Silloth Group Medical Practice

Quality Report

Lawn Terrace, Silloth, Wigton, Cumbria, CA7 4AH
Tel: 01697 331309
Website: www.sillothgroupmedicalpractice.nhs.uk

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Silloth Group Medical Practice on 24 November 2015. Overall the practice is rated as good.

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

- Risks to patients were assessed and well managed. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised, external agencies were informed of the outcome if they were involved. There were strong comprehensive safety systems in place.
- The practice had scored very well on clinical indicators within the Quality and Outcomes Framework (QOF).They achieved 99.1% for the year 2014/15, which was above the average in England of 93.5%. The QOF is part of the General Medical Services (GMS) contract for general practices. Practices are rewarded for the provision of quality care.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Patients commented that they thought they received a very good service from the practice.
- Information about services and how to complain was available and easy to understand.
- Patients said they were able to get an appointment with a GP when they needed one, with urgent appointments available the same day. The practice had recently reviewed the appointments system, in order to improve the service they provided to patients and offered an open access appointment system every morning for two hours.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure in place and staff felt supported by management. The practice sought feedback from staff and patients, which they acted on. Staff throughout the practice worked well together as a team.

We saw two areas of outstanding practice including:

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- The practice offered personalised mentoring with one to one support. The CCG pharmacist had been mentored into their role of medicines optimisation pharmacist. They had been trained by the practice, at their expense, to be a prescriber. This meant they could carry out complex medication reviews and polypharmacy clinics; polypharmacy is the concurrent use of multiple medications.The practice said the pharmacist had reviewed 117 people in the last 11 months; they ran clinics every two weeks and carried out regular reviews on all patients who have over three medications and also carried out reviews of the patients in their care and residential homes.One of the GPs was mentor for the health care assistant, they had arranged for spirometry training with a specialist nurse off site to meet their learning needs.
- The practice provided an excellent palliative care service. This included providing patients and family members with support; they had open access to a GP and counselling was routinely offered. The nearest conventional palliative hospice was one hours journey away in Carlisle. The practice recognised this and arranged to have one community bed in the local charity run nursing home where they could admit end of life patients who needed the care, without having to involve social services. This ensured the patient could access the care needed as soon as possible.

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. Patients and staff were protected by strong, comprehensive safety systems. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents to support improvement. Appropriate recruitment checks had been carried out for staff including Disclosure and Barring Service (DBS) checks for those who acted as chaperones. There were infection control arrangements in place and the practice was clean and hygienic. There were systems and processes in place for the safe management of medicines. There was enough staff to keep patients safe. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. We found systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the clinical commissioning group. The practice was using innovative and proactive methods to improve patient outcomes. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice were able to show us examples of staff appraisals and their personal development plans. Staff worked well with multidisciplinary teams.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services. Data showed that patients rated the practice much higher than others for almost all aspects of care, for example the proportion of patients who said they found the receptionists at the practice helpful was 97% compared to the national average of 87%. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture which included excellent palliative care. Information for

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patients about the services available was easy to understand and accessible. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We saw many examples of where staff went above or beyond their duty to patients.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. They reviewed the needs of their local population and engaged with the clinical commissioning group (CCG) in an attempt to secure improvements to services where these were identified. The practice had recently reviewed the appointments system, in order to improve the service they provided to patients and offered an open access appointment system every morning for two hours. Patients told us it was easy to obtain an appointment. Data from the national GP survey showed that 90% of patients reported a good experience of making an appointment, the national average is 73%; and 97% of patients said it was easy to get through on the phone compared to the national average of 73%. There was continuity of care, with urgent appointments available the same day. 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.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients and they had an active patient participation group (PPG).

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that the practice had higher than average levels of patients aged over 60 and outcomes for patients were very good for conditions commonly found in older people. For example, the practice had a very strong performance in the clinical commissioning group (CCG) area for management of COPD chronic obstructive pulmonary disease (COPD); they were third top in the local area and had achieved 100% of the maximum number of points available to them for providing recommended care and treatment for patients with this condition. This was above the local CCG average of 97.6% and above the England average of 96%.

The practice offered proactive, personalised care to meet the needs of the older people in its population. For example, the practice had care plans in place for the elderly with complex health conditions. Those with a care plan in place had either a face to face or a home visit review of their care plan with their named GP at least annually.

The practice was responsive to the needs of older people, including offering home visits. All patients had a named GP. Prescriptions could be sent to any local pharmacy electronically.

