Castlehead Medical Centre

Quality Report

Castlehead Medical Centre
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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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a planned comprehensive inspection of Castlehead Medical Centre on 11 November 2014.

Overall, we rated the practice as good. Our key findings were as follows:

- The practice covered a large geographical and rural area; services had been designed to meet the needs of the local population.
- We saw that the practice had made improvements which addressed the concerns we raised, at our inspection in May 2014, about the management of medicines.
- Feedback from patients was positive; they told us staff treated them with respect and kindness.
- Staff reported feeling supported and able to voice any concerns or make suggestions for improvement.
- The practice manager regularly monitored the cleanliness of the premises. Actions highlighted in infection control audits were addressed.
- The practice learned from incidents and took action to prevent a recurrence.

We saw the following areas of outstanding practice:

- The practice supported their GPs in their emergency work with the Great North Air Ambulance Service, the local mountain rescue team and the paramedic pathfinder initiative run by the North West Ambulance Service, to provide care to their own patients, patients of other practices in the area and visitors.
- The practice was able to meet patients' needs in their own home environment or close to home, such as using effective referral processes to treat them at the local cottage hospital wherever possible, which reduced admissions to major hospitals some distance away.

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. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Care and treatment was being delivered in line with current published best practice. Patients' needs were being met and referrals to other services were made in a timely manner. The practice regularly undertook clinical audits, reviewing their processes and monitoring the performance of staff.

Staff had received training appropriate to their roles and arrangements had been made to support clinicians with their continuing professional development. The practice worked with other healthcare professionals to share information.

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 were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above their contractual obligations. They acted on suggestions for improvements and changed the way they delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of their local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Patients told us it was easy to get an appointment with a named GP or a GP of choice, with continuity of care and urgent appointments available the same day. The practice had good facilities and was

Summary of findings

well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

The practice used the Short Term Intervention Services Team (STINT) process. STINT is a team that includes social workers, allied health professionals, nurses and therapists assistants, working together to meet patients' needs to help keep them at home in their own environment.

The practice was able to admit their patients to the local cottage hospital whose nurses provided care and monitoring with their GPs that prevented referral to secondary health care provided in a hospital setting. This enabled patients to receive a higher level of care and monitoring than was available from the practice alone.

The practice supported their GPs in their emergency work with the Great North Air Ambulance Service, the local mountain rescue team and the paramedic pathfinder initiative run by the North West Ambulance Service to provide care to their own patients, patients of other practices in the area and visitors.

Are services well-led?

Good

The practice was rated as good for well-led. The practice had a clear vision and strategy which had quality and safety as its top priority. The strategy to deliver this vision was regularly reviewed and discussed with staff.

Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events. We found there was a high level of staff engagement and staff satisfaction.

Summary of findings

What people who use the service say

We spoke with three patients during our inspection.

They told us the staff who worked there were very helpful and polite. 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.

We reviewed 29 CQC comment cards which had been completed by patients prior to our inspection. All were complimentary about the practice, staff who worked there and the quality of service and care provided.

The latest National GP Patient Survey completed in 2014 showed the large majority of patients were satisfied with the services the practice offered. There were 252 surveys sent out and 121 were returned. This is a 48% completion rate. The results were:

- The proportion of patients who would recommend their GP surgery – 90%, compared to the national average – 79%;
- GP Patient Survey score for opening hours – 85%, compared to the national average – 77%;
- Percentage of patients rating their ability to get through on the phone as 'easy' or 'very easy' – 91%, compared to the national average – 73%;
- Percentage of patients rating their experience of making an appointment as 'good' or 'very good' – 98%, compared to the national average – 75%;
- Percentage of patients rating their practice as 'good' or 'very good' – 96%, compared to the national average – 86%.

We saw that the practice had conducted a patient survey over a two and a half week period between 14 April 2014 – 2 May 2014. The practice distributed 300 surveys of which 235 were returned. The completion rate was 78%. Most responses were very positive about the practice.

Outstanding practice

The practice was considered to be outstanding in terms of their responsiveness.

- The practice supported their GPs in their emergency work with the Great North Air Ambulance Service, the local mountain rescue team and the paramedic pathfinder initiative run by the North West Ambulance Service, to provide care to their own patients, patients of other practices in the area and visitors.
- The practice was able to meet patients' needs in their own home environment or close to home, such as using effective referral processes to treat them at the local cottage hospital wherever possible, which reduced admissions to major hospitals some distance away.

Castlehead Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team also included a GP.

Background to Castlehead Medical Centre

Castle Medical Centre is located in the town of Keswick in Cumbria and provides primary medical care services to patients living in the town and surrounding rural areas. Some of the GPs from the practice deliver daily sessions at the local Cottage Hospital which patients from the practice attend.

The practice provides services to around 6,200 patients, from one location, Castlehead Medical Centre,

Ambleside Road, Keswick, Cumbria CA12 4DB. We visited this address as part of the inspection.

The practice is located in a purpose built two storey building. All patient facilities are situated on the ground floor which included six GP consulting rooms, three nurse/ health care rooms and a dispensary. It also offers on-site parking, disabled parking, and a toilet for the disabled, wheelchair and step-free access.

