Maryport Group 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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Good ●

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Maryport Group Practice on 27 August 2015. Overall the practice is rated as outstanding.

Specifically, we found the practice to be good for providing safe, caring, effective and well-led services. It was also good for providing services for the following population groups: People with long-term conditions; Families, children and young people; Working age people; People experiencing poor mental health (including people with dementia); people whose services may make them vulnerable. We found the practice to be outstanding for providing responsive services as well as for services for older people.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients, staff and visitors to the practice were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The majority of patients said they found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day.
- The practice offered pre-bookable telephone consultations which improved access for patients who worked full time or were unable to attend the surgery.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw several areas of outstanding practice:

Summary of findings

- The practice held 'daily lunch bite' meetings which gave all staff groups a daily opportunity during protected time to discuss concerns and for feedback from training, significant events, complaints and clinical audits to be shared
- The practice had developed a consultant-led frail and elderly clinic which had reduced unplanned admissions to hospital for patients in that group
- The practice had empowered its patients with atrial fibrillation and those at risk of stroke and taking Warfarin to remotely monitor and self-manage their conditions.
- The practice was an active member of the Maryport Health Assets Group. This was a multi-agency partnership group, which included local resident groups which looked at the causes of ill-health, prevention and self-management
- The practice employed two paediatric nurses who were also trained in dealing with minor injuries and delivered a minor injuries service. The practice also hosted a consultant-led weekly paediatric outpatient clinic which was run by a consultant paediatrician in conjunction with the paediatric nurses.
- The practice was the only practice in Cumbria hosting a Local Area Co-ordinator employed by Cumbria Councty Council. The role of the Local Area Co-ordinator involved targeting early intervention services at people at risk of reaching crisis point and in supporting them to fulfil their vision of a good life.

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 with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The partners and practice management team took action to ensure lessons were learned from incidents, concerns and complaints and shared these with staff as and when required to support improvement. The practice held a daily 'lunch bite' programme. This ensured that protected time was given to a round the table discussion between GPs, clinical and non-clinical staff to share information and highlight any concerns or problems. There were enough appropriately trained staff on duty at all times to keep patients safe. The practice was clean and hygienic and there was evidence to confirm that cleaning and infection control audits were regularly completed. All staff had attended training on infection control. The practice had a chaperone policy in place and staff called upon to act as a chaperone had received the appropriate training. All staff had been checked with the Disclosure and Barring Service (DBS). Effective arrangements were in place for the storage of all medicines kept on the premises, including those requiring refrigeration. Processes were in place for the safe management of prescriptions, including repeat prescription requests and the safe storage of blank prescriptions.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services.

Nationally reported data showed patient outcomes for effectiveness were in line with other practices in the local Clinical Commissioning Group (CCG) and England. Patients' needs were assessed and care was planned and delivered in line with current legislation and best practice guidance produced by the National Institute for Health and Care Excellence (NICE). This included assessing capacity and promoting good health. The practice had systems in place for completing clinical audit cycles to review and improve patient care and to support multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the information and equipment they needed to deliver effective care and treatment. Arrangements were in place to support clinical staff with their continual professional development and all staff had received training appropriate to their roles and responsibilities. Staff received yearly appraisals which gave them the opportunity to formally discuss personal and performance issues and identify training and development needs.

Summary of findings

The practice was a member of the Maryport Health Assets Group. This was a multi-agency partnership which looked at the causes of ill health, prevention and self-management and was currently working on improving outcomes for patients with diabetes, obesity, mental health issues and smoking/alcohol dependency.

The practice was able to demonstrate action it had taken which had resulted in a reduction in acute and unplanned admissions to hospital. In addition the practice could evidence a reduction in prescribing following comprehensive clinical audit.

Are services caring?

Good

The practice is rated as good for providing caring services.

Nationally reported data showed patient outcomes for caring were generally better than the national average. Patients said they were treated well and were involved in making decisions about their care and treatment. Patients had access to information and advice on health promotion, and they received support to manage their own health and wellbeing. We saw staff treated patients with kindness and respect and were aware of their responsibilities with regard to maintaining patient confidentiality. The practice had developed an effective working relationship with the local carers association and carers' information/referral leaflets and packs were readily available.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services.

Nationally reported data showed patient outcomes for this area were generally in line with or better than the national average. Services had been planned so they met the needs of the key population groups registered with the practice. Patient feedback about the practice was good and most stated they found it was easy to make an appointment with a GP within an acceptable timescale. The practice was taking steps to reduce emergency admissions to hospital for patients with complex healthcare conditions by ensuring these patients had fully comprehensive personal care plans. Systems were in place to ensure patients discharged from hospital were supported. Unplanned admissions had also been reduced by the implementation of a consultant led frail and elderly clinic. There were dedicated paediatric nurses and the practice hosted a weekly consultant-led paediatric outpatient clinic. The practice also delivered a minor injuries service to ensure that the local population had access to emergency treatment without having to travel some distance. The practice had introduced remote monitoring for its patients with atrial fibrillation and those at risk of stroke and on warfarin (a blood thinning medication to prevent

Summary of findings

blood clotting) which not only made it easier for patients to self-manage and monitor their conditions but also freed up GP and nurse appointments. Improvements had been made to the practice as far as possible to ensure the premises were well equipped to treat patients and meet their needs. The practice worked cohesively with multi agency practitioners. Easy to understand information about how to complain was available and evidence showed the practice responded quickly and appropriately to issues raised

Are services well-led?

Good

The practice is rated as good for being well-led.

The leadership and management of the practice assured the delivery of person-centred care which met patients' needs. The practice had a clear vision for improving the service and promoting good patient outcomes. Staff were clear about their roles and responsibilities and felt well supported and valued. The practice had a range of policies and procedures covering its day-to-day activities which were easily accessible by staff. The practice proactively sought feedback from patients, which they acted upon. The practice had an active patient participation group (PPG) which met regularly. The practice worked collaboratively with the PPG to identify problem areas and improve services. Comprehensive induction guidance was available for staff. Regular staff meetings were held and staff received yearly appraisals.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

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

Nationally reported data showed the practice had achieved good outcomes in relation to the conditions commonly associated with older people. Patients over the age of 75 had a named GP and were offered an over 75 health check where appropriate. Home visits were available following triage by a GP to ascertain whether there was a more appropriate course of action.

