The Lakes Medical Practice

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of The Lakes Medical Practice on 26 November 2014.

We have rated the practice overall as good.

Our key findings were as follows:

- Patients we spoke with told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Patients positively commented that they recognised the practice was always trying to improve the service provided.
- CQC comment cards were completed by patients prior to the inspection and comments were overwhelmingly positive.
- Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. They said they were proud to work there and felt that communication between the various teams within the practice was a strong point.
- There was a range of qualified staff to meet patients' needs and keep them safe.
- There was good leadership and a strong learning culture and the staff had a clear vision, with quality and safety as their top priority. Staff responded to change and were encouraged to bring suggestions for improvement. We saw a high level of constructive staff engagement and staff satisfaction. Staff had received resilience training, this involved them reflecting on what they did, how they supported each other and how they moved forward together as a team.

We saw two areas of outstanding practice including:

- The practice had recently introduced a home blood pressure monitoring system for patients. The patients take their own blood pressure at home and then text their reading to the surgery where it is monitored by the healthcare assistant. There were at the time of our visit 109 patients who were using this service.
- The practice had a holistic approach to managing long-term medical conditions and patients received reviews which looked at their overall needs rather than having to attend specific clinics for each condition.

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 was rated as good for providing safe services. 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. 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 was rated as good for effective. Systems were in place to ensure that all clinicians were up-to-date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We saw evidence that confirmed that these guidelines were influencing and improving practice and outcomes for their patients. The practice was using innovative and proactive methods to improve patient outcomes and it worked in partnership

with other healthcare organisations. There was a system for completing and learning from clinical audit cycles, with learning being shared within the practice. The practice took a holistic approach to patient with long term health conditions. The practice had very good skills mix between the GPs.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice as in line with other practices in the area for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We saw that staff treated patients with kindness and respect and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice was rated as good for providing responsive services. They reviewed the needs of their local population to secure improvements to services where these were identified. Patients said they could make an appointment with a named GP and that there

Summary of findings

was continuity of care, with urgent appointments available the same day. The practice had engaged with the practice population to assess the effectiveness of recent change in the way patients obtained an appointment with a GP.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

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. High standards were promoted and owned by all practice staff, and teams worked together across all roles and communication was good. 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 had a 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 was rated as good for the care of older people. Staff were able to recognise signs of abuse in older people and knew how to escalate or refer these concerns. There was a pathway of care for frail and elderly patients including those with dementia. They all had a named GP. There were currently care plans for 2% of the practice's patients with complex needs and they were working towards increasing this to 3% and also to review the patients' needs every three months. Patients with complex needs and those on the palliative care register have two named GPs to ensure most of their care was by one GP and there is an identified deputy for each patient. Each of the practice's GPs took responsibility for a nursing or care home.

People with long term conditions

Good

The practice was rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Whole person reviews were carried out for those with one or more long term conditions. All these patients had a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice was 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 A&E attendances. Immunisation rates were just below average for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Working age people (including those recently retired and students)

Good

The practice was 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. There was an extended access system and NHS health checks were available for those aged between 40 and 75.

People whose circumstances may make them vulnerable

Good

The practice was rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those registered with a drug and alcohol service and those with a learning disability. They had carried out annual health checks for people with a learning disability and they offered longer appointments for this group.

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. Patients who were receiving care from drug and alcohol services could be seen weekly by the drug and alcohol worker in joint surgeries with their GP. Carer's details were coded on the practice software system.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated good for people experiencing poor mental health. They had achieved good outcomes in relation to meeting the needs of patients with mental health needs. The practice kept a register of these patients which they used to ensure they received relevant checks and tests. Where appropriate, a comprehensive care plan had been completed for patients who were on the register. The care plans had been agreed with the patients and their carers. The practice worked with multi-disciplinary teams to help meet the needs of patients experiencing poor mental health.

Summary of findings

What people who use the service say

We spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Patients positively commented that they recognised the practice was always trying to improve the service provided.

We reviewed 27 CQC comment cards completed by patients prior to the inspection. Comments were overwhelmingly positive. Common words used by patients included “excellent”, “very good”, “caring” and “understanding”.