The practice has five GP partners, one salaried GP, two practice nurses, a health care assistant, two dispensers, a practice manager, and a number of support staff who carry out reception and administrative duties.

Opening times at the practice are: 8:00am to 18:00pm on a Monday, Wednesday, Thursday and Friday; 08:00am to 20:00pm on a Tuesday.

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

Why we carried out this inspection

We inspected this service as part of our new 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 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.

When we previously inspected the practice in May 2014 we told the provider that they were not compliant with the following regulation:

- Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Management of Medicines. We said, "Patients were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Appropriate arrangements were not in place for prescribing medicines."

The provider told us they would take steps to ensure that appropriate arrangements for prescribing medicines were in place and followed. During this inspection we checked and found that improvements had been made.

Detailed findings

Please note that when referring to information throughout this report, for example, any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at the time.

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 our inspection we carried out an analysis of data from our Intelligent Monitoring system. The system draws on national data systems such as Quality and Outcomes Framework (QOF) and the GP Patient Survey and identifies indicator scores that are significantly worse than the expected values to prompt questions for the inspection team. This highlighted one area of significant risk across the five key question areas. 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 11 November 2014. We spoke with three patients, one GP, the practice manager, the senior administrator, two dispensers, two nurses, a health care assistant and a receptionist. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 29 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.

Are services safe?

Our findings

Safe track record

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

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 were very complimentary about the service they had received and raised no concerns about their safety. Some of the patients we spoke with had been receiving care and treatment from the practice for a number of years, one since 2002 and another since 2009.

Information from the Quality and Outcomes Framework (QOF) showed that for the last three years (2011/12, 2012/13 and 2013 /14) the practice consistently achieved overall scores above the England average when compared with other practices. For 2013/14 the practice achieved an overall score of 99.1% which is 5.6 points above the England average. (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, e.g. diabetes and implementing preventative measures. The results are published annually.)

We saw that the practice had a significant event audit policy (SEA) and procedures that staff followed. SEAs enable the practice to learn from patient safety incidents and 'near misses', and to highlight and learn from both strengths and weaknesses in the care they provide. The practice showed us an action plan dated October 2014 which addressed the issues arising from a review of seven significant events that had occurred over the last 12 months. The plan included a check to determine the effectiveness of their solutions.

The practice manager told us that all staff were required to complete a training course provided by the local clinical commissioning group (CCG) to understand the purpose of SEA reporting. All staff were encouraged to complete SEA reports. The staff we spoke with demonstrated an understanding of their responsibilities and could describe their roles in the reporting process.

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 system in place for reporting, recording and monitoring significant events. We spoke with the practice manager about the arrangements in place. They told us that all staff had responsibility for reporting significant or critical events. Records of those incidents had been kept on the practice computer and were made available to us. We looked at two significant event records. We saw 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 team meetings to ensure learning was disseminated and implemented. Audits were also undertaken to determine the effectiveness of changes that had been made. We saw records of an audit undertaken in October 2014 which included dates when remedial action had been completed, dates when the effectiveness of the changes would be checked and the audit closed. Annual reviews of all SEA were also undertaken.

We saw there had been a significant event in relation to dispensing medication and one relating to the forms used in the handover process with the out-of-hours service. Thorough investigations had taken place. These had identified some key learning points, which had been shared with the relevant staff. The changes were implemented and the practice told us they would be reviewed at a later date to confirm they remained effective.

We discussed the process for dealing with safety alerts with a GP. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. They told us alerts came into the practice from a number of sources, including the General Medical Council (GMC) and the clinical commissioning group (CCG.) Alerts came through to the practice by email to the practice manager. The practice manager told us that they printed out hard copies of the alerts and distributed them to all relevant staff. They also completed a spread sheet to log actions taken and followed this up with an audit. We saw that the practice had undertaken an audit of medicine alerts in July 2014. The GP told us that if a medicine alert related to stopping medication the practice took action to identify the patients involved and changed their medication.

Reliable safety systems and processes including safeguarding

We saw the practice had safeguarding policies in place for both children and vulnerable adults which were based on the local CCG guidelines. This provided staff with

Are services safe?

information about safeguarding legislation and how to identify, report and deal with suspected abuse. It also included a contact list of other agencies that may need to be informed when concerns arose such as the local police and Social Services.

Two GPs had lead responsibilities for overseeing safeguarding children and adults within the practice. This role included reviewing the procedures used in the practice and ensuring staff were up-to-date and well informed about protecting patients from potential abuse. The practice manager ensured that all staff were up-to-date with their safeguarding training. The lead GPs were up-to-date with their training in safeguarding adults. In addition they had received training at Level 2 in safeguarding children and were scheduled to undertake Level 3 training in February 2015. We saw staff training records that confirmed this. The 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 that each surgery displayed a poster which informed staff who to contact and processes to follow if they had any safeguarding concerns.

The practice had a process to highlight vulnerable patients on their computerised records system. This information would be flagged up on patient records when they attended any appointments so that staff were aware of any issues.