The percentage of patients aged 65 and older who had received a seasonal flu vaccination was higher than the national average. The practice held an annual flu vaccination day which was supported by their patient participation group and attended by local voluntary groups such as Age UK, West Cumbria Carers and Shelter.

The practice actively identified and flagged palliative care patients to ensure they were supported appropriately and regular multi agency palliative care meetings were held.

The practice had developed an in-house frail and elderly clinic which had been running since July 2015. This was a weekly multi-disciplinary clinic consisting of a consultant elderly care physician, GP, practice nurse, rehabilitation team member and the falls champion. Appointments could either be clinic or home visit based and although mainly aimed at the over 75 year old age group the practice was flexible in whom it referred to the service. The practice was able to demonstrate that this initiative would not only improve the care of older people but had also reduced emergency admissions to hospital and the prescribing budget.

People with long term conditions

Good ●

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

The practice was able to demonstrate comprehensive and regularly reviewed care planning for patients with long-term or complex conditions and had a system in place to ensure patients were recalled for reviews when required. The practice was in the process of promoting self-held care plans for patients with chronic diseases.

Chronic disease management clinics were held to cover a wide variety of diseases and the practice had ensured that self-held care plans were in place for a number of patients including those at risk of an unplanned admission to hospital.

Summary of findings

The practice offered patients suffering from atrial fibrillation and those identified as being at risk of stroke and taking warfarin the opportunity to remotely monitor their conditions. This not only encouraged patients to self-test and monitor their conditions but also gave patients increased choice and flexibility over how their condition was managed and freed up capacity on GPs and nurses.

Families, children and young people

Outstanding ☆

The practice is rated as outstanding 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 looked after children or children subject of a child protection plan. The practice had identified two of the GPs as safeguarding leads who were responsible for attending multi-agency safeguarding forum meetings and serious case reviews. The practice also held regular meetings with health visitors and midwives to discuss safeguarding cases and concerns.

The practice had a recall system in place for childhood immunisations and rates were broadly in line with local averages for all standard childhood immunisations. Appointments were available outside of school hours and the practice operated an emergency/walk in clinic. Telephone appointments were routinely available and bookable in advance. Cervical screening rates for women aged 25-64 were in line with local and national averages.

The practice employed two paediatric nurses to specifically provide care and support to children and families. The paediatric nurses were also trained in dealing with minor injuries and delivered a minor injuries service. The practice also hosted a consultant-led weekly paediatric outpatient clinic which was run by a consultant paediatrician in conjunction with the paediatric nurses. The practice told us that this initiative had resulted in a reduction in the number of outpatient attendances and emergency admissions to hospital for children by a third.

Working age people (including those recently retired and students)

Good ●

The practice is rated as good for the care of working age patients (including those recently retired and students).

Nationally reported data showed that 42.9% of the practice population either worked or was in full time education (national average 60.2%). The practice was proactive in meeting the needs of these patients by offering online services such as being able to order repeat prescriptions, book appointments and view parts of their medical records. The practice was open until from 8:00am to 6:00pm

Summary of findings

every weekday with appointments times running from 8.10am to 5.20pm. The practice also offered pre-bookable telephone consultations. Repeat prescriptions could be ordered at any time either online, by post or by handing in a request slip to reception. The practice were also involved in the eReferral scheme which enabled patients referred to a hospital or clinic to choose the provider of their choice and at date and time which is convenient.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable.

The practice had a register of patients aged 16 or over with a learning disability and had a recall system in place to ensure these patients were offered an annual health check, some of which were carried out during a home visit. Longer appointments were routinely available for this group of patients and the practice ensured that they contributed towards the development of their own health action plans.

Staff knew how to recognise signs of abuse in vulnerable adults and children and how to raise safeguarding concerns with the relevant agencies. The practice had identified a clinical leads for dealing with vulnerable adult and vulnerable children cases and all practice staff had undertaken safeguarding training at a level appropriate to their role.

The practice was proactive in identifying and responding to the needs of carers and had developed an effective working relationship with the local carers association, West Cumbria Carer's who attended the practice on a weekly basis. The practice had also developed an effective working relationship with and hosted a Local Area Co-ordinator whose role involved targeting early intervention services at people at risk of reaching crisis point and to support them in fulfilling their vision of a good life.

People experiencing poor mental health (including people with dementia)

Good

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

The practice had exceeded the national average in ensuring comprehensive and agreed care plans were in place for patients with schizophrenia, bipolar affected disorder and other psychoses (90.7% compared to an England average of 86%) but was slightly below the England average for ensuring patients diagnosed with dementia had received a face-to-face review within the preceding 12 months (76.8% compared to an England average of 83.8%).

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The practice was committed to proactively offering assessment to patients at risk of dementia and to continually improving the quality and effectiveness of care provided to this group of patients.

Practice clinicians were aware of their responsibilities under the Mental Capacity Act (2005) and in respect of gaining consent to care and treatment. Two of the practice GPs were undertaking a mental health diploma and the practice hoped it would become a mental health GPwSI (GP with specialist interest) service.

Summary of findings

What people who use the service say

During the inspection we spoke with six patients (four of whom were members of the patient participation group) and reviewed 49 Care Quality Commission (CQC) comment cards completed by patients. The feedback we received indicated the vast majority of patients were very happy with the care and treatment they received, felt they were treated with dignity and respect and received a service which met their needs.

Findings from the 2015 National GP Patient Survey published in July 2015 for the practice indicated most patients had an average level of satisfaction with the care and treatment they received. For example:

- 79.5% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care. Local CCG average 85.3% and national average 81.5%
- 88.2% of respondents said the last GP they saw or spoke to was good at treating them with care and concern. Local CCG average 88.7% and national average 85.1%
- 93.4% of respondents said the last nurse they saw was good at treating them with care and concern. Local CCG average 93.5% and national average 90.4%

These results were based on 119 surveys that were returned from a total of 330 that were sent out (a response rate of 36.1%)

Maryport Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

A Care Quality Commission (CQC) Inspector, a second CQC Inspector, a GP specialist advisor and a specialist advisor with experience in practice management.

Background to Maryport Group Practice

The practice is located within a residential area of Maryport and adjacent to the community hospital. The practice provides care and treatment to 13,700 patients from Maryport, is part of the NHS Cumbria Clinical Commissioning Group (CCG) and operates on a Personal Medical Services (PMS) contract.