The practice provided dedicated clinics at the local nursing home every Tuesday. Home visits would be carried out to the three residential care homes in the practice area on an ad hoc basis and all of the patients had care plans in place.

The practice had arranged to have one community bed in the local charity run nursing home where they could admit end of life patients who needed the care, without having to involve social services.

The practice had access to a service called 'STINT', a local team which provides short term interventions at home for patients and their carers in need of urgent care. This included physiotherapy, social services and care packages. The service aims to prevent unnecessary hospital or residential care admission, to facilitate hospital discharge and help people regain and retain as much independence as possible. They estimated they referred approximately three patients a month to this service.

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

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People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. The practice maintained chronic disease registers. Longer appointments and home visits for housebound patients were available when needed.

All patients had a named GP. There were care plans in place for those with long term conditions. The practice were also involved in the diabetes year of care project in providing personalised care to patients to provide shared goals and action plans for patients to enable them to self-manage their condition. High risk issues were flagged electronically to enable the out of hours service to have access to this information. The named GP received a discharge summary for all patients who had a care plan and then the GP made contact within 24-48 hours either via telephone or home visit to review and discuss discharge from hospital.

Nationally reported Quality and Outcomes Framework (QOF) data (2014/15) 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 asthma. This was above local clinical commissioning group (CCG) average of 98.5% and above the England average of 97.4%.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of accident and emergency attendances. Immunisation rates were mostly higher than CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds were 100% and for five year olds ranged from 77.3% to 100%. The practice's uptake for the cervical screening programme was 82.5%, which was above the CCG and national averages of 79.8% and 76.9%. Appointments were available outside of school hours and the premises were suitable for children and babies.

There were six week checks and post-natal reviews with the GPs. Maternity care clinics with the midwife were held at the practice every Wednesday afternoon.

Working age people (including those recently retired and students)

Good

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

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been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services which included appointment booking, test results and ordering repeat prescriptions. Telephone appointments were available.

There was a full range of health promotion and screening that reflected the needs for this age group. Flexible appointments were available. Minor surgery clinics were available and the practice ran a minor injury service.

Family planning and sexual health clinics were run at the practice. The practice provided intrauterine device (IUD) coil fitting and contraceptive implant 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 staff almost all lived locally and as part of the community had excellent local knowledge acting as an early warning system when a patient was vulnerable. The geographical isolation of the locality disadvantaged patients at times and the practice were well aware of this. GPs had offered lifts to the surgery for patients and frequently collected medication for home visits to elderly patients.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability and there was a lead GP for this area. They carried out annual health checks for people with a learning disability.

Carers were recorded on IT system and flagged so they could be offered enhanced care, for example a proactive update of immunisations and were invited to the local carers organisation.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health. They carried out advanced care planning for patients with dementia. 92.2

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% of patients identified as living with dementia had received an annual review in 2013/14 (national average 83.8%) and had agreed care plans in place. All patients with a chronic illness were screened for dementia as a matter of routine. Double appointments were offered as routine for those experiencing poor mental health.

The practice had a monthly multi-disciplinary team meeting with the community psychiatric nurse to discuss and highlight patients at risk. They told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had received training on how to care for people with mental health needs and dementia. Household members of patients experiencing poor mental health were offered counselling to help them manage the situation.

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What people who use the service say

We spoke with nine patients on the day of our inspection, which included three members of the practice's patient participation group (PPG).

All of the patients we spoke with were satisfied with the care they received from the practice. Words used to describe the practice included brilliant, very good and very happy. They told us staff were friendly and helpful and they received an excellent service. Patients said they did not have difficulty obtaining an appointment to see a GP. Emergency appointments were always available on the same day and routine appointments were usually available the next day.

We reviewed 46 CQC comment cards completed by patients prior to the inspection. Comments we received from patients were overwhelming positive. Patients said they had no difficulty in obtaining appointments. Staff were friendly and caring. Patients found the GPs to be understanding and caring. Three patients commented that the open surgeries which were held on a morning were a good idea. Two comment cards contained unrelated negative comments.