The practice had a chaperone policy. There were notices on display in the waiting area and surgeries to inform patients of the availability of chaperones. Staff told us that the chaperones were trained. The staff we spoke with were clear about the requirements of their roles as chaperones. They also told us that if there were no trained chaperones on duty they would defer the examination until one was available. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.)

Medicines management

Castlehead Medical Centre was a dispensing practice and offered this service to those patients who lived more than 1.5 km from a pharmacy. The dispensers had undergone appropriate training and some dispensers were registered as Pharmacy Technicians. There was a named GP who had responsibility for the Dispensary.

Medicines for use in the GP practice and for dispensing were kept in a secure store to which only clinical and dispensary staff had access. We looked at how controlled drugs were managed. Controlled drugs are medicines that require extra checks and special storage arrangements because of the potential for misuse.

The records showed the controlled drugs were recorded, stored, checked, used, and dispensed in accordance with the current regulations. We also saw records that demonstrated medicines were disposed appropriately.

The dispensary staff we spoke with told us how they undertook stock control which ensured that all the medicines used at the practice were within their expiry dates. The dispensary staff also told us that they checked each other's work to lessen the likelihood of dispensing errors.

When we last inspected the practice in May 2014, we identified a concern with the medicines management arrangements. The system used to deal with repeat prescriptions meant that most medicines supplied to patients on repeat prescriptions were not checked by a doctor before issue. The prescriptions were not checked and signed by the GP until the end of each day, by which time prescriptions had been dispensed.

At this inspection we checked to see that the practice had changed their repeat prescriptions system to ensure that prescriptions were checked by a GP before medicines were dispensed. The practice had made the necessary changes. This was confirmed when dispensary staff told us that they kept prescriptions in trays for GPs to sign throughout the day and said they did not dispense medicines unless the relevant prescription had been signed by a GP.

During this inspection we checked vaccines stored in the medicine refrigerators. We found they were stored securely and were only accessible to authorised staff. Maximum and minimum temperatures of the refrigerators were monitored daily. Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions that the nurses signed and kept for reference. We saw that regular clinical audits were undertaken to improve the way medicines were managed. Staff told us that the dispensary distributed a list to GPs of patients requiring medication reviews on a weekly basis. For patients who were prescribed a number of medicines

the practice undertook annual medication reviews to minimise the risk of patients receiving unnecessary medicines. For example, GPs undertook annual joint medication review visits with district nurses for patients living in care homes. In addition, medication reviews were undertaken opportunistically when patients attended the practice for other reasons. The clinicians were alerted by the patients' computerised records when a review was due.

We looked at the system for managing hospital discharge letters and letters from consultants. The patients' usual GPs received letters and reviewed them or this was done by a colleague if they were unavailable. The letters were actioned on the day of receipt. This enabled the practice to ensure any changes to patient medication was reviewed and recorded so that the correct medication was dispensed.

Cleanliness and infection control

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.

The practice had a clinical lead for infection control. We saw there was an up-to-date infection control policy and detailed guidance for staff about specific issues. For example, action to take in the event of a spillage. All of the staff we spoke with about infection control said they knew how to access the practice's infection control policies. Infection control training was provided for all staff annually. Staff we spoke with confirmed they had received this training.

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. Most treatment rooms had walls and flooring that were impermeable, and easy to clean. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels.

Staff we spoke with told us that they always cleaned the patient couches between patients and used the paper roll sheets. They also confirmed that the premises were cleaned daily. The practice used an outside contract cleaner. We saw that there was a cleaning rota for them to follow. The practice manager regularly checked the premises to ensure that the practice was clean and recorded when those checks took place. We saw that the practice had undertaken an infection control audit in July 2014 which highlighted that some treatment rooms needed their taps and carpets replaced with suitable alternatives. The practice had planned for their replacement. We also saw that each of the nurses' treatment rooms had a slop hopper for the safe disposal of appropriate clinical waste. We spoke with the practice manager about this. We were told that the practice had plans to remove the hoppers and convert a lavatory into a sluice in replacement. This is due to take place in January 2015. In the meantime the nurses are required to clean the hopper daily. The nurses we spoke with confirmed this.

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 had been signed and dated as required.

Equipment

The practice had processes in place to make sure that equipment was regularly checked to ensure that it was safe and effective to meet patients' needs. The practice had a range of equipment in place that was appropriate to the service. This included medicine fridges, patient couches, a defibrillator and oxygen on the premises, sharps boxes (for the safe disposal of needles), electrocardiogram (ECG - equipment to record electrical activity of the heart to detect abnormal rhythms and the cause of chest pain) and fire extinguishers. We saw that a portable appliance test (PAT) had been undertaken in July 2004. (Portable appliance testing (PAT) is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use.)

The practice had an emergency trolley which held emergency equipment. It was located in room where patients could be treated and could also be easily moved around the practice if necessary.

The practice manager was the lead for overseeing the Control of Substances Hazardous to Health Regulations (COSHH) relevant to the practice. Manufacturers of those substances periodically publish updates on how the

substances should be stored and used safely. This information was readily available to all staff. We saw that the practice reviewed and updated their records when required.

Staffing and recruitment

The practice manager told us that they had a formal recruitment and induction process for all new staff. The practice always took up references before confirming an employee's appointment. Staff we spoke with confirmed this. There was a lead clinician for recruitment who was involved in the recruitment and selection process along with the practice manager.