The practice is part of a 34 practice GP Federation, 1st Care Cumbria which consists of practices from the Allerdale, Eden and Copeland areas of Cumbria. The aims of the federation include the improvement of collaborative working, sharing of best practice and developing greater strength in bidding for enhanced service contracts with the aim of ensuring primary care services are available locally.

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

Maryport Group Practice, Alneburgh House, Ewanrigg Road, Maryport, Cumbria, CA15 8EL

The practice is located in a two storey building with all consultation rooms being on the ground floor and fully accessible. Counselling rooms were situated on the first floor. If patients with mobility problems need to access the upper floor of the building for any reason a stair lift is in operation. The practice has a car park and on-street parking is also readily available nearby. The practice is open between 8.00am to 6.00pm on a Monday to Friday with appointments running from 8.10am to 12.20pm and 2.00pm to 5.20pm. The practice ensured there was a GP on duty each weekday until 6.30pm to deal with emergencies and the practice also offered an emergency/walk-in appointment system for urgent cases from 9.00am to 11.00am and 2.00pm to 5.00pm on a Monday to Friday. Pre-bookable telephone consultations were also available.

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

Maryport Group Practice offers a range of services and clinic appointments including chronic disease management clinics, antenatal clinics, baby clinics, family planning/sexual health/teenage sexual health, minor injuries service and minor operations and cervical screening. The practice consists of:

- Ten GP partners (five male and five female)
- Three salaried GPs (one male and two female)
- Six practice nurses
- One treatment room nurse
- Two paediatric nurses
- Two research nurses
- Five health care assistants
- A practice manager, medicines manager and IT manager
- 20 administration and reception staff
- Four cleaners

The practice is a teaching practice and provides training to third year medical students and registrars.

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

Detailed findings

The practice's age distribution profile showed higher percentages of patients aged over 60 than the national average. Average life expectancy for the male practice population was 79 (national average 79) and for the female population 82 (national average 83).

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008, as part of our regulatory functions. This inspection was planned to check whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008: to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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 Care Quality Commission (CQC) at that 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 visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 27 August 2015. During our visit we spoke with a mix of clinical and non-clinical staff including GPs, practice nurses, the practice manager, the medicines manager and administration and reception staff. We spoke to four patients, all of whom were members of the practice patient participation group (PPG) and observed how staff communicated with patients who visited or telephoned the practice on the day of our inspection. We reviewed 49 Care Quality Commission (CQC) comment cards that had been completed by patients. We also looked at the records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Safe track record and learning

As part of planning our inspection we looked at a range of information available about the practice including information from the latest National GP Survey results published in January 2015 and the Quality and Outcomes Framework (QOF) results for 2013/14. None of this information identified any areas of concern. The local Clinical Commissioning Group (CCG) did not raise any concerns with us about how the practice operated. Patients we spoke to told us they felt safe when they attended appointments and comments from patients who completed Care Quality Commission comment cards reflected this.

The practice used a range of information to identify potential risks and to improve quality in relation to patient safety. This included reported incidents, national patient safety alerts, comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report accidents and near misses. For example, an incident had been recorded where an infant had been given the 2nd dose of a immunisation later than recommended. The practice was able to demonstrate that it made immediate contact with the child's mother to warn her of adverse signs to look out for, had reported the incident to NHS England and considered what had happened at a subsequent practice meeting as a lessons learned exercise. As a result all relevant staff were reminded of the importance of ensuring details were checked more vigilantly and of ensuring that the Child Health immunisation sheet, parent held record and practice computer record were checked against each other. We also saw that the practice had added a duty of candour section to their significant event recording sheet to ensure patients were informed of errors and apologies issued if appropriate.

We reviewed a sample of significant event audit records and serious incident reports, and minutes of meetings where these were discussed. We were satisfied that the practice had managed these consistently over time and taken all necessary action to avoid possible recurrences. The practice held a daily 'lunch bite' session which was an opportunity for all staff groups to discuss areas of concern during protected time. These were generally an additional opportunity to discuss significant events and incidents and clinical audit outcomes with a view to identifying and addressing learning requirements.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We found the practice had recorded 60 significant events/ incidents during the period 1 August 2014 to 31 July 2015 covering a wide range of issues. Although this appeared to be high given the size of the practice this amount was acceptable and demonstrated that the practice was recording all issues effectively and taking the appropriate action. The practice was able to demonstrate the action taken to ensure these issues did not happen again and also how information regarding such incidents was disseminated to staff by way of minuted practice meetings. Clinical and non-clinical staff knew how and when to raise an issue immediately or for future consideration at staff meetings.

The practice manager was responsible for cascading national patient safety alerts to the clinical staff and the medicines manager and had a system in place to ensure these were acted upon. Clinical staff and the medicines manager would then ensure appropriate action was taken which included medication reviews, contacting affected patients and amending their care plans.

Reliable safety systems and processes including safeguarding

The practice had effective systems in place to manage and review risks to vulnerable children, young people and adults. The practice's safeguarding policies and procedures were under review as it was waiting for new information and policies to be disseminated by Cumbria County Council safeguarding hub. In the meantime staff were working in line with the old procedure and knew how to report safeguarding concerns and contact the relevant agencies. Two of the GPs had been identified as the leads for safeguarding vulnerable children and adults and effective working relationships had been established with multi agency practitioners. For example, monthly multi-disciplinary meetings were held involving the GP, health visitor and school nurses and cases causing concern were discussed more regularly at weekly multi-disciplinary team meetings. Staff we interviewed stated they would feel

confident in making a safeguarding referral and were aware of who the nominated safeguarding lead was within the practice. We saw practice training records that confirmed staff had received the appropriate level of safeguarding training relevant to their individual roles. A system was in place to highlight vulnerable patients on the practice's electronic records so staff were aware of any relevant issues when they rang to make or attend appointments.

A chaperone policy was in place and information about this was displayed in the practice waiting room. The practice nurses and health care assistants had received training on their roles and responsibilities as a chaperone (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) and had received a Disclosure and Barring Service (DBS) check. Non clinical staff had not received DBS checks but a risk assessment was in place which identified mitigating action the practice had taken to ensure this was not necessary.

Patients' records were kept on an electronic system which stored all relevant medical information. As well as flagging vulnerable children and adults, the system also flagged patients with dementia, mental health issues, learning difficulties and those receiving palliative care which helped ensure risks to patients were clearly identified and reviewed.

Staff were able to easily access the practice's policies and procedures. This helped to ensure that when required, all staff could access the guidance they needed to meet patients' needs and keep them safe from harm.