The latest GP Patient Survey completed in 2013/14 showed most patients were satisfied with the services the practice offered. Results were the same or below the England average. The results were:

- Percentage of patients who would recommend the practice – 72% (The England average is 79%);
- Percentage of patients rating their ability to get through on the phone as ‘very easy’ or ‘easy’ – 79% (The England average is 77%);
- GP Patient Survey score for opening hours – 80% (The England average is 80%).

The practice carried out its own survey in 2014. This included eleven detailed questions about the call back system for appointments to test its effectiveness. 141 responses were received, results were positive. 77% of patients said it was ‘easy’ or ‘fairly easy’ to get through to someone at the surgery on the telephone, 77% were called back in under two hours, 81% thought the call back time was acceptable and 94% of the enquiries were resolved at call back. 55% of patients saw a doctor within a working day.74% of patients said they were happy with the ability to obtain an appointment.

Outstanding practice

- The practice had recently introduced a home blood pressure monitoring system for patients. The patients take their own blood pressure at home and then text their reading to the surgery where it is monitored by the healthcare assistant. There were at the time of our visit 109 patients who were using this service.
- The practice had a holistic approach to managing long-term medical conditions and patients received reviews which looked at their overall needs rather than having to attend specific clinics for each condition.

The Lakes 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, and a specialist advisor with experience of GP practice management and a CQC strategy manager.

Background to The Lakes Medical Practice

The area covered by the Lakes Medical Practice is in a circular boundary approximately 10 miles around the town of Penrith. The surgery is located in Penrith on the same site as Penrith hospital close to the A6 road. The building is shared with another practice; however, there are no shared treatment or consulting rooms. The surgery is fully accessible - all rooms and patient services are on the ground floor. There are some parking spaces directly outside the surgery including disabled parking.

The practice has seven GPs, four male and three female, including a salaried GP. At the time of our inspection one of the GP partners was working overseas and due to return the following year. The provider is a partnership of six doctors.

The practice provides services to approximately 9,000 patients of all ages. The practice is commissioned to provide services within a General Medical Services (GMS) Agreement with NHS England. The practice is a training practice. There are three practice nurses and four health care assistants. There is a practice manager, practice pharmacist, reception and administrative staff.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

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

Why we carried out this inspection

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.

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?

Detailed findings

- 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 26 November 2014. During our visit we spoke with a range of staff. This included GPs, the practice manager, practice nurses, healthcare assistants, reception and administrative staff. We also spoke with five patients who used the service. We reviewed 27 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

As part of our planning we looked at a range of information available about the practice as part of our Intelligence Monitoring. This included information from the General Practice High Level Indicators (GPHLI) tool, the General Practice Outcome Standards (GPOS) and the Quality Outcomes Framework (QOF). The latest information available to us indicated there were no areas of concern in relation to patient safety.

The practice had comprehensive systems in place to monitor patient safety. Minutes of meetings demonstrated that significant events and changes to practice were discussed with all practice staff if they were involved in the incident. Action was taken to reduce the risk of recurrence in the future and incidents were dealt with promptly. GPs completed evaluations of and discussed changes their practice could make to enable better outcomes for their patients.

Administration and reception staff were aware of the significant event analysis policy and knew how to escalate any incidents. Staff were aware of forms that required completion and all staff said they would report any incidents to the practice manager.

There were formal arrangements in place for obtaining patient feedback about safety. The practice had carried out an in-practice patient survey and had an active Patient Participation Group (PPG). The practice manager told us that any concerns raised would be used to inform action taken to improve patient safety.

Learning and improvement from safety incidents

The practice had a robust system in place for reporting, recording and monitoring significant events.

For example, a recent significant event had been recorded regarding a patient's negative experience of the practice's telephone call back system. There was a face-to-face meeting with the patient, discussion during staff protected learning time (PLT) and improvements were made to the call back system. We were told a two hour call back window was introduced as a result of this significant event.

Significant events were recorded on a log. We saw a description of the event, type, the risk level, action taken, the date it was completed and the learning points taken from the significant event. We saw evidence that changes in practice had been applied. For example, following a threat response to an individual patient safety incident outside of their control, a practice plan was implemented in case of a further reoccurrence, and the need for a joined up plan across other healthcare services was highlighted and taken forward.

National patient safety alerts were disseminated by the prescribing lead to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at staff meetings to ensure all were aware of any relevant to the practice and where action needed to be taken. This ensured the whole team were engaged in reviewing and improving safety.