The latest GP Patient Survey published in July 2015 showed that scores were mostly above national and local averages. The percentage of patients who described their overall experience as good was 88%, which was in line with the local clinical commissioning group (CCG) average of 88% and the national average of 85%. Other results were as follows;

- The proportion of patients who would recommend their GP surgery – 89% (local CCG average 80%, national average 78%).
- 89% said the GP was good at listening to them compared to the local CCG average of 91% and national average of 89%.
- 98% said the GP gave them enough time compared to the local CCG average of 90% and national average of 87%.
- 97% said the nurse was good at listening to them compared to the local CCG average of 94% and national average of 91%.
- 98% said the nurse gave them enough time compared to the local CCG average of 94% and national average of 92%.
- 97% said they found it easy to get through to this surgery by phone (local CCG average 80%, national average 73%).
- Percentage of patients who were able to see or get to speak to their usual GP - 67% (local CCG average 62%, national average 60%).
- Percentage of patients who usually had to wait 15 minutes or less after their appointment time to be seen- 62% (local CCG average 65%, national average 65%).
- Percentage of patients who find the receptionists at this surgery helpful - 97% (local CCG average 90%, national average 87%).

These results were based on 123 surveys that were returned from a total of 252 sent out; a response rate of 49%.

The practice carried out its own survey in 2014. They had recognised that their main area of concern was the appointments system and this was the theme for the survey which was carried out. 152 responses were received.

- 90% rated their experience of the GP surgery as excellent, very good or good, 2% fair or poor and 8% provided no response.
- 99% of patients found the receptionists very or fairly helpful.
- 92% found it very or fairly easy to get through on the phone to make an appointment.
- 55% said they could get to see a GP urgently on the same day, 17% said they could not and 28% said they had never needed to or provided no response.

Summary of findings

Outstanding practice

We saw two areas of outstanding practice including:

- The practice offered personalised mentoring with one to one support. The CCG pharmacist had been mentored into their role of medicines optimisation pharmacist. They had been trained by the practice, at their expense, to be a prescriber. This meant they could carry out complex medication reviews and polypharmacy clinics; polypharmacy is the concurrent use of multiple medications. The practice said the pharmacist had reviewed 117 people in the last 11 months; they ran clinics every two weeks and carried out regular reviews on all patients who have over three medications and also carried out reviews of the patients in their care and residential homes.

  One of the GPs was mentor for the health care assistant, they had arranged for spirometry training with a specialist nurse off site to meet their learning needs.

- The practice provided an excellent palliative care service. This included providing patients and family members with support; they had open access to a GP and counselling was routinely offered. The nearest conventional palliative hospice was one hours journey away in Carlisle. The practice recognised this and arranged to have one community bed in the local charity run nursing home where they could admit end of life patients who needed the care, without having to involve social services. This ensured the patient could access the care needed as soon as possible.

Silloth Group Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Silloth Group Medical Practice

Silloth Group Medical Practice provides Primary Medical Services to the town of Silloth and surrounding villages in a remote part of the West Cumbrian coast. The practice provides services from one location, Lawn Terrace, Silloth, Wigton, Cumbria, CA7 4AH. We visited this address as part of the inspection

The practice building was purpose built in the 1980s. All consultation rooms are on the ground floor. There is wheelchair access and a low rise reception counter. There are disabled toilet facilities and a marked disabled bay in the large dedicated car park for patients at the rear of the surgery.

The practice has two male GP partners and a practice manager who is a managing partner. There is a female salaried GP. There are two part time practice nurses, a healthcare assistant, eight reception and administration staff and a cleaner.

The practice provides services to approximately 4,220 patients of all ages. The practice is commissioned to provide services within a General Medical Services (GMS) contract with NHS England.

Data from Public Health England shows that the practice has higher than average levels of patients aged over 60 and lower levels of patients below the age of 40. There is a 5% increase in patients during the summer months due to temporary residents which are mostly people on holiday at one of the number of caravan parks within the practice area.

The practice is open between 8:00am - 6:30pm Mondays to Friday.

Consulting times are Monday to Friday 9am to 11am and between 2pm and 5:40pm.

The service for patients requiring urgent medical attention out of hours is through 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

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meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

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

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

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

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

We carried out an announced visit on 24 November 2015. During our visit we spoke with a range of staff. This included two GP partners, a salaried GP, the practice manager, a practice nurse, a healthcare assistant and reception and administrative staff. We also spoke with nine patients. We reviewed 46 CQC comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record and learning

The practice had an excellent system in place for reporting, recording and monitoring significant events. They were open and transparent when there were near misses or when things went wrong. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. The incidents were discussed monthly at staff meetings held in protected learning time. At the meetings learning points were formally identified and at subsequent meetings, previous significant events would be reviewed to ensure the learning points had been completed. All staff received the minutes electronically after each meeting. A summary of significant events was kept, we saw six significant events had been recorded in the 12 months prior to the inspection. We saw each individual event had been investigated, the root cause established and any learning to be taken from it identified. For example, feedback had been collated and fed back to an outside agency when medication errors had been discovered. We saw minutes of the yearly review meeting of significant events.