Medicines management

Effective arrangements were in place to ensure medicines requiring cold storage, such as vaccines, were stored appropriately. A policy was in place to ensure refrigerator temperatures were checked and recorded to comfirm that medication stored in the refrigerators was safe to use.

The practice maintained a register of emergency drugs held on the premises. These drugs were stored in a locked cabinet with restricted access. During our inspection we found that a process was in place to check these drugs on a monthly basis to ensure they were in date, destroyed appropriately and re-ordered when required.

Patients were able to re-order repeat prescriptions either on-line or by completing a request slip to hand in to reception. All staff were well aware of the processes they needed to follow in relation to the authorisation and review of repeat prescriptions and were clear about what action to take when a patient had reached the authorised number of repeat prescriptions or when prescriptions were not collected. Blank prescription forms were stored securely and in line with best practice guidance issued by NHS Protect.

We saw evidence to confirm that the practice recorded medicines incidents and prescribing errors as significant events to ensure that similar errors did not recur. An example of this was when a patient was mistakingly prescribed a course of medication for a longer period than required for that particular condition. The matter was recorded as a significant event and the learning from this incident disseminated to practice staff.

The practice nurses used patient group directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance.

Cleanliness and infection control

The premises were clean and hygienic throughout. None of the patients we spoke with or who completed CQC comment cards had any concerns regarding the level of cleanliness at the practice. A cleaning schedule was in place and audits of cleaning standards were carried out on a regular basis.

An infection control policy was in place which provided guidance to staff about the standards of hygiene they were expected to follow. This included guidance on the use of personal protective equipment (PPE) such as aprons and latex gloves as well as how to deal with patient specimens, needle stick injuries and the disposal and management of clinical waste. One of the practice nurses and the treatment room nurse had been designated as the infection control leads and provided advice and guidance to colleagues when needed. Both clinical and non-clinical staff had received infection control training. The practice was able to demonstrate that it carried out infection control audits and acted upon any concerns raised as a result.

The clinical rooms we inspected contained PPE and there were paper covers and privacy curtains for the consultation couches. A process was in place to ensure the curtains were checked for cleanliness and replaced every six months or more regularly if required.

Good

Are services safe?

Spillage kits were available to enable staff to deal safely with any spills of bodily fluids. Sharps bins were available in treatment rooms and were appropriately labelled, dated and initialled. The treatment rooms also contained hand washing sinks, hand soap and hand towel dispensers to enable clinicians to follow good hand hygiene and infection control practice. The practice had a protocol for the management of clinical waste and a contract was in place for its disposal on a fortnightly basis. All waste bins were visibly clean and in good working order.

The practice was able to demonstrate that a process was in place for the management, testing and investigation of legionella (a bacterium that can grow in water and can be potentially fatal) on a six monthly basis. This was confirmed by records we viewed that showed tests were carried out every three months, the last test having been carried out In June 2015.

Equipment

Staff had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. We saw evidence to confirm the equipment was regularly inspected and serviced. This included the practice defibrillator, spirometer, oxygen equipment and portable electrical equipment. The practice mainly used single use equipment wherever possible but did have some speculums and ear syringes that required sterilising after use; however we saw evidence to confirm that this equipment was sterilised appropriately. A contract was in place with an external provider for the sterilisation and decontamination of the speculums and the ear syringes were cleaned and sterilised after use with an appropriate sterilising agent.

Staffing and recruitment

The practice had a recruitment policy that set out the standards they intended to follow when recruiting staff. This included seeking proof of identification, evidence of a legal entitlement to work in the UK, references, qualifications, licence to practice if appropriate and Disclosure and Barring (DBS) checks. We viewed staff files and found this to be the case. We also checked the General Medical (GMC), Nursing and Midwifery Council's (NMC) records to confirm that all of the clinical staff were licensed to practice. The exception to this was that the GP Registrar currently working with the practice was not listed on the national performers list. This was due to a change in who held the contracts for GP Registrars and was in the process of being addressed. In the meantime the practice had taken the appropriate action and the GP Registrar was only observing consultations. In addition we found that all clinical staff had received DBS checks.

The assistant practice manager told us about the arrangements that were in place to ensure there were enough staff on duty at all times. A rota and buddy system was in place and only a certain number of members of any staff group were allowed to be on annual leave at the same time. Administrative staff performed dual roles so staff absences could be covered. The practice rarely relied on using locum GPs but when this was necessary we saw evidence of a comprehensive locum induction pack and locum handbook. The GP federation of which Maryport Group Practice was a member was considering setting up a bank of locum GPs across the federation.

Staff and patients we spoke to on the day of our inspection told us they felt there were enough staff to maintain the smooth running of the practice and to keep patients safe.

Monitoring safety and responding to risk

The practice had systems in place to manage and monitor risks to patients, staff and visitors to the practice. This included regular checks of medicines management, premises, equipment and staffing. The practice had a health and safety policy and staff had received health and safety training. We checked the premises and found it to be safe and hazard free.

Staff told us of the process they would follow if there was a medical emergency on site. The member of staff informed about the incident would activate an alarm on the practice computer system which would alert any available clinician that their immediate attendance was required. Emergency bags and equipment were readily available. As the practice had three separate waiting areas those areas not visible to reception staff were monitored by CCTV camera. The practice had dealt with such an emergency two days prior to our visit when a child had attended with profuse bleeding from a head wound. The child was immediately seen and treated by one of the paediatric nurses and spillage kits were readily available to deal with the blood spillage. The practice manager told us that staff had remained calm and in control and were clearly aware of their roles and responsibilities.

Good

Are services safe?

The practice had systems in place to monitor risks to patients, staff and visitors to the practice by way of risk assessments which also recorded what mitigating action had been taken to reduce identified risks. Health and safety information was displayed for staff to see.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records confirming that staff had received training in basic life support and cardio-pulmonary resuscitation (CPR).

Emergency equipment was available including a defibrillator and oxygen. Emergency medicines held on site were in line with national guidelines, stored securely and only accessible by relevant practice staff. This included medicines for the treatment of cardiac arrest and life threatening allergic reactions. Arrangements were in place to regularly check these were within their expiry date and suitable for use.

The practice had a comprehensive business continuity plan for dealing with a range of potential emergencies that could impact on the day-to-day operation of the practice. Mitigating actions had been recorded to reduce and manage the risks. Risks identified included the loss of the building, utilities, equipment (including IT and telephones), personnel and supplies.