We saw the computerised records that showed all staff had annual appraisals and action plans were completed to address relevant issues. The practice manager told us that the practice had an open culture and staff discussed issues with management when the need arose. Staff we spoke with confirmed this and told us that the practice was very supportive and they had no concerns about raising any matters with colleagues, management or the partners.

We looked at the training records for the practice and saw that they offered staff comprehensive training that covered safeguarding, complaints, fire safety and infection control among other courses appropriate to their work.

All clinical staff who were in contact with patients had been subject to Disclosure and Barring Service (DBS) checks, in line with the practice's recruitment policy. This demonstrated that the practice had taken reasonable steps to ensure that the staff they employed were suitable to work with vulnerable patients.

The practice employed sufficient numbers of suitably qualified, skilled and experienced staff. The practice had a procedure for managing staff absences. Staff we spoke with were flexible in the tasks they carried out and they also told us that they worked well as a team and covered for each other when necessary to ensure their patients received good care.

Monitoring safety and responding to risk

The practice manager told us that the practice would not turn any patient away if they needed same day care and treatment. Feedback from patients we spoke with, and those who completed CQC comment cards, did not raise any concerns about getting an appointment with a clinician on the day if their need was urgent.

The practice had well established systems in place to manage and monitor health and safety. Their health and safety policy reminded staff of their individual responsibility for the health and safety of other people who may be affected by the practice's activities. The practice had a nominated fire officer, deputy fire officer and six fire marshals. We saw that the practice had undertaken a fire risk assessment in November 2014. Fire alarms and emergency lighting was tested and fire exits were checked.

The practice identified their uneven driveway as a risk. The practice manager told us that they had arrange for the driveway to be resurfaced early 2015. We saw that the practice had installed extra lighting in the car park and driveway for the benefit of all staff and patients.

Arrangements to deal with emergencies and major incidents

The practice had detailed plans in place to ensure business continuity in the event of any foreseeable emergency, for example, a fire or flood. The practice manager told us that they had a secure system in place that enabled staff to access patients' records away from the practice if the premises were inaccessible or unavailable for any reason.

Each of the doctors had their own 'on-call' bag. This demonstrated that 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.

The practice had a room set aside for medical emergency situations that may occur on the premises. The practice had resuscitation equipment and medication available for these emergencies. Arrangements were in place to check emergency medicines were within their expiry date and suitable for use. All of the staff we spoke with told us they had attended CPR (resuscitation) training. We looked at records which confirmed this. Staff had sufficient support and knew what to do in emergency situations.

The practice also supported their GPs in their emergency work with the Great North Air Ambulance Service, the local mountain rescue team and the paramedic pathfinder initiative run by the North West Ambulance Service.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines.

There was a strong emphasis on keeping up-to-date with clinical guidelines, including guidance published by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE) and from local health commissioners (Cumbria Clinical Commissioning Group (CCG)). The practiced had processes in place to ensure current guidance was being followed. They used the data from the Quality Outcomes Framework (QOF) to assess how the practice was performing. We saw that new guidelines were added to the relevant protocols which were accessed by clinical staff via the practice's computer.

We saw that the practice had developed pathways for caring for patients. For example, there was a pathway for managing patients with deep vein thrombosis (DVT). A DVT is a blood clot in one of the deep veins in the body.

The practice coded patient records which enabled them to easily identify patients with long-term conditions and those with complex needs. We found from our discussions with the GPs and nurses that staff completed, in accordance with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, the practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. We spoke with staff about how the practice helped patients with long-term conditions to manage their health. They told us that there were regular clinics where patients were booked in for an initial appointment and then scheduled for recall appointments. This ensured patients had routine tests, such as blood or spirometry tests to monitor their condition. A spirometer measures the volume and speed of air that can be exhaled and is a method of assessing lung function.

For patients receiving anticoagulant medication such as warfarin their blood was regularly monitored. Anticoagulant medicines work by interrupting part of the process involved in the formation of blood clots. Regular international normalisation ratio (INR) blood testing is required to ensure that patients receive correct doses of medication over time. The practice used a system that ensured the blood results from these tests were posted on to GPs daily message list. Those lists were checked at the end of the day to ensure that they had all been actioned.

We were told that all patients over 75 years of age had been allocated a named GP, which they could change if they wished, who was responsible for their care. In addition, patients on the practice 'At Risk' register also had a named GP wherever possible. This helped to ensure continuity of care. We saw that the practice had care plans for patients with complex needs. For example, one care plan detailed actions that could be taken by the patient and clinicians to avoid any unnecessary admissions to hospital.

The practice kept a register of patients with learning disabilities which enabled them to monitor their care effectively. For those patients with mental health issues we saw that the practice undertook annual health checks and medication reviews. We were shown an example of a health check that highlighted other clinical concerns which were addressed.

If patients failed to collect their repeat prescriptions we were told that the dispensary staff would email their GP to let them know. The GP would arrange an appointment for the patient, or if the patient was in a high risk category, the GP would telephone the patient or visit them at home to assess their needs.