Reliable safety systems and processes including safeguarding

Safeguarding policies and procedures for children and vulnerable adults were up to date and staff knew where to locate them. One of the GP partners acted as the safeguarding lead for the practice and attended safeguarding lead meetings hosted by the Clinical Commissioning Group (CCG). All staff had completed training in adult and child safeguarding. Two of the GPs, including the safeguarding lead, had completed child safeguarding training to level 3 and training was updated on a three yearly basis. Staff had also completed Mental Capacity Act training via e-learning.

The staff at the practice had attended a protected learning time (PLT) event earlier in 2014 called "courageous conversations" regarding safeguarding. This was a multi-disciplinary team event attended by different agencies involved in safeguarding. Staff were taught how to look for triggers of abuse around child safeguarding, alcohol abuse and domestic violence. The team were therefore engaged in improving safeguarding systems in the practice.

Staff who were trained to undertake chaperoning procedures had their names displayed on notices regarding chaperones for patients, which were displayed around the practice, including the waiting area and the treatment rooms. Staff who had agreed to take on the role of chaperone had received training and understood the role. The practice had a chaperone policy which was up-to-date.

Good

Are services safe?

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found all medicines were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures and this was being followed by the practice staff.

Controlled drugs for use in the practice (medicines that require extra checks and special storage arrangements because of their potential for misuse) were safely stored. These medicines were all in date and tallied with the register which was kept to record them. However, the register had not been checked since May 2014, guidance states these should be checked monthly. We brought this to the attention of the practice manager and lead GP who said this would be looked at immediately.

All the medicines we checked within the surgeries were within their expiry dates. We checked two of the GPs emergency bags which carried stocks of medicines and found they were organised and in date, and the bags were locked with a combination padlock.

Vaccines were administered by nurses using protocols that had been produced in line with legal requirements and national guidance. The health care assistants also administered vaccines under directions which had been reviewed and approved in line with national guidance and legal requirements.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in the practice. The protocol complied with the legal framework and covered all required areas. We saw an example of the process that was followed when a patient's medication had been changed following a visit to hospital. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We saw the practice was clean, tidy and well maintained. Patients we spoke with told us they were happy with the cleanliness of the facilities. Comments from patients who completed CQC comment cards reflected this. The practice had recently reviewed its cleaning arrangements which were now outsourced. There were cleaning schedules in place for cleaning staff to follow which we saw and the practice manager checked that they were followed.

The practice had a nominated infection control lead who was one of the practice nurses. They received additional support in this role from a named GP. We saw there was an up-to-date infection control policy and detailed guidance for staff about specific issues. All of the staff we spoke with about infection control said they knew how to access the practice's infection control policies. There were yearly audits of infection control. The practice nurse had received specific infection control training and all other staff had completed on-line training.

The risk of the spread of inspection 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. The treatment room had walls and flooring that was 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. The privacy curtains in the consultation rooms were disposable. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades.

The practice manager explained that the landlord of the building carried out the management, testing and investigation of legionella (a bacteria found in the environment which can contaminate water systems in buildings).

Equipment

Staff told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of the calibration of relevant equipment; for example, weighing scales and blood pressure machines displayed stickers indicating when the next testing date was due.

Staffing and recruitment

We saw that all staff had received appropriate recruitment checks. For example, proof of identification, references, qualifications, registration with the appropriate

Good

Are services safe?

professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

There was little movement of staff and sickness absence was low. The practice manager told us this promoted consistency and the practice felt they had a committed team. The practice manager showed us how they managed the planning and monitoring of staff and ensured they had the correct numbers of staff working to cover patients' needs. Administration staff explained they all had a deputy to ensure their work was covered when they were absent; they told us that annual leave was managed by the practice manager to ensure enough staff were on duty.

The practice manager explained to us that there was a protocol for GP annual leave and if they knew that there was a forthcoming shortfall in GP cover they would arrange for extra sessions to be worked by existing GPs as far as possible. There were arrangements with a locum GP who had provided cover when necessary to the practice for some time. We were shown records of how this was managed. The practice manager and staff were very aware of ensuring there was appropriate cover to provide a service to keep patients safe.