The practice carried out a fire risk assessment on an annual basis and held weekly fire alarm tests and six monthly fire drills. Staff had received training in fire safety and fire marshalls had been identified. Fire extinguishers had been subject to an annual check and fire exits were clearly signposted.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinical staff we spoke with were able to clearly explain why they adopted particular treatment approaches. They were familiar with current best practice guidance and were able to access National Institute for Health Excellence (NICE) guidelines. From our discussions with clinical staff we were able to confirm they completed thorough assessments of patients' needs and these were reviewed when appropriate.

Practice staff were given regular protected time to carry out online training activities and attend training events. Learning and new protocols etc. would be disseminated by colleagues through daily lunch bite meetings which covered discussions such as new guidelines, case and medication reviews, significant events and clinical audit outcomes. As the practice had been identified as a high prescriber for antibiotics it was taking steps to ensure there were effective protocols in place to monitor the prescribing of antibiotics and other drugs in conjunction with the local clinical commissioning group. One of the GPs had been designated as the lead for prescribing and was the locality representative on the Area Prescribing Committee which met on a bi-monthly basis. Practice prescribing meetings were held on a quarterly basis. We saw evidence of clinical audits including one on the prescribing of benzodiazepine (a minor tranquilliser used primarily to treat anxiety and sleeping problems). The audit had led to a reduction in the number of patients prescribed this medicine by 21%. Another GP was the sub-locality representative on the locality executive committee of the local clinical commissioning group.

Chronic disease management clinics were held to cover a wide variety of diseases. The time between recalls was agreed with the patient dependent on how well they were self-managing their condition. The practice had considered offering patients with multi long term conditions one review clinic but realised after carrying out an audit of patients with long term conditions and patient satisfaction surveys that one combined review may be too intensive for some patients. The practice had ensured that self-held care plans were in place for over 300 patients including those at risk of unplanned admission to hospital. They reported that this had led to a 10% reduction in acute admissions.

The practice was a member of the Maryport Health Assets Group, which was chaired by one of the practice GPs. This was a multi-agency partnership which looked at the causes of ill health, prevention and self-management and current priorities lay with improving outcomes for patients with diabetes, obesity, mental health issues and smoking/ alcohol dependency. This had resulted in better communication between member organisations including the local authority, health care services, third sector agencies, the police and resident groups. The group were also able to share and analyse each other's statistical information as a way of identifying and highlighting areas of concern. A discussion within the group about diabetes had led to an analysis being carried out of the health check data for the Maryport area by Cumbria County Councils public health team. This had identified possible areas of improvement which were now being followed up on. The group were also considering offering physical activity sessions in conjunction with weight management advice and exploring the link between domestic abuse and alcohol to name but a few of the incentives currently being considered.

Interviews with the clinical staff demonstrated the culture in the practice was that patients were referred to relevant services on the basis of need. Patients age, sex and ethnicity was not taken into account in the decision making process unless there was a clinical reason for doing so.

Management, monitoring and improving outcomes for people

The GP partners monitored how well the practice performed against key clinical performance indicators such as those contained within the Quality and Outcomes Framework (QOF) (QOF is a voluntary incentive scheme for GP practices in the UK which financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures).

The practice was able to demonstrate that it undertook clinical audit cycles to help improve patient outcomes. We saw examples of a number of audits including completed two cycle audits in relation to the prescribing of benzodiazepine, the combined contraceptive pill and emergency contraception. The audits showed improvement between cycles.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The practice used the information collected from QOF and performance against national screening programmes to monitor outcomes for patients. For example:

- QOF performance results for 2013/14 indicated that 90.7% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in their record in the preceding 12 months which had been agreed with the patient and their family/carers. This increased to 96.3% for 2014/15.
- QOF performance results for 2013/14 indicated that 93.9% of patients with diabetes had received a foot examination and risk classification within the preceding 12 months (the practice had 1084 diabetic patients on its list at the date of our visit). This increased to 98% for 2014/15.
- QOF performance results for 2013/14 indicated that 89.6% of patients with hypertension in whom the last blood pressure reading measured within the preceding 9 months was 150/90mmHg or less. This decreased to 87.1% for 2014/15.

The practice had scored above the England average in the majority of QOF indicators. We confirmed the practice had obtained the maximum number of points available to them in 2013/14 and 2014/15 for delivering a good standard of care to patients with a range of conditions including asthma, chronic obstructive pulmonary disease, depression, heart failure, hypothyroidism, rheumatoid arthritis, stroke & ischaemic heart failure and to patients with a learning disability or those in need of palliative care. At 8.7% the clinical exception rate for 2013/14 was that same as the local CCG average and 0.8% above the national average. For 2014/15 this had increased to 10.9% which was 0.8% above the local CCG average and 1.7% above the national average. Clinical exception reporting allows pratices to pursue the quality improvement agenda without being penalised where, for example, patients do not attend a review, or where a medication cannot be prescribed due to a contraindication or side effect.

There was a protocol for repeat prescribing which was in line with national guidance. Staff were aware of the action to take when a patient had reached the authorised number of repeat prescriptions or when a prescription had not been collected.

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

The practice also held a register of those patients with a learning disability or mental health condition. These patients were offered an annual health check and flu vaccination. An alert was placed on the practice computer system for all vulnerable patients which enabled staff to identify them and ensure their needs were met when requesting appointments or during consultations. The practice had taken steps to ensure all dementia patients were identified and received appropriate treatment and services.

Effective staffing

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

The GPs were up to date with their yearly continuing professional development requirements and had been revalidated (every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list). The practice nurse reported they were supported in seeking and attending continual professional development and training courses. The practice was also a teaching and training practice, providing tuition to medical students and training for GP Registrars wishing to gain experience in general practice.

All staff undertook annual appraisals and a separate training needs analysis tool was used to identify and record training requirements. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

We looked at staff cover arrangements and identified that there were always sufficient GPs on duty when the practice was open. Holiday, study leave and sickness were covered in house whenever possible. The GPs, management team

and reception staff covered for each other and the practice rarely relied on the use of locum GPs. When the practice had needed to use a locum GP a comprehensive locum induction pack and handbook was in place.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. The practice received written communication from local hospitals, the out-of-hours provider and the 111 service, both electronically and by post. Staff we spoke to were clear about their responsibilities for reading and actioning any issues from communications with other care providers. They understood their roles and how the practice's systems worked.