Management, monitoring and improving outcomes for people

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 clinical meetings. We saw the minutes of a meeting held in October 2014 that confirmed this.

The practice had appointed clinical and area leads for QOF data. They used the information from QOF to monitor the practice's progress against their QOF targets to ensure that patients were invited for routine regular monitoring tests such as blood pressure checks.

We reviewed a range of data available to us prior to the inspection relating to health outcomes for patients. These demonstrated that the practice was performing the same as, or better than average, when compared to other practices in England. There were no areas of risk identified from available data. For example, 100% of patients within

Are services effective?

(for example, treatment is effective)

the 'Mental Health' category who were on lithium therapy had their lithium levels recorded in the therapeutic range in the preceding 4 months. This was 11.1% higher than the England average.

Effective staffing

Practice staffing included administrative, clinical and managerial staff. The practice was an accredited training practice and all GPs were involved in training both Registrars (qualified doctors training to become GPs), medical students and colleagues. Some GPs also specialised in areas such as sexual health, cardiology and palliative care. We reviewed staff training records and saw that the practice had a comprehensive list of courses for staff which included safeguarding for children and vulnerable adults, fire safety, complaints and infection control. All staff were up-to-date with attending mandatory courses such as basic life support. The practice regularly closed for Protected Learning Time (PLT). This gave the staff an opportunity to undertake undisturbed formal and informal training.

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.

All other staff had received an annual appraisal. During the appraisals, training needs were identified and personal development plans put into place. The practice manager told us that the practice had an 'open door ' policy whereby all staff were encouraged to freely raise any issues or concerns in meetings or privately with her or colleagues. All staff we spoke with confirmed this and told us they would have no problems in raising any issues and they felt supported by the practice.

The patients we spoke with were complimentary about the staff. The 29 CQC comment cards we reviewed included the following comments about the staff: 'very capable', 'excellent', 'attentive', 'helpful and patient centred'.

Working with colleagues and other services

The practice worked closely with other health and social care providers, to co-ordinate care and meet their patients' needs. In particular, some GPs undertook daily sessions at the local cottage hospital where their patients and those from other practices attended. In collaboration with the hospital the practice had been allocated beds for their patients. They used those beds to keep patients in their local environment whenever possible avoiding the need for them to travel long distances to major hospitals for care and treatment that could be provided locally.

The practice worked with other health care services which included health visitors, district nurses and therapists. Staff told us that they worked with the short-term intervention team. This team included social workers and health care professionals, nurses and therapies assistants who worked together to meet individual patient needs to help keep them at home where appropriate. In addition, the practice worked with other agencies such as Age Concern and Singing for the Brain.

We saw various multidisciplinary meetings were held. For example, there were weekly primary healthcare team meetings with district nurses and GPs, where discussions included how the practice could provide help and support to the district nurses. In addition, there were quarterly multidisciplinary palliative care meetings which included district nurses, Macmillan nurses and GPs. The practice told us that they worked in collaboration with a specialist geriatrician and local care homes.

The practice had arrangements in place to deal with patients needing end of life care. The practice in conjunction with their patients and supporters had produced a personalised care package. The file was kept at the patient's home for ease of access by relevant health care professionals. A copy was also held at the practice. The file contained details such as advanced decisions, care plans and information about end of life medication.

Correspondence from external health care and service providers, such as letters from hospital including discharge summaries, out-of-hours providers and the 111 service, were received both electronically and by post. Where blood tests had been requested the results were passed on to the person who had requested the test (or whoever was covering for them if they were not available). This 'buddy' system ensured that correspondence was actioned on the day of receipt.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was

used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

We saw that the practice had formal information sharing agreements with hospitals which complied with the relevant clinical governance protocols.

The practice used electronic systems to communicate with other providers. For example, making referrals to hospital services using the Choose and Book service (the Choose and Book system enables patients to choose which hospital they will be seen in and allows them to book their own outpatient appointments). The practice manager told us that staff helped their patients with the service and had achieved a 99% success rate in getting a referral on the day the service was contacted.

Regular meetings were held throughout the practice. These included staff, clinical and multidisciplinary team meetings. Information about risks and significant events were shared openly at meetings. Patient specific issues were also discussed with appropriate staff and other health care professionals to enable continuity of care.

Consent to care and treatment

The practice had a protocol for gaining patient consent to care and treatment. We saw that the protocol distinguished between implied and express consent. It explained how staff could obtain consent and how to manage a patients' right to refuse consent. Staff we spoke with were able to give examples of how they obtained verbal or implied consent.

GPs we spoke with showed they were knowledgeable about how and when to carry out Gillick competency assessments of children and young people. 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. For example, if school children from a local boarding school attended an appointment with the school matron or another member of staff the GP would offer to see the child on their own.

We found that staff were aware of the Mental Capacity Act (MCA) 2005 and their responsibility in respect of consent prior to giving care and treatment. The GP described the procedures they would follow where patients lacked capacity to make an informed decision about their treatment.