Monitoring safety and responding to risk

The practice had robust systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

There was an incident and accident book and staff knew where this was located. Staff reported that they would always speak to the practice manager if an accident occurred. They knew where to record the information and to share what could be done with other staff to reduce the risk of it happening again. All events and incidents were discussed at staff meetings and staff told us that reflection and learning was seen as a normal part of the day. Staff saw it as their responsibility to respond to risks which affected patients and staff who used and worked in the practice.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The staff we spoke to knew the location of this equipment and records confirmed that it was checked regularly.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. Staff said they had contributed to the development of the practice business continuity plan. They had laminated small cards which they showed us to keep in their purses with emergency information for them to use if necessary.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up-to-date with fire training and that they practised regular fire drills. There was a comprehensive evacuation procedure displayed on the walls within the practice which set out who the 'emergency controller' was in case of evacuation and their role. The procedure also listed which staff were designated fire wardens.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE). We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs and practice manager told us they lead in specialist clinical areas such as heart disease, drug misuse, kidney disease, palliative care and IT. The practice nurses supported this work. One of the GPs supported the practice nurses in the co-ordination of care for patients with long term conditions.

There was a pathway of care for frail and elderly patients including those with dementia. They all had a named GP. There were currently care plans for 2% of the practice's patients with complex needs and they were working towards increasing this to 3% and they also aimed to review the patients' needs every three months. Patients with complex needs and those on the palliative care register had two named GPs. We were told this system helped to ensure patients received most of their care from a named GP. Each of the practice's GPs were attached to a nursing or care home.

The practice had recently introduced a home blood pressure monitoring system for patients. This enabled patients to monitor their blood pressure at home and text message their readings to the surgery where it was monitored by a healthcare assistant. There were at the time of our visit 109 patients who were using this service. This demonstrated that the practice were using innovative approaches to improve patient care.

Nationally reported data, taken from the Quality Outcomes Framework (QOF) for 2013/14, showed that overall the practice had achieved 98% of the total points available to them for delivering best practice clinical care. This achievement was above the England average when compared to other practices. (The QOF is a voluntary incentive scheme for GP practices which rewards them for how well they care for patients.)

Interviews with GP staff demonstrated the culture in the practice was that patients were referred to relevant services on the basis of need. Patients' age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support clinical audit activity. We were supplied with an audit schedule listing the dates they were carried out, the name of audit and the actions or outcomes from these.

The practice showed us three clinical audits that had been undertaken in the last year. All three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audits had been carried out. An example of this was the prescribing of a drug used for anxiety or sleeping difficulties. This audit showed there had been a large scale reduction in those patients prescribed this medicine on a long-term basis. The audit demonstrated that the numbers of patients prescribed this medicine had reduced from 181 to 62. Plans were in place to further reduce prescribing rates for this medicine. Other examples included audits which the practice nurses had carried out, for example, they carried out an audit of inadequate cervical cytology tests. This had been discussed at the practice nurses' team meeting and there were plans to repeat this in the next year.

The practice used the information collected for the QOF, and performance against national screening programmes, to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and

saw that all staff had received annual training such as annual basic life support, fire and safeguarding training. Other basic training included information governance and infection control 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).

We saw records of staff appraisals which were comprehensive and included a six monthly review for each member of staff. Staff told us that the practice was proactive in providing staff development which included training. For example, a healthcare assistant had been supported to undertake a National Vocational Qualification in healthcare. We saw a training induction plan for the newest member of administration staff.

The practice was a training practice, one of the GP partners was the GP trainer and they had a GP registrar training with the practice at the time of our visit.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, nurses giving family planning advice had received training in emergency contraception. Those with extended roles involving seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked closely with other health and social care providers, to co-ordinate care and meet patients' needs. We saw multidisciplinary team meetings were held to discuss those patients at high risk or living in vulnerable circumstances. The multidisciplinary team included community nurses, social work and health visitor teams.

We found appropriate and effective end-of-life care arrangements were in place. The practice maintained a palliative and pre-palliative care register which was updated as necessary, and the patients on these registers were usually visited at home. We saw procedures were in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out-of-hours provider, Cumbria Health On Call (CHOC).

Correspondence from other services such as test results and letters from hospitals were received either electronically or via the post. All correspondence was scanned and passed to the patient's referring GP and the duty doctor. We saw the practice computer system was used effectively to log and progress any necessary actions

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out-of-hours provider. This enabled patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals using the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

Consent to care and treatment

Patients were supported to express their views and were involved in making decisions about their care and treatment. Of the patients who participated in the 2014 National GP Patient Survey, 71% said the GP they visited had been 'good' at involving them in decisions about their care, the England average was 81%. A similar level of satisfaction was noted in relation to the care and treatment provided by nurses working at the practice.

Staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in complying with it and told us about training sessions they had received. The GP partners we spoke with demonstrated a clear understanding of consent and capacity issues and the Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). They were able to clearly explain when consent was necessary and how it would be obtained and recorded.

The practice had a consent policy which provided clinical staff with guidance about how to obtain patients' consent to care and treatment, and what to do in the event a patient lacked the capacity to make an informed decision. This policy also highlighted how patients' consent should

Good

Are services effective?

(for example, treatment is effective)

be recorded in their medical notes, and it detailed what type of consent was required for specific interventions. The practice kept a register of patients who had learning disabilities.

Health promotion and prevention

The practice required all new patients to complete a medical questionnaire; we were told patients might be called in for a medical dependent upon the information contained in the medical questionnaire. The medicals would be carried out by a GP or nursing staff employed by the practice. Patients with long-term conditions had regular recalls to check on their health and review their medications for effectiveness, ranging from annually to three monthly as appropriate. Processes were also in place to ensure the regular screening of patients was completed, for example, cervical screening.

The practice identified patients who needed additional support, for example, they kept a register of all patients with a learning disability and those who experienced poor mental health. Patients who were receiving care from drug and alcohol services could be seen weekly by the drug and alcohol worker in joint surgeries with their GP. GPs told us that they viewed all patients in the practice as vulnerable when they were unwell or undergoing investigation these patients were usually seen by the same GP wherever possible.

We saw a health promotion board displayed in the waiting area. Information was available regarding sexual health, smoking cessation and how to access help from the local carers association.

There was a range of information for patients on the practice website. This included what services and clinics were provided for example contraceptive services and baby clinic. There were NHS Health checks available for those aged 40 to 75.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice regarding levels of patient satisfaction. This included information from the 2014 National GP Patient Survey. The evidence from all these sources showed the practice scored mostly above the England average for how patients were treated and the quality of the care and treatment they received. 84% of patients said their GP was good at treating them with care and concern, compared to the England average of 85%.

We reviewed 27 CQC comment cards completed by patients prior to the inspection. Comments were overwhelmingly positive, with no negative comments. Common words used by patients included “excellent”, “very good”, “caring” and “understanding”. We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Patients positively commented that they recognised the practice were always trying to improve the service provided.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting and treatment rooms so that patients’ privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Responses to the practice’s own survey had highlighted that patients had an issue with confidentiality in the waiting area. As a result of this, the practice had installed a self-check-in screen, which reduced the number of patients waiting at the reception desk. The practice were also exploring what other changes could be made to the waiting area regarding confidentiality with the landlord of the building.

Staff were aware of the need to keep records secure. We saw patient records were mainly computerised and systems were in place to keep them safe in line with data protection legislation. There was a practice leaflet available to patients explaining about confidentiality of the information the practice kept about them.

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

Care planning and involvement in decisions about care and treatment

Patients told us they felt they had been involved in decisions about their care and treatment. They said the clinical staff gave them 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. Patient feedback on the comment cards we received was also positive and in keeping with these views.

The results of the National GP Patient survey showed 71% of patients surveyed rated the question asking about the GP involving them in their care as ‘good’ or ‘very good’ compared to the England average of 81%.

We asked staff how they made sure that people who did not have English as a first language were kept informed about their treatment. Staff told us they had access to an interpretation service which was usually by telephone. Longer appointments were booked where necessary to support patients’ needs.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day told us staff responded compassionately when they needed help and provided support when required. We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and support groups.

Support was provided to patients during times of bereavement. There was evidence of sharing information for those patients who were reaching the end of their life with other healthcare professionals. Support was tailored to the needs of individuals, with consideration given to their preferences at all times. Where there was a death the practice contacted the family by phone or visited, whichever was appropriate to offer help and support. One patient gave us positive feedback via a CQC comment card regarding the help and support given to their family during a time of bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Systems were in place to assess patients' needs and the practice was responsive to them. The practice had a holistic approach to long-term medical conditions. Patients received reviews which looked at overall needs of the patient instead of having specific clinics for each condition and they had a named GP. Patients received text messages and telephone reminders for recall appointments. The practice were aware that they had a higher prevalence of those aged over 75 as part of their practice population, there were 1121 patients, of these 12 of them had not contacted the practice in the last 12 months. We were told this group of patients were due to be contacted in the New Year and would receive a medical questionnaire, therefore systems were in place to follow up those over 75 with which the practice had no contact for over a year.