The practice demonstrated they worked with other services to deliver effective care and treatment across the different patient population groups. The practice held monthly multidisciplinary team meetings to discuss palliative care patients and vulnerable children. The practice also held a weekly multi-disciplinary meeting in the surgery and attended quarterly multi-disciplinary meetings at the adjacent community hospital. Meetings were minuted appropriately. The practice was also able to demonstrate effective multi-agency working with a number of other multi-agency practitioners and provided consultation and meeting rooms free of charge to podiatrists, dieticians, social workers, West Cumbria Carers, hearing aid clinicians, Ewanrigg Local Trust volunteers and community psychiatric nurses and the local area co-ordinator.

The practice had a system in place to ensure that hospital discharge letters were reviewed and patients contacted, if appropriate to review their medication and ensure the patients' needs were being met. A named link GP was attached to each of the local care/nursing homes.

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

The practice worked collaboratively with other agencies and regularly shared information to ensure timely communication of changes in care and treatment. For example, the practice had a palliative care register and held weekly multidisciplinary meetings to discuss patients and their families' care and support needs. Practice staff were also able to demonstrate that they worked closely with other health care professionals.

Emergency hospital admission rates for the practice were slightly higher than the national average at 19% (national average 13.6%); however the practice was able to show us documentation confirming that their emergency admission rate had dropped from 364 admissions in 2013/14 to 336 admissions in 2014/15 resulting in a cost saving of £191,880. This improvement had been linked to the success of the frail and elderly clinic.

Information sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and the practice made referrals through the e-Referral service which gave patients the ability to choose their own appointment dates and times.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to co-ordinate, 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.

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 111 patients who participated in the 2014 National GP Patient Survey published In January 2015, 82.8% reported the last GP they visited had been good at involving them in decisions about their care. This compares to a national average of 74.6% and local CCG average of 79.5%. The same survey revealed that 70.3% of patients felt the last nurse they had seen had been good at involving them in decision about their care compared with a national average of 66.2% and local CCG average of 72.7%.

Staff told us that they asked patients for their consent before undertaking any care or treatment and acted in accordance with their wishes. Staff told us that they ensured they obtained patients' written, verbal or implied consent to treatments.

GPs we spoke with showed they were knowledgeable of 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.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing and the use of independent advocates. Clinicians we spoke with were able to demonstrate an understanding of the Mental Capacity Act (MCA) 2005 and their responsibilities in relation to this. The practice worked with the 'Deciding Right' body to identify patients who lacked mental capacity and for whom do not attempt resuscitation (DNAR) directives were appropriate. They also held specific 'best interest' meetings which involved multi-agency practitioners, the patient and their family/carers. Deciding Right is a toolkit which ensures the correct care decisions are made for people who lack capacity to make decisions themselves.

Health promotion and prevention

There was a range of information on display within the practice reception area which included a number of health promotion and prevention leaflets, for example on mental health, dementia, sexually transmitted diseases, stress and addictions. The practice website also included links to a range of patient information including family health, long-term conditions and minor illnesses.

We found patients with long-term conditions were recalled to check on their health and review their medications for effectiveness. The practice's electronic system was used to flag when patients were due for review. Processes were in place to ensure the regular screening of patients was completed, for example, cervical screening. Performance in this area for 2013/14 at 81.8% was in line with the national average of 81.9%. For 2014/15 performance had increased to 84.5% which was 2% above the CCG average and 2.7% above the England average.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice performance for immunisations was in line with or slightly above averages for the CCG. For example, meningococcal C (Men C) vaccination rates for 12 month old children were 84.2% compared to 82.5% locally; for two year old children 97.0% compared to 96.6%; and for five year old children 98.9% as compared to 96.6% locally.

The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination during 2013/14 was 57.0% (national average 52.3%) and the percentage of patients aged 65 or older who have received a seasonal flu vaccination was 77.8% compared to a national average of 73.2%. The percentage of patients with chronic obstructive pulmonary disease who had received an influenza immunisation during the period 1 August 2014 to 31 March 2015 was 98.5%.

The practice also offered NHS health checks for patients between the age of 40 and 74 and new patient health checks. The practice had invited 697 patients for a NHS health check between 1 September 2014 and 31 August 2015 and 387 patients had accepted the invitation.

The practice had adopted the 'Year of Care' approach as their model for providing personalised care to patients with certain long term conditions such as diabetes and obesity. This model focusses on promoting self-management and educating patients about their condition.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients we spoke with said they were treated with respect and dignity by the practice staff. Comments made by patients on Care Quality Commission (CQC) comment cards reflected this. Of the 49 CQC comment cards completed 41 were positive. Words used to describe the practice and staff included excellent, helpful, efficient, friendly, courteous, consideration and second to none. The majority of the negative comments received were in respect of delays in getting appointments, especially with a named GP.

Data from the National Patient Survey, published in January 2015, showed the practice was rated as being generally in line with CCG and national averages.The practice was also below or in line with averages for its satisfaction scores on consultations with doctors. For example:

- 87.3% said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 91% and national average of 88.6%.
- 86.5% said the GP gave them enough time compared to the CCG average of 90.2% and national average of 86.8%.
- 92.9% said they had confidence and trust in the last GP they saw compared to the CCG average of 96.1% and national average of 95.3%

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was considerate and caring whilst remaining respectful and professional. This was clearly appreciated by the patients who attended the practice. We saw that any questions asked or issues raised by patients were handled appropriately and the staff involved remained polite and courteous at all times. National GP Patient Survey results showed that 89.1% of respondents found the receptionists at the practice helpful compared with the CCG average of 89.9% and national average of 86.9%.

Reception staff made efforts to ensure patients' privacy and confidentiality was maintained. Voices were lowered and personal information was only discussed when absolutely necessary. A separate room was available if a patient wished to speak to a receptionist in private.

Staff were familiar with the steps they needed to take to protect patients' dignity. Consultations took place in 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.

Staff were aware of the need to keep records secure and maintain confidentiality and had received training on information governance. We saw that patient records were computerised and systems were in place to keep them safe in line with data protection legislation.

Care planning and involvement in decisions about care and treatment

The National GP Patient Survey information we reviewed showed patients response was slightly below average in relation to questions about their involvement in planning and making decisions about their care and treatment. For example, the survey showed 79.5% of the 119 patients who responded to the survey said the last GP they saw or spoke to involved them in decisions about their care and 86.8% said the last nurse they saw or spoke to involved them in decisions about their care. Both these results were slightly lower than the CCG and national averages.