Health promotion and prevention

A range of health promotion information was available to patients in the reception and waiting area of the practice. This included information about lifestyle management, services for cancer sufferers, Castlehead young person's clinic and support networks for carers. Staff told us about some of the services offered to patients. These included 'singing for the brain' and access to a local health and wellbeing service. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. The practice's website provided some further information and links for patients on health promotion and prevention in various categories such as teenage health, women's health, senior health and mental health. It also provided a link to a symptom checker which patients could use to inform themselves of their condition.

All new patients were offered new patient checks to discuss their medical histories, current care needs, assessing any risks and planned future care such as arranging routine blood tests.

The practice proactively identified patients who needed ongoing support. In particular, they identified carers and placed a flag on their records so that clinicians were made aware of this before these patients attended appointments. The practice undertook annual reviews for patients with long term conditions in addition to more frequent appointments when necessary. This included those receiving end of life care and those at risk of developing a long-term condition.

The practice identified patients who would benefit from treatment and regular monitoring, for example, they offered flu vaccinations and immunisations for children in line with current national guidance. The practice also offered travel vaccinations to patients travelling abroad. In addition, for patients with high blood pressure, we saw from the QOF data that the practice had undertaken a high number of blood pressure readings in the preceding nine months exceeding both the CCG and England averages.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with three patients during our inspection. They told us that they were always treated with dignity and respect and received good care. Comments left by patients on the 29 CQC comment cards we received also reflected this. Words used to describe the approach of staff included courteous, good, pleasant, attentive, helpful, supportive and first class care.

We looked at data from the National GP Patient Survey, published in July 2014. They issued 252 questionnaires and 121 were returned. This showed that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the practice was above national average scores, on the overall good experience, achieving 96%, compared to the national average of 86% and the helpfulness of reception staff, achieving 98%, compared to the national average of 87%. We saw that 95% of patients said they had confidence and trust in their GP, compared to the national average of 93% and 88% said their GP was good at treating them with care and concern, compared to the national average of 83%.

Staff we spoke with told us how they would protect patient'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 that conversations taking place in those rooms could not be overheard. We saw that staff always knocked on closed consultation room doors and waited to be invited in before entering the rooms.

We saw the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. Staff spoke quietly so their conversations could not be overhead. Staff were aware of how to protect patients' confidential information. There was a room available if patients wanted to speak to a receptionist privately. This facility was advertised in the reception area and waiting room.

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 plenty of time to ask questions and responded in a way they could understand. They were satisfied with the level of information they had been given. We reviewed the 29 completed CQC comment cards and found they echoed these comments. One person commented that all the advice they had been given had been delivered in layman's terms and easy to understand. Another patient said the doctor was always attentive and a good listener who responded to their needs.

The results of the National GP Patient Survey from July 2014 showed patients felt the GPs and nurses involved them in decisions about their care achieving 86% and 68% respectively, compared to the national averages of 75% and 67% and explained the need for any tests or treatment achieving 86% and 85% respectively, compared to the national averages of 82% and 78%.

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

Patient/carer support to cope emotionally with care and treatment

In addition to pre-bookable appointments the practice staff told us that they would not turn any patients away. Patient would be offered same day appointments on a sit and wait basis if necessary. This service gave patients assurance that their needs would be met on the day they contacted the practice.

Staff told us that they had processes in place which they used to arrange respite care at day centres for patients which gave patients' families and carers a brief break from their caring responsibilities.

For patients receiving end of life care at home, or at the cottage hospital, the practice offered them support, for example, we were told that one GP had visited a patient daily for a month. Staff told us that within three days of the death of a patient a GP would contact or visit the bereaved relatives and carers to offer them support.

We saw there was a variety of patient information on display throughout the practice. This included information

Are services caring?

on health conditions, health promotion and various support groups and services such as First Step which is a helpline for common mental health problems, and UNITY a service for alcohol and drug misuse.

The practice held weekly multidisciplinary team meetings where they planned help for patients that were discharged from hospital. Staff told us that when the practice was advised that a patient had been discharged from hospital, they would notify the patient's GP who would telephone them or visit within three days of the notification.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Staff told us that patients suffering from some long term conditions such as diabetes were given longer appointment times if necessary.

Patients we spoke with told us they felt they had sufficient time during their appointment. Results of the National GP Patient Survey from 2014 confirmed this with 90% of patients stating the doctor gave them enough time and 86% stating they had sufficient time with the nurse. These results were well above the national averages (86% and 81% respectively).

Due to the rural location, large hospital services can be difficult to access for many patients living in the practice area. The practice had therefore arranged for some services to be provided at the local cottage hospital such as vasectomies and minor surgery. This reduced the number of referrals to other services and patients did not have to travel as far to receive care and treatment. In addition, under a 'Step-up Step-down' process GPs referred their patients to the local cottage hospital. This process enabled patients who would otherwise need to travel to acute hospitals for treatment, to receive treatment locally. For example, patients who needed monitoring whilst receiving certain medication through a 'drip' over a long period or those who needed monitoring overnight could be referred to the cottage hospital. Some of the GPs at the practice also worked at the cottage hospital. The close links between the cottage hospital and the practice enabled patients to receive a higher level of care and monitoring closer to home than was available from the practice alone.

The practice used electronic notes and alerts which were attached to medical records to advise staff that patients had additional needs such as, for example, a learning disability or that they were a carer.