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. The responsibility for these was shared between the practice manager and the medicines manager, with one of the secretaries as back up if either was not at work. There was a protocol for sharing the alerts. Audits were routinely carried out as a result of safety alerts; they were discussed and included in the practice meetings.

Safety was monitored using information from a range of sources, including the National Patient Safety Agency and National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. There was a lead member of staff for safeguarding. Informal concerns were discussed at clinical team meetings and monthly safeguarding meetings were held with health visitors and district nurses, which were formally minuted. The lead GP always provided reports where necessary for other agencies. All GPs had received level 3 safeguarding children training. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- There were notices displayed in the waiting area, advising patients that they could request a chaperone, if required. The practice nurses or health care assistant usually carried out this role. There were two other members of staff who were trained as chaperones who could also carry out this role if the nurse or healthcare assistant was unavailable. All staff who acted as chaperones were trained for the role 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). There was a chaperone policy and guidelines for staff who acted as chaperone.
- There were comprehensive procedures in place for monitoring and managing risks to patients and staff safety. The IT manager had also been trained to be the health and safety lead for the practice. They had attended a health and safety at work course which included level 2 training in health and safety, including how to complete risk assessments, level 2 fire safety training and how to use fire extinguisher awareness courses with outside contractors. They then trained the staff at the practice regarding health and safety. The lead showed us the practice health and safety information which included, fire and health and safety policies and risk assessments, fire equipment checks, risk assessments for display screen equipment for staff, details of eye tests for staff, and the fire evacuation report. There was a folder with pictures of products used by the practice which were products covered by control of substances hazardous to health (COSHH). New members of staff were given training in health and

safety when they started work at the practice. There were regular fire drills and every time a new member of staff was employed a fire drill would be carried out in protected learning time.

- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy, patients commented positively on the cleanliness of the practice. The practice manager was the infection control lead. They had attended a link practitioner infection control training course. Staff had received on-line infection control training and the lead had provided staff with hand hygiene training. There were infection control policies, including a needle stick injury policy. Regular infection control and hand hygiene audits had been carried out and where actions were raised these had been addressed.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Prescription pads were securely stored and there were systems in place to monitor their use. The practice carried out regular medicines audits, with the support of the local clinical commissioning group (CCG) pharmacist. The CCG pharmacist had been trained by the practice at their expense, via a mentoring scheme, to be a prescriber. This meant they could carry out complex medication reviews and polypharmacy clinics; polypharmacy is the concurrent use of multiple medications. They ensured prescribing was in line with best practice guidelines for safe prescribing. The practice said the pharmacist had reviewed 117 people in the last 11 months; they ran clinics every two weeks and carried out regular reviews all patients who have over three medications and also carried out reviews of the patients in their care and residential homes.
- Recruitment checks were carried out and the files we sampled showed that 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 DBS checks.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There were policies in place regarding the numbers of staff required to be on duty. For example the administration staff covered each other and there were always two GPs on duty.

Arrangements to deal with emergencies and major incidents

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

The practice had a business continuity plan in place for major incidents such as building damage. The plan included emergency contact numbers for staff and was updated on a regular basis.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. Evidence based practice was discussed at weekly clinical meetings.

Management, monitoring and improving outcomes for people

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

The latest publicly available data from 2014/15 showed the practice had achieved 99.1% of the total number of points available, with a clinical exception reporting rate of 13%. The QOF score achieved by the practice in 2014/15 was 5.6% above the England average; the clinical exception rate was 3.8% above the England average and 2.9% above the local clinical commissioning group (CCG) average.

The data showed:

- Performance for asthma related indicators was better than the national average (100% compared to 97.4% nationally).
- Performance for diabetes related indicators was better than the national average (98.8% compared to 89.2% nationally).
- Performance for mental health related indicators was above the national average (100% compared to 92.8% nationally).
- Performance for dementia indicators was above the national average (100% compared to 94.5% nationally).
- Performance for chronic obstructive pulmonary disease (COPD) related indicators was above the national average (100% compared to 96% nationally).