The majority of the survey results for the practice were slightly lower than the national averages. For example, 78.7% of respondents described their overall experience at the GP surgery as fairly good or very good compared to the CCG average of 88% and national average of 85.2%. The percentage of patients who stated they would recommend the surgery to someone new to the area was 66.8% (CCG average 79.9%, national average 78%). Practice staff felt this may have been due to problems they had experienced in the past whereby patients had reported that they found it difficult to get an appointment within an acceptable timescale. The practice had tried to address this problem, however, by tightening up the procedure for dealing with patients who regularly did not attend for appointments, encouraging patients to cancel and reschedule appointments online and signposting patients to other healthcare professionals such as the practice nurses or local pharmacies.

We saw that a translation and interpretation service was available for patients who did not have English as their first

Good

Are services caring?

language and a hearing loop was available for patients with a hearing impairment. Providing this type of service helps to promote patients' involvement in decisions about their care and treatment.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our visit told us staff responded compassionately when they needed help and provided support when required. The CQC comment cards we received were also consistent with this feedback. For example, patients commented that staff were helpful, courteous, respectful, considerate and friendly.

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.

The practice was proactive in identifying and responding to the needs of carers and had forged effective working relationships with the local carers association (West Cumbria Carers) and other support agencies to which patients could be signposted. A comprehensive carer's pack was available giving carers information on various support mechanisms. Clinicians had carer's association referral and information pads on their desks which they could give to patients during consultations. West Cumbria Carers attended the practice for two hours one day per week and were involved in trying to identify carers and provide support services. In addition the carers association also promoted and attended the annual flu vaccination clinic and helped to identify patients with dementia. Bookable appointments slots were available with the carers association in the practice. West Cumbria Carers told us that the practice was proactive in identifying and signposting carers and that the majority of the carers they worked with were as a result of a GP referral (86 of the 136 referrals they received for the period 1 July 2014 to 30 June 2015).

The practice adhered to the six step end of life care strategy for its palliative patients to ensure they were involved in decisions about their pre and post death care. A lead GP had been identified for palliative care patients. Patients experiencing bereavement were regularly discussed at multi-disciplinary meetings to consider whether support or intervention was required. Referrals were made to the Cruse bereavement service or the Local Area Co-ordinator. The practice information leaflet gave practical advice to patients on what to do in times of bereavement. Two of the GPs were undertaking a mental health diploma and the practice was in discussion with mental health commissioners with a view to developing a mental health GP with specialist interest (GPwSI) service.

The National GP Patient Survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 88.2% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88.7% and national average of 85.1%.
- 93.4% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93.5% and national average of 90.4%.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had introduced several initiatives to ensure it was responding to the needs of its patient population. These included:

- The development of a consultant led in-house frail and elderly clinic and the secondment of a falls champion from the local Community Trust which had resulted in a reduction in the number of unplanned admissions to hospital
- The employment of paediatric nurses and the hosting of a weekly consultant led paediatric outpatient clinic
- Delivering a minor injuries service under an enhanced service arrangement to ensure patients did not have to travel some distance to the nearest accident and emergency department
- Introducing remote diagnosis of patients suffering from atrial fibrillation who had access to a smart phone. This involved patients downloading an application onto their smart phone which, when used in conjunction with a small handheld device issued by the practice could take an electrocardiogram (ECG) reading. This information was then recorded in the application and could be used by the patient or clinicians to diagnose the condition. The results could also be printed off for consideration by cardiologists following a referral.
- Introducing remote monitoring for patients at risk of stroke and taking warfarin (a blood thinning agent used to prevent blood clots). This involved the patient being given a small hand held device to use at home to test their own blood. The results would then be input into an automated telephone system by way of the telephone keypad. This information would then be reviewed by a nurse to determine the correct warfarin dosage and this would be communicated to the patient, together with the required date for the next test by another automated phone call.

The practice had policies and systems in place to check the safety and effectiveness of their remote monitoring arrangements. Remote monitoring was felt to be more convenient for patients, encouraged patients to self-manage their conditions and free up appointments with GPs and practice nurses; however, there were concerns that funding for this initiative would cease.

The practice had a higher than England average number of patients over the age of 75 (9.6% compared to the national average of 7.6%) but ensured that all of these patients had a named GP and were offered a health check where appropriate. The practice was proactive in identifying and responding to the needs of carers.

The practice could demonstrate that it had considered suggestions for improvement and changes to the way services were delivered as a consequence of feedback from patients. This had included ensuring patients were informed of possible delays in being called in for their appointment time as soon as possible or offered an alternative appointment or appointment with a practice nurse.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups of people in the planning of its services. The practice had access to a telephone translation service if required for those patients for whom English was not their first language. The practice also maintained registers for patients with caring responsibilities, patients with learning disabilities and patients receiving palliative care. All of these measures helped to ensure that all patients had equal opportunities to access the care, treatment and support they needed.

The premises were situated on the ground floor of the building which met the needs of people with disabilities. The reception area, treatment and consultation rooms were all accessible by those with mobility difficulties and there was step free and wheelchair access to the building. The practice had a car park and on-street parking was readily available free of charge nearby

The practice had male and a female GPs, which gave patients the ability to choose to see a doctor of a particular sex if preferred.

Patients were easily able to register with the practice and patients who were not registered, such as holiday makers or those of no fixed abode/homeless were able to access appointments as temporary residents or by using the practice address as their home address.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

The practice was the only GP surgery in Cumbria to host a Local Area Co-ordinator, a role developed by Cumbria County Council as an early intervention measure to prevent people from reaching crisis point and to reduce the pressure on local health, social care and other services.

Relevant patients were signposted to the Local Area Co-ordinator to provide a single point of contact for people requiring information, advice and support and to enable and encourage those most at need to develop personal and local networks to fulfil their vision of a good life.

The practice reported that although Maryport only represented 2% of the Cumbria population the practice had 10% of the Cumbria population receiving treatment for drug and alcohol dependency on its list. They had responded to this by ensuring they had developed an effective working relationship with Unity (a drug and alcohol recovery service) who had a weekly presence in the surgery. Two of the GPs were undertaking a mental health diploma and the practice was hopeful that it would be able to deliver a mental health service in future.