The practice had a register of patients who they had identified as being at risk of an unplanned admission into hospital which helped them to manage their care and try to reduce unnecessary emergency admissions to hospital.

The practice had an active Patient Participation Group (PPG) which met regularly. Minutes of their meetings were available on the practice website for the last four years. There were also patients who signed up to receive regular email updates about the work of the PPG. The last survey the practice conducted of its patients was driven by the PPG and looked at the call back system which had been introduced in the previous year and also access to GPs and practice nurses. As a result of this survey a report was produced with actions documenting how the practice could improve the system and these were carried out.

Of those respondents to the 2014 National GP Patient Survey of the practice: 76% said they were satisfied with the practice's opening times, compared to the England average of 79%.

In the waiting area of the practice there was a board with a display on it called "What you said, what we did". This showed the practice had carried out in response to suggestions patients had made. The practice had planned its services to meet the needs of the working age population, including those that had recently retired. The practice provided an extended hour's service every Saturday morning and late opening three nights a week until 7pm to facilitate better access to appointments for working patients and those with family commitments. The practice website provided working age patients with information about how to book appointments and order repeat prescriptions.

The practice worked collaboratively with other agencies and regularly shared patient information to ensure good, timely communication of changes in care and treatment. The practice provided the out-of-hours and emergency care services with access to care plan information about patients who had palliative care or complex health needs.

We were told by the practice manager and staff that carers' details were coded on the practice software system and they were sign posted to the local carers association as well as offered support by the practice.

The practice received details of any contact the out-of-hours service had had with its patients electronically the following morning. We were told any information received was checked by a designated GP so that appropriate action could be undertaken by the right member of staff.

Turnover of staff at the practice was low. We were told some staff had worked at the practice for a considerable number of years which increased the levels of continuity of care to patients.

Tackling inequity and promoting equality

Reasonable adjustments had been made which helped patients whose first language was not English. Staff had access to a telephone translation service. There was a loop system available to aid those patients with a hearing impairment. We saw that staff had received equality and diversity training.

The patient facilities were all on the ground floor. There were electronic doors at the rear of the premises to ensure access for wheelchairs and prams and disabled parking was available. The waiting area was large enough to accommodate patients with wheelchairs and prams, and enabled easy access to the treatment and consultation rooms. A disabled toilet was available.

Access to the service

Appointments were available from 8:00am to 6:30pm Mondays and Fridays and 8:00am to 7:00pm Tuesday to Thursday. There were extended hours on a Saturday morning by appointment only from 8:30am to 11:30pm.

Good

Are services responsive to people's needs?

(for example, to feedback?)

In the last two years the practice had changed the appointment system for patients who wished to be seen by a GP, to a GP-led telephone triage system. On the day patients contacted the switchboard and gave a brief description of their need. They were then placed on a GP call back list. The GP would then call the patient back within two hours. If there was an urgent need or the patient required a home visit they would be called back within 30 minutes, and if a visit was needed they would be visited within two hours. We were told that when the GP called the patient back they would go through their symptoms with them and assess if they needed an appointment. The aim of the system was to manage appointments appropriately and ensure those who need to see a GP do.

Practice nurse and healthcare appointments could be booked in advance, however there was a duty practice nurse available on the day who could contact patients if needed.

Information was available to patients about appointments on the practice website and in the practice information leaflet. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message provided details of the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was also provided to patients.

The practice manager undertook regular capacity reviews (looking at what staff were available for the coming week) and was clear about the number of appointments needed to meet predicted levels of demand (numbers of appointments needed.) GP partners were involved in this process when demand for appointments was high. Monday was identified as always being a busier day for demand for appointments and there were higher levels of appointments available on that day and more GPs working. The practice manager also showed us how individual GPs response times to the telephone triage system were monitored to ensure responses were within the agreed time call back limits.

Data from the National 2014 GP Patient Survey showed: 65% said they found it 'easy' to get through on the telephone to someone at the practice, 75% is the average in practices in England; 76% said they were happy with the surgery's opening hours, the England average being 79%. None of the patients we spoke with or feedback on CQC comment cards expressed concerns about access to appointments or getting through to the surgery on the telephone.