The practice had been recognised by the CCG as achieving high performance, in QOF, in the treatment of COPD and they were the third highest performers in the CCG area for this area of care out of 81 GP practices.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. We saw examples of seven clinical audits of which four were two cycle audits; they covered management and clinical topics. We also saw CCG medication optimisation audits which were reviewed at the weekly clinical meetings.

The practice had carried out a recent audit on the use of medication which is used to treat anxiety and insomnia. The practice identified 81 patients who were invited into the practice to discuss being placed upon a reduction programme for this medication. The programme included a self-help guide and a reduction regime. From February 2013 to March 2015 there was a reduction of 95% in patients using this medication. The audits were then repeated every four months to ensure patients who were taking the medication were doing so appropriately. This scheme was successful and had been rolled out across the CCG area.

Effective staffing

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

- The practice had an induction and mentoring programme for newly appointed non-clinical members of staff that covered such topics as fire safety, health and safety and responsibilities of their job role. New GPs had a formalised induction process which included time with the IT manager to ensure computer compliance and to explain the locum induction pack.
- Staff received comprehensive training that included: safeguarding vulnerable adults and children, fire procedures, health and safety, basic life support and information governance awareness. Clinicians and practice nurses had completed training relevant to their role.
- The learning needs of staff were identified through a system of appraisals, personal development plans,

meetings and reviews of practice development needs. Staff had access to appropriate training to meet those learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision, and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months. Staff told us they felt well supported in carrying out their duties.

Coordinating patient care and information sharing

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. High risk patients were identified via RAIDR, which is a risk stratification tool and reviewed monthly by GPs and the CCG clinical integration manager, to ensure that care registers and care plans were up to date. All relevant information was shared with other services in a timely way, for example, when people were referred to other services.

All patients had a named GP. The practice estimated they had care plans in place for approximately 4% of the patient's population. Those with a care plan in place had either a face to face or a home visit review of their care plan with their named GP at least annually. There were care plans for patients with long term conditions, those at risk of unplanned admission into hospital, the housebound, patients with learning disabilities and those experiencing severe mental health. High risk issues were flagged electronically to enable the out of hours service to have access to this information, this information was reviewed three monthly. The named GP received a discharge summary for all patients who have a care plan and then the GP made contact within 24-48 hours either via telephone or home visit to review and discuss discharge from hospital.

One of the GP partners had responsibility for the local nursing home where 34 patients lived. The GP provided dedicated clinics there every Tuesday, seeing residents with acute problems and carrying out routine reviews. As a result of this comprehensive healthcare plans had been produced for residents with the aim to reduce unplanned admissions to hospital. There were also emergency care plans in place if the resident became unwell. The aim was to give guidance to the staff at the care home about action to take. Resuscitation wishes were also discussed as part of the care plan. The practice were piloting asking the residents direct about burial and cremation wishes to ensure their wishes were carried out.

District nurses worked in the building next door to the surgery; therefore there was regular informal communication. We saw evidence that formal multi-disciplinary team meetings took place monthly.

Consent to care and treatment

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

Health promotion and prevention

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

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 82.5%, which was above national average of 81.8%. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Any patients for these screening programmes who did not attend received a personalised letter urging them to attend a future appointment.

Childhood immunisation rates for the vaccinations given were higher than CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds were 100% and five year olds from 77.3% to 100%. The flu vaccination rates for the over 65s was 73.3% (compared to 73.2% nationally), and for at risk groups was 59.2% (compared to 52.3% nationally).

Good

Are services effective?

(for example, treatment is effective)

Patients had access to appropriate health assessments and checks. These included health checks for new patients. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

We reviewed 46 CQC comment cards completed by patients prior to the inspection. Comments we received from patients were overwhelming positive. Patients said staff were friendly. They said they found the GPs to be understanding and caring.

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

Results from the National GP Patient Survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was above local and national satisfaction scores on consultations with doctors and nurses. For example:

- 98% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 92% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89% and the national average of 85%.
- 100% 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%.
- 96% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and the national average of 90%.
- 97% said they found the receptionists at the practice helpful compared to the CCG average of 90% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us that they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were mostly above local and national averages. For example:

- 90% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and the national average of 86%.
- 89% said the GP was good at listening to them compared to the CCG average of 91% and the national average of 89%.
- 88% 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 involving them in decisions about their care compared to the CCG average of 85% and the national average of 81%.
- 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%.
- 98% said the nurse gave them enough time compared to the CCG average of 94% and the national average of 92%.