Access to the service

Surgery opening times were between 8.00am to 6.00pm on a Monday to Friday with appointments running from 8.10am to 12.20pm and 2.00pm to 5.20pm. The practice ensured that there was a GP on-site each weekday until 6.30pm to deal with emergencies. The practice also held a GP led emergency appointment/walk-in system for urgent cases from 9.00am to 11.00am and 2.00pm to 5.00pm on a Monday to Friday.

The practice had recognised the needs of different groups in the planning of its services. For example, the practice offered an extended opening time up to 7.00pm one night per week and pre-bookable telephone consultations to ensure the needs of people who worked and students could be accommodated. 42.9% of the practice population were reported to be in work or full time education compared to the national average of 60.2%.

The majority of the patients we spoke with and those who completed Care Quality Commission (CQC) comment cards said they were satisfied with the appointment system operated by the practice. Of the patients who participated in the 2015 National GP Patient Survey published in July 2015, 85.6% said they could easily get through to someone at the practice on the telephone (CCG average 80.3%; national average 74.4%) and 71.9% stated they were satisfied with the practice opening hours (CCG average 77.8%; national average 75.7%).

Appointments could be booked in the surgery, by telephone or online. We looked at the practice's appointment system during our inspection and found that a routine appointment was available with a GP two days later. Urgent appointments were available the same day and telephone consultations were available by appointment. Requests for home visits were triaged to ascertain whether a more appropriate course of action was appropriate.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed there was an answerphone message advising the called to ring the NHS 111 service for further advice and guidance.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was designated to handle all complaints and would investigate complaints in conjunction with the GP partners.

We saw that information detailing how to make a complaint was included in the practice information leaflet, on a poster displayed in the waiting room and on the practice website.

The practice recorded 18 complaints for the period 1 April 2014 to 31 March 2015. From the complaints we looked at we found that they had been dealt with appropriately and apologies issued where a complaint was felt to be justified. Lessons learned and matters arising from complaints were disseminated to practice staff via team meetings with the aim of trying to identify trends and themes. Staff were able to give us examples of where action had been taken when concerns had been identified.

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. This was clearly outlined in their statement of purpose which outlined their commitment to:

- Providing high quality patient-centered primary care services
- Focussing on the prevention of chronic diseases by promoting health living advice
- Providing their patients with an enviroment which is comfortable, relaxing and friendly
- Engaging and involving patients in decisions about their care

The staff we spoke to told us they understood and were committed to their roles and responsibilities in relation to this.

The practice had a written business plan and all staff and PPG members were involved in its development by way of business planning meetings. One of the goals/objectives the practice was currently working on was to improve the premises to create more space with the aim of being able to develop a community café for local residents at the front of the building. This would give people a place to meet, purchase affordable and healthy food and access advice and voluntary organisations. The practice was working in conjunction with the Ewanrigg Local Trust, which had been set up with Big Lottery funding to make the community and area a better place in which to live.

Governance Arrangements

There was a clear leadership structure with named members of staff in lead roles. For example, there were GPs leads for safeguarding, cancer/palliative care and QOF performance. Another of the GPs was the nominated Caldicott Guardian (member of staff responsible for protection patients' confidentiality and enabling appropriate information sharing). Members of staff we spoke with told us they were clear about their own roles and responsibilities as well of the roles of others. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared drive on any computer within the practice. We looked at a sample of these policies and procedures which were up to date.

The practice held regular staff, clinical and practice meetings. We looked at minutes from recent meetings and found that performance, quality, risks and issues outstanding from previous meetings had been discussed.

Leadership, openness and transparency

The practice manager was responsible for human resource policies and procedures. A staff handbook was available and policies and procedures were easily accessible both electronically and in paper format. All new staff went through an induction process and an induction pack was available.

We found there were good levels of staff satisfaction which had resulted in a stable workforce and good staff retention rates. Staff we spoke with were proud of the practice and felt it was well led and a good place to work. They told us there was an open and honest culture within the practice and they were happy to raise issues both informally and during team meetings.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comments and complaints received.

The practice had an active patient participation group (PPG) consisting of approximately six male and 14 female members with representation from the 25-34, 45-54, 55-64, 65-75 and 75+ age groups. The PPG met on a monthly basis, produced a regular newsletter and carried out annual patient surveys. The priorities identified from the survey carried out in August 2014 and resulting actions were:

- Delays in obtaining a routine appointment. As a result the practice had reviewed its process for dealing with patients who did not attend booked appointments and further promoted the use of online services to book and cancel appointments
- Delay in being called in at appointment time. Patients will now informed of anticipated delay when they attend the surgery and asked if they would like to reschedule.

Are services well-led?

Good

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

- Length of time in being called in for an emergency/walk in appointment. A dedicated receptionist is now allocated to the walk in clinic and will inform patients that they will be seen in order of urgency and if delays are likely.

The patient participation group had also donated a suggestion box to the practice to enable continual feedback from patients.

The practice had considered reviews posted on the NHS Choices website and had signed up to the 'I Want Great Care' campaign where patients could provide feedback on the care afforded to them by GP practices and hospitals. The practice has received a 5 star rating on the 'I Want Great Care' website and a number of very positive comments.

The practice gathered feedback from staff through staff meetings and on a more informal day to day basis. Staff we spoke with told us they regularly attended staff meetings and felt these 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 and management. Staff told us they felt involved and engaged in the practice which they said helped to improve outcomes for both staff and patients.

A whistle blowing policy was in place which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of the policy, how to access it and said they would not hesitate to raise any concerns they had.

Management lead through learning and improvement

The practice provided staff with opportunities to continuously learn and develop. The practice nurse told us they had opportunities for continuous learning to enable her to retain her professional registration and develop the skills and competencies required for chronic disease management. Regular staff appraisals were taking place and personal development plans identified.

The practice had regularly reviewed significant events and other incidents with a view to identifying any trends or themes and determine learning opportunities. These events were shared with relevant staff as and when appropriate through team meetings.

Innovation

We saw several areas of innovation during our inspection, including:

- The practice 'daily lunch bite' meetings which gave all staff groups a daily opportunity to discuss concerns and for feedback from training, significant events, complaints and clinical audits to be shared
- The practice had developed a consultant led frail and elderly clinic which had reduced unplanned admissions to hospital for patients in that group
- The practice was the only GP surgery in Cumbria to host the Local Area Co-ordinator
- The practice had empowered its patients with atrial fibrillation and those at risk of stroke and taking Warfarin to remotely monitor their conditions.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.