Catherine Street Surgery

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Catherine Street Surgery on 13 November 2014 and visited the surgery in Whitehaven. We inspected this service as part of our comprehensive inspection programme.

Overall, we rated the practice as good, although there were some areas where the practice should make improvements. Our key findings were as follows:

- Patients reported good access to the practice, with urgent appointments available the same day.
- Patients said, and our observations confirmed, they were treated with kindness and respect by staff who worked in the practice
- Patient outcomes were generally at the average for the locality and good practice guidance was referenced.
- The practice was visibly clean and tidy.
- The practice learned from incidents and took action to prevent a recurrence.

We saw the following area of outstanding practice:

- The practice employed a co-ordinator to work with patients who were at risk of falls. The co-ordinator focused on patients who did not have input from other clinical services, for example Community Matrons or District Nurses. These patients were generally housebound and not regular attenders of the practice. The co-ordinator completed an assessment of their needs. If it was identified patients could benefit from changes to daily living, the co-ordinator would facilitate the change by working with other agencies. Re-assessments of people's need would be completed by the co-ordinator after an agreed time to measure the impact of any changes made.

However, there were also areas of practice where the provider should make improvements.

- Patients were kept waiting in the practice to see a GP up to one hour beyond their allotted appointment times. We also found it was difficult for patients to get an appointment with the male (locum) GP or the GP of their choice, as their appointments were frequently fully booked.

Summary of findings

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were around average for the locality. Staff referred to good practice guidance and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for caring. Patients said they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect, ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Feedback from patients indicated that urgent appointments were available the same day, although access to a named GP was not always available quickly. Patients told us they had to wait well beyond their appointment times to see a GP and other feedback the practice had received from patients reflected this. The practice was equipped to treat patients and meet their needs. Patients could get information about how to complain in a format they could understand. The practice did not offer extended opening hours on weekdays or at weekends.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a vision and strategy and staff were clear about their responsibilities in relation to this. There was a leadership structure and staff felt supported by management. The practice had a number of policies

Summary of findings

and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients, which it acted on. The patient participation group (PPG) had recently been set up. Staff had received inductions, performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice employed an elderly care co-ordinator who provided support, social contact and facilitated input from other agencies for patients who were not otherwise accessing services.

People with long term conditions

Good

The practice is 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. Longer appointments and home visits were available when needed. All these patients had a named GP and 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 is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and we saw evidence to confirm this. 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 and health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The age profile of patients at the practice is mainly those of working age, students and the recently retired. The practice did not offer extended opening

Summary of findings

hours for appointments. Patients could request repeat prescriptions and cancel appointments online, however they could not book appointments online. The practice offered a range of health promotion and screening that reflected the needs for this age group. Health promotion advice and material was available through the practice and on its website.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and longer appointments were available on request.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice provided information and told patients experiencing poor mental health about how to access various support groups. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for patients with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with seven patients who were mostly complimentary about the services they received at the practice. They told us the staff who worked there were helpful and friendly. They also told us they were treated with respect and they found the premises to be clean and tidy. Patients were generally happy with the appointments system. Some of the patients said they were unhappy with the length of time they had to wait when visiting the practice for an appointment with a doctor.

We reviewed three CQC comment cards completed by patients prior to the inspection. Feedback left by patients reflected what the patients we spoke with had told us. Patients were generally happy with the staff and services provided, however some comments were made with regards to having to wait too long for their appointments.

The latest National GP Patient Survey completed in 2013 showed patients were mostly satisfied with the services the practice offered. The results were mainly in line with other GP practices locally, and in some areas, including waiting time to be seen, not so good. The results included:

- The proportion of respondents who would recommend their GP surgery– 64.6%;
- The proportion of respondents who stated that the last time they wanted to see or speak to a GP or nurse from their GP surgery, they were able to get an appointment – 93.8%;
- GP Patient Survey score for opening hours– 83.3%;
- The proportion of respondents who gave a positive answer to 'Generally, how easy is it to get through to someone at your GP surgery on the phone – 82.2%;
- Percentage of patients rating their experience of making an appointment as good or very good – 86.9%;
- The proportion of respondents who described the overall experience of their GP surgery as good or very good – 81.8%.

These results were based on 98 surveys that were returned from a total of 281 sent out; a response rate of 35%.

Areas for improvement

Action the service SHOULD take to improve

Patients were kept waiting in the practice to see a GP up to one hour beyond their allotted appointment times. We also found it was difficult for patients to get an appointment with the male (locum) GP or the GP of their choice, as their appointments were frequently fully booked.

Outstanding practice

The practice employed a co-ordinator to work with patients who were at risk of falls. The co-ordinator focused on patients who did not have input from other clinical services, for example Community Matrons or District Nurses. These patients were generally housebound and not regular attenders of the practice. The co-ordinator completed an assessment of their needs. If it was identified patients could benefit from changes to daily living, the co-ordinator would facilitate the change by working with other agencies. Re-assessments of people's need would be completed by the co-ordinator after an agreed time to measure the impact of any changes made.