The practice's own 2014 patient survey asked eleven detailed questions about the call back system for appointments to test its effectiveness. 141 responses were received, results were positive. 77% of patients said it was 'easy' or 'fairly easy' to get through to someone at the surgery on the telephone, 77% were called back in under two hours, 81% thought the call back time was acceptable and 94% of the enquiries were resolved at call back. 55% of patients saw a doctor within a working day. 74% of patients said they were happy with the arrangements for accessing to appointments. Actions were collated following the survey to address the issues raised, for example; better levels of understanding by the patients were required as to how the appointment system worked and the practice were to work on this.

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.

We saw that information was available to help patients understand the complaints system. A comprehensive leaflet was available from the reception staff and information was on the practice website. This set out what the patients' options were for complaints. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We saw that the practice took any feedback seriously and informal complaints were formally logged and dealt with as a formal complaint would be. All complaints were dealt with in a timely way and acknowledged within three months. Where necessary an apology had been issued to the patient.

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 clear vision to deliver high quality care and promote good outcomes for patients. The practice's mission statement set out its values and principles. This was displayed on the website, within the practice and in the practice information leaflet. The practice mission statement included the following aims; to deliver high quality patient care, encourage personal well-being through good communication and team work.

We spoke with five members of staff and they all knew and understood the mission statement and knew what their responsibilities were in relation to this. Staff said this had been developed in conjunction with them and was regularly reviewed at staff meetings.

The practice manager and lead GP explained they were working on a documented business plan which was something they wanted to develop over the forthcoming year, however, they could explain to us where they thought they should be taking the practice in the future. For example, they wanted to encourage wider patient engagement, have further improvements regarding the premises and extend the use of digital solutions such as digital or video consultations. There were plans to develop a health questionnaire for older patients which they felt may have unmet needs.

Governance arrangements

The practice had a number of policies and procedures in place to govern their activities and these were available to staff on computer desktops. We looked at five of these policies and procedures and saw they had been reviewed annually and were up-to-date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and one of the GP partners was the lead for safeguarding. Staff also had lead roles, for example, for clinical 'read coding' and care planning. We spoke with five members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We saw a schedule of audits which had been completed in the last year by both GPs and practice nurses. We saw that the full audit processes were completed and the audits resulted in improvements for patients.

The practice held bi-monthly governance meetings with the practice partners and the practice manager. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

The practice manager had a schedule of meetings which she kept to keep track of when staff meetings were due to be held. The GPs had meetings every Monday with different topics for discussion. The practice nurses and healthcare assistants met monthly. Occasional informal meetings were held with administration staff to update them on practice issues. The practice manager confirmed monthly meetings were also held with administrative staff on alternated days to take into account part time working so those members of staff could attend. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager met with the partners every other month to discuss staffing and the management of the business. They then provided an update for staff via email of the items discussed and agreed.

The practice manager explained they had provided resilience training for staff at a Protected Learning Time (PLT) session in the summer of 2014. This involved them reflecting on what they did, how they supported each other and how they moved forward together as a team.

We saw the practice had a culture of continuous improvement and were open to change.

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

The practice had gathered feedback from patients through patient surveys, compliments, suggestions and complaints received. The practice had introduced a GP led telephone

Are services well-led?

Good

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

triage system and then surveyed the patients to obtain feedback on how successful it had been regarding improving access for patients and how it could be further improved. The practice had recently purchased a computer tablet to put in the waiting area in order to capture feedback from patients; this was a good innovative plan to gather feedback from patients.

The practice had an active patient participation group (PPG). Patients had signed up to receive regular email updates about the work of the PPG and were encouraged to forward feedback. The last practice survey was designed in conjunction with the PPG. The results and actions agreed from the survey were available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. They said they were proud to work there and felt that communication between teams was a strong point.

The practice had a whistleblowing policy which was available to all staff in the staff handbook as well as electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files and saw that regular appraisals took place which included a personal development plan for each staff member. Staff told us that the practice was very supportive of staff training and they had access to PLT. The practice had completed reviews of significant events and other incidents and shared these with staff at meetings to promote shared learning.

The practice had achieved accreditation as a training practice. To do this the practice had to meet higher than usual standards of performance in areas such as patient medical records and providing a safe working environment.