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

Patient and carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice and rated it well in this area. The CQC comment cards we received were also consistent with this feedback. For example, patients

Outstanding ☆

Are services caring?

commented the GPs were caring, reassuring and supportive. Notices in the patient waiting room told patients how to access a number of support groups and organisations.

Most of the practice staff were part of the local community and all were dedicated to the care of patients. We saw many examples of where staff went above or beyond their duty to patients. One of the nurses was concerned about a patient who had not attended a diabetic clinic and called to check on them on their way home. The patient was found to be hypoglycaemic and was rushed to hospital. Due to the remote environment in which some patients live, GPs often offered lifts to the surgery for patients and frequently collected medication for home visits to elderly patients. One patient who was elderly was isolated at home due to a visual impairment. One of the GPs arranged for the patient to have a large tap keyboard fitted to the patient's computer so they could communicate easier.

The practice were very proud of the palliative service they provided to all patients who required it including those with a diagnosis of cancer. The key ethos of this service was to provide family members support, so all relatives of end of life patients had open access to a GP. Counselling was routinely offered to patients and their relatives. The practice held formal palliative MDT meetings monthly with extended health care team.

The nearest conventional palliative care hospice was one hours journey away in Carlisle. The practice recognised this and arranged to have one community bed in the local charity run nursing home where they could admit end of life patients who needed the care, without having to involve social services. This ensured the patient could access the care needed as soon as possible.

Carers were recorded on IT system and flagged so they could be offered enhanced care, for example a proactive update of immunisations and were invited to the local carers organisation.

The practice had access to a service called 'STINT', a local team which provided short term interventions at home to patients and their carers in need of urgent care. This included physiotherapy, social services and care packages. The service aimed to prevent unnecessary hospital or residential care admission and to facilitate hospital discharge. They estimated they referred approximately three patients a month to this service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. For example, the practice had identified through feedback from patients that the appointment system was not working as well as it could and telephone consultations were becoming unmanageable. As a result of this a new open access system to emergency consultations for two hours every morning was piloted from January 2015 and was well received by patients. Telephone consultations were reduced by over 1,000 to date and this had allowed for 200 more face to face consultations.

The practice worked with the local clinical commissioning group (CCG) to improve outcomes for patients in the area. The CCG asked the practice to present their findings of their report which they had compiled on the positive changes they had made to their appointment system.

One of the GPs was involved locally with the Royal National Lifeboat Institution (RNLI). They were the medical officer for the local branch. They were also the medical officer for the local fire station which was manned by volunteers. These were voluntary positions which supported a local charity and the community.

The practice provided dedicated clinics at the local nursing home every Tuesday. Home visits were carried out to the three residential care homes in the practice area on an ad hoc basis and all of the patients had care plans in place.

The practice had a virtual patient participation group (PPG) with 29 members. They planned to have their first face to face meeting in December 2015. We spoke with the group members who commented positively on how the practice was open to change. Examples of improvements the group had influenced included asking for the children's toys to be removed from the waiting area as they made the area look untidy.

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

- Booking appointments with GPs and requesting repeat prescriptions was available online.
- Home visits were available for housebound patients or those who could not travel to the surgery.
- There was a telephone consultation service available.
- Specialist Clinics were provided including minor surgery, sexual health, including and chronic disease management.
- The practice provided a minor injury service due to the distance which patients had to travel to the local accident and emergency department at the local hospital.
- Phlebotomy was available daily in the practice via an appointment with the health care assistant.
- The surgery offered an INR clinic for patients on warfarin. INR (International Normalised Ratio) is a blood test which needs to be performed regularly on patients who are taking warfarin to determine their required dose. By being able to go to the clinic, patients no longer had to travel to hospital for the test.
- Electronic records were used to flag up high risk issues, for example, mental health.

Access to the service

The practice was open between 8:00am and 6:30pm Monday to Friday. Consulting times were Monday to Friday 9am to 11am and between 2pm and 5:40pm.

Patients we spoke with said they found it easy to obtain an appointment to see a GP. Emergency appointments were always available on the same day and routine appointments were usually available the next day. In feedback from the CQC comment cards patients said they had no difficulty in obtaining appointments. Three patients commented on the open surgeries which were held on a morning to be a good idea.

The practice recognised that access had become a problem for patients and introduced an open surgery every morning for two hours between 9am and 11am so that patients who needed to be seen on the day could be. Patients were able to make a routine appointment with the GP of their choice usually within two days.