Catherine Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP.

Background to Catherine Street Surgery

The practice is located in the centre of Whitehaven. The practice covers the area of Whitehaven and the areas that immediately surround it on the West coast of Cumbria. The practice provides services from the following address and we visited here during this inspection:

3 Catherine Street, Whitehaven, Cumbria, CA28 7PD.

The practice is based in a two storey building. A disabled parking bay is located directly in front of the practice building and the practice also offers wheelchair access and a WC that can be accessed by all patients. On-site parking for patients is not provided. The practice provides services to just over 2,700 patients of all ages based on a General Medical Services (GMS) contract agreement for general practice.

The practice has two GP partners (both female) and uses a regular locum GP (male) one day per week. The practice also employs two practice nurses, one health care assistant, a practice manager and a team of administrative, reception and support staff.

The service for patients requiring urgent medical attention out-of-hours is provided by Cumbria Health on Call (CHoC).

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. This service had been inspected before in May 2014 as part of our pilot programme. At that inspection we identified some action the practice must take to improve. This was because the practice did not have effective systems to regularly assess and monitor the quality of services provided. As part of this inspection we reviewed whether the practice had made improvements. We found improvements had been made in this area.

How we carried out this inspection

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

- 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
- Mothers, babies, children and young people

Detailed findings

• The working-age population and those recently retired

• People in vulnerable circumstances who may have poor access to primary care

• People experiencing poor mental health

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. This did not highlight any significant areas of risk across the five key question areas. As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. This included the local Clinical Commissioning Group (CCG).

We carried out an announced visit on 13 November 2014. We spoke with seven patients and nine members of staff from the practice. We spoke with the practice manager, two GPs, two practice nurses and four administrative and reception staff. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed three CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Safe Track Record

Patients we spoke with said they felt safe when they came into the practice to attend their appointments.

As part of our planning we looked at a range of information available about the practice. 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 used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibility to raise concerns, and how to report incidents and near misses. Staff said there was an individual and collective responsibility to report and record matters of safety. For example, a recent incident had been recorded where a paper-based prescription query for antibiotics was lost. This had resulted in the patient receiving delayed treatment. The practice had reviewed the incident and planned to introduce an electronic solution to prevent reoccurrence as a result.

We reviewed safety records and incident reports and minutes of meetings where these were discussed. This showed the practice had managed these over a period of time and so could demonstrate a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We asked for and saw records were kept of significant events that had occurred during the last two years, and these were made available to us. Significant events were discussed at the practice's monthly meetings and a review of significant events was completed annually. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings.

We saw incident forms were available and accessible to staff within the practice. Once completed these were sent to the practice manager who managed and monitored them. We looked at some of the incidents recorded recently and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was recorded.

National patient safety alerts were disseminated by the practice manager to practice staff. Alerts were also discussed at practice meetings to ensure staff were aware of any relevant to the practice and where action needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice had a dedicated GP appointed as lead in safeguarding vulnerable adults and children who had been trained to level three to enable them to fulfil this role. Staff we spoke with were aware of who the safeguarding lead in the practice was if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments.

A chaperone policy was in place and a notice was displayed in the patient waiting area to inform patients of their right to request one. Clinical staff carried out chaperoning duties when patients requested this service.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals.

Good

Are services safe?

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators. They were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures. The practice staff followed the policy and we saw records of fridge temperatures were kept.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of carbocistene prescribing in the practice had been reviewed and discussed. Carbocistene is a medicine that can be helpful for people with a long-term respiratory disease. We saw recommendations and changes made as a result of the review had been recorded and discussed.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. Nurses had received the appropriate training for this.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. For example, the practice regularly monitored patients who were prescribed medicines known as disease-modifying anti-rheumatic drugs (DMARD's). Appropriate action was taken based on the results; for example these patients had regular blood tests.

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. The practice manager showed us plans were in place to improve how these were tracked through the practice.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice manager was the lead for infection control. All staff received induction training about infection control specific to their role and received annual updates via an e-learning package. We saw evidence that infection control audits had been completed, including in relation to minor surgery and of the building and facilities. The practice manager told us they planned to re-audit the building and facilities in the next few weeks, including to check that actions identified previously had been completed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these. There was also a policy for needle stick injury and guidance for staff to follow in the event of this was displayed in consultation and treatment rooms throughout the practice.

Notices about hand hygiene techniques were displayed in the practice. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

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

Equipment

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

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate

Good

Are services safe?

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

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. We saw records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring Safety & Responding to Risk

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

We saw the practice maintained a risk assessment register. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Examples of risks that had been assessed included for slips, trips and falls, manual handling, lone working and fire.

We saw staff were able to identify and respond to changing risks to