There was information available to patients in the waiting room and reception area about support groups, various clinics such as the flu clinics, and health and wellbeing advice. In addition, the practice website offered patients access to other health and wellbeing advice and campaigns such as 'Stoptober' which was a campaign that encouraged smokers to stop smoking for October and further encouraged patients give up smoking altogether.

We spoke with a representative of the Patient Participation Group (PPG). The PPG is a group of patients registered with a practice who work with the practice to improve services and quality of care. We were told that the group had a very good relationship with the practice. Concerns raised by the group were acted upon, for example, the group had discussions with the practice about the pot holes in the driveway. The practice manager confirmed that they had arranged for the driveway to be resurfaced early in 2015.

The practice supported their GPs in their emergency work with the Great North Air Ambulance Service, the local mountain rescue team and the paramedic pathfinder initiative run by the North West Ambulance Service, to provide care to their own patient, patients of other practices and visitors to the area. For example, the practice released a GP one day a month for air ambulance duties and GP colleagues would cover their absence. The support also included GP colleagues covering for the on-call GP attending emergencies at short notice. The on-call GP was available to the ambulance service under the pathfinder initiative. The practice operated a direct telephone on which ambulance staff could contact the on-call GP for assistance, which included attending the scene, visiting the patient at their home, meeting the ambulance at the cottage hospital or at the practice.

The practice manager told us that when they were booking patients to see the on-call GP they were advised that their appointments may need rescheduling if the on-call GP is called out on an emergency. They checked to see the patients were happy to book the appointment and if not they would offer an alternative appointment.

Tackling inequity and promoting equality

The practice had recognised the needs of the different groups in the planning of its services.

Nationally reported data showed the practice had achieved good outcomes in relation to meeting the needs of patients whose circumstances may make them vulnerable. Registers were maintained, which identified which patients fell into these groups. The practice used this information to ensure patients received an annual healthcare review and access to other relevant checks and tests. The data showed that for patients experiencing certain mental health problems the practice had comprehensive care plans in place.

Are services responsive to people's needs?

(for example, to feedback?)

The practice used the Short Term Intervention Services Team (STINT). STINT is a team that includes social workers, allied health professionals, nurses and therapists working together to meet patient needs to help keep them at home in their own environment for up to six weeks instead of having to be admitted to hospital.

Staff told us that the practice offered extended appointments for patients who needed them.

The practice had access to local medicine and alcohol misuse support services for patients. In addition, the community psychiatric nurse also held sessions at the practice for those patients.

Free parking was available in a car park directly outside the building. The practice building had step free access for patients with mobility difficulties. The consulting and nurse/health care rooms were accessible for all patients. There was also a toilet that was accessible to disabled patients. A large waiting room with plenty of seating was available.

The practice had arrangements in place to access interpretation services for patients whose first language was not English.

Access to the service

Most patients who commented were satisfied with the appointments system and accessibility to the services.

Opening times at the practice were from 8:00 to 18:00pm on a Monday, Wednesday, Thursday and Friday. The practice opened between 08:00am to 20:00pm on a Tuesday. Patients were able to book appointments either by calling into the practice, on the telephone or using the on-line system. Face-to-face and telephone consultations were available to suit individual needs and preferences. Home visits were also undertaken daily for those patients who physically could not attend the practice for an appointment. The practice also undertook visits to their patients who were in local care homes.

A GP told us that the practice guaranteed that if any patient telephoned and needed to speak to a GP and the GP was unavailable, the patient would be called back the same day. We saw records that confirmed this. The GP also told us that they never turned patients away and always saw children the same day. In addition, the practice offered a same day appointment on a sit and wait basis if required.

All of patients we spoke with, and most of those who filled out the CQC comment cards, commented on the appointments system. They said they were satisfied with the appointment systems operated by the practice. Some patients commented that they were able to get an appointment or speak to someone at short notice. This was reflected in the results of the most recent National GP Patient Survey (2014). This showed 98% of respondents described their experience of making an appointment as 'good' compared to the national average of 74% and 99% said that the last appointment they got was 'convenient for them compared to the national average of 92%.

The practice had an up-to-date practice leaflet which provided information about the services available, contact details and repeat prescriptions. The practice also had a clear, easy to navigate website which contained detailed information to support patients.

Listening and learning from concerns and complaints

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

The complaints policy was outlined in the practice leaflet and a notice was also displayed in the waiting room outlining the process. In addition, the website had a facility where patients could rate the service.

None of the three patients we spoke with on the day of the inspection said they had felt the need to complain or raise concerns with the practice. In addition, none of the 29 CQC comment cards completed by patients indicated they had felt the need to make a complaint.

Staff we spoke with were aware of the complaints policy and the action they needed to take if they received a complaint. They told us they would try and address the matter straight away, but would inform the practice manager of any complaints made to them.

The practice manager told us that all complaints were recorded including informal ones. We saw the summary of complaints that had been received in the period October 2013 to October 2014. There were five complaints. A summary of the complaint, details of the steps taken, the

Are services responsive to people's needs?

(for example, to feedback?)

outcome of the investigation, and details of any contact with the complainant, were recorded. We also saw that any learning from the complaints was recorded and shared with staff and other stakeholders.

