how to access it and said they wouldn't hesitate to raise any concerns they had.

Management lead through learning and improvement

Staff said that the practice supported them to maintain their clinical professional development through training and mentoring. We saw that appraisals took place which resulted in each member of staff having an agreed personal development plan. Staff told us that the practice was supportive of training and development opportunities.

The practice had completed reviews of significant events and other incidents and shared these with staff via meetings. These events were discussed, with actions taken to reduce the risk of them happening again.

The practice manager met with other practice managers in the area and shared learning and experiences from these meetings with colleagues.

GPs met with colleagues at locality and clinical commissioning group (CCG) meetings. This included Clinical Reference Group meetings where referrals to secondary care services across the area were discussed and reviewed. One such review highlighted that the practice referred a higher proportion of dermatology patients to secondary care services. Changes to the system were made which resulted in an increased referral rate to GPs with Special Interests (GPwSIs) from 30% in 2013 to 45% in 2015, which then reduced referrals to secondary care services.

GPs also attended learning events and shared information from these with the other GPs in the practice. Information and learning was shared between staff. The practice's schedule of meetings was used to facilitate the flow of information, including meetings of administrative staff and clinical staff.