We looked at the practice's appointments system in real-time on the afternoon of the inspection. Routine appointments to see a GP were available to be booked on the same or next day dependent upon which GP the patient wished to see. There were appointments available with the practice nurse the next day for dressings and the next routine appointment with the nurse was the following week.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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

- 97% patients said they could get through easily to the surgery by phone compared to the local CCG average of 80% and national average of 73%.
- 90% patients described their experience of making an appointment as good compared to the local CCG average of 79% and national average of 73%.
- 62% patients said they usually waited 15 minutes or less after their appointment time compared to the local CCG average of 65% and national average of 65%.
- 74% said they did not feel they had to wait too long to be seen compared to the local CCG average of 61% and national average of 58%.
- 76% of patients were satisfied with the practice's opening hours compared to the local CCG average of 78% and national average of 75%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. 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 included leaflets in the patient waiting area, in the practice information leaflet and the complaints policy was on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. Staff we spoke with were aware of the practice's policy and knew how to respond in the event of a patient raising a complaint or concern with them directly.

We saw the practice had received four formal complaints in the last 12 months and these had been investigated in line with their complaints procedure. Where mistakes had been made, it was noted the practice had apologised formally to patients and taken action to ensure they were not repeated. Complaints and lessons to be learned from them were discussed at staff meetings. We saw minutes of the yearly meeting where there were formal reviews of complaints, including significant events, received by the practice.

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 mission statement which was included in their patient information leaflet. This was 'To continually strive to provide a high standard of care and to treat all of our patients with dignity and respect'.

The practice manager was a managing partner and the culture was one of continuous improvement. The practice had a long established base of staff with little staff turnover.

The practice had a business development plan which set out changes the practice deemed necessary to introduce over the next three years. This included an ongoing refurbishment programme, improvements to patient services and more involvement of the patient's participation group.

The staff we spoke with, including clinical and non-clinical staff, all knew the provision of high quality care for patients was the practice's main priority. They also knew what their responsibilities were in relation to this and how they played their part in delivering this for patients.

Governance arrangements

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

- There was a clear staffing structure and staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- Managers had a comprehensive understanding of the performance of the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

In the staff room there was a wall decorated with cards which explained to staff who were the leads for different areas in the practice and what this meant. For example, the card for safeguarding explained who the lead and deputy lead in the practice were, who the emergency outside agencies were and their contact details and that if they saw anything suspicious or were in any doubt that a child or a vulnerable adult was in danger of physical, emotional, neglect or sexual abuse they must contact the safeguarding lead immediately.

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice. Staff told us that they were approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness and honesty.

There were consistently high levels of staff engagement. All practice decisions were team decisions, even business decisions, such as premises issues and organisational matters. Staff were involved in the redesign of the reception area. Staff told us that there was a full team meeting every month or six weekly. Clinicians held regular weekly clinical meetings. All line managers in the practice met together every week on a Tuesday. Minutes of meetings we saw confirmed this.

We found there were high levels of staff satisfaction. Staff were openly proud of the organisation as a place to work, spoke highly of the open and honest culture and they had the opportunity to raise any issues at team meetings, were confident in doing so and felt supported if they did. They felt they had a good relationship with the patients. Staff said they felt respected, valued and supported.

The recently appointed salaried GP told us they found the surgery to be extremely friendly and chose this surgery over two other job offers.

The practice knew their priorities they had plans in place for areas they needed to work on and knew in what areas they had improved.

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

The practice encouraged and valued feedback from patients. They had gathered feedback from patients through surveys, patient suggestion box and formal and informal complaints received and the practice participation group (PPG). Patient feedback in a survey had influenced the change in the appointment system to meet their needs.

Are services well-led?

Good

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

The practice had also gathered feedback from staff. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. All staff were encouraged to identify opportunities for future improvements and how the practice was run.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area, such as the changes to the appointment system to improve patient access and holding a GP session at the local nursing home every week.

The practice had care plans in place for approximately 4% of the practice population, above its contractual arrangements which demonstrated that they were constantly improving in delivering safer, more patient focused care and treatment to the most vulnerable.

The CCG pharmacist had been trained by the practice to be a prescriber. This meant they could carry out complex medication reviews and polypharmacy clinics.

The practice attended quarterly locality practices meeting where CCG medicines prescribing parameters and performance were discussed and then priorities set for forthcoming 12 months.