The practice had an effective approach to dealing with complaints in that it reviewed them all, even ones that were out of their control but involved their patients. We saw that within a patient complaint to the practice they had also complained about other services. The practice responded to their complaint and advised the patient on how to gain help to raise a complaint about the other services.

Are services well-led?

(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 clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's aims and objectives. The practice vision and values included the delivery of good quality services and to maintain the highest professional and ethical standards.

We spoke with eight members of staff and they all knew and understood the vision and values and what their responsibilities were in relation to these. They all told us they were patient focussed. We saw that the practice held regular staff meetings. The practice manager told us that they promoted the practice vision at their meetings and all staff were involved in their patient journey.

Governance arrangements

We saw that the practice had a clear leadership structure which included details of nominated individuals who were responsible for various clinical and non-clinical areas, for example, there were lead clinicians for diabetes, alcohol reduction and long-term conditions. There were also leads for complaints, information governance and the premises.

There were systems in place for monitoring all aspects of the service such as complaints, incidents, safeguarding, clinical audit and infection control. The practice had a number of policies and procedures in place which governed their day-to-day activities. Staff were able to access these electronically. In addition, there was a file held in the administration office which contained all of the policies. Staff signed a form to say they had read and understood each policy relevant to their role. All of the policies we looked at had been reviewed and were in date. Staff told us that if they worked in accordance with their policies and procedures, for example, they told us they followed patient group directions (PGDs) and patient specific directions (PSDs). These are specific guidance on the administration of medicines including authorisation for nurses and healthcare assistants to administer them. The policies and procedures that were in place, and feedback from staff, showed us that effective governance structures were in place.

We saw that the practice held various regular team meetings which included management meetings. The practice held weekly multidisciplinary meetings at a local cottage hospital. Attendees included district nurses, occupation therapists, physiotherapists, ward and community psychiatric nurses and social workers. The practice also held weekly meetings with district nurses and quarterly palliative care meetings with the GPs and Macmillan and district nurses. We saw that management meetings were held to discuss any serious incidents, complaints and clinical governance issues in detail.

The practice manager and GPs actively encouraged staff to be involved in shaping the service.

Staff told us that they felt able to raise any concerns or offer any ideas to improve the service and said they felt they would be listened to.

Leadership, openness and transparency

The practice had a clear corporate structure designed to support transparency and openness. There was a well-established management team with clear allocation of responsibilities. The GPs all had individual lead roles and responsibilities, for example, safeguarding, risk management, performance and quality. Staff we spoke with were clear about their own roles and responsibilities. Managers had a good understanding of, and were sensitive to, the issues which affected patients and staff.

Staff told us there was an open culture in the practice and they could report any incidents or concerns they might have. This environment helped to promote honesty and transparency at all levels within the practice. Staff were trained in and encouraged to report significant events. We saw evidence of 13 incidents that had been reported during 2013 and 2014, and these had been investigated and actions identified to prevent a recurrence. Staff told us they felt supported by the practice manager and clinical staff and they worked well together as a team.

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

The practice gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff we spoke with told us these meetings provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues. We saw the

Are services well-led?

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

practice also used the meetings to share information about any changes or action they were taking to improve the service. Staff told us they felt involved and engaged in the practice to improve outcomes for both them and patients.

We saw that the practice had conducted a patient survey over a two and a half week period between 14 April 2014 and 2 May 2014. The practice distributed 300 surveys of which 235 were returned. This is a completion rate of 78%. Most responses were very positive about the practice. The practice analysed the results of the survey, identified the areas that required action and then took steps to address the points raised.

The practice had an active PPG, considered their views and acted on their recommendations where possible.

The practice had a whistleblowing procedure and a detailed policy in place. Staff we spoke with were aware of the policy and able to explain how they would report any such concerns. They were all confident that concerns would be acted upon.

Management lead through learning and improvement

The practice had management systems in place which enabled learning and improved performance.

Staff told us that the practice was very supportive of training. They said they had received the training they needed, both to carry out their roles and responsibilities and to maintain their clinical and professional development. We saw that regular appraisals took place and staff told us that the practice was very supportive of training and development opportunities. Staff also attended the monthly Clinical Commissioning Group (CCG) protected learning time (PLT) initiative. This provided the team with dedicated time for learning and development.

The practice was an accredited training practice for GP registrars. GP registrars are fully qualified and registered doctors. They are currently on a GP registration course which includes an attachment to a practice working under a supervising qualified GP. In addition, the practice in collaboration with a university medical school has provided placements to medical students in their third and fifth year of medical school. At the time of this inspection the practice had one registrar and two medical students. This demonstrates the practice's commitment to constantly improving GPs' clinical knowledge and skills and sharing their experiences with medical students, colleagues and other clinicians for the benefit of patients.

The practice had an effective approach to incident reporting in that it encouraged reporting and the review of all incidents. Management and clinical team meetings were held to discuss any significant incidents that had occurred. The practice had completed reviews of significant events and other incidents and shared these with staff. Staff meeting minutes showed these events, and any actions taken to reduce the risk of them happening again, were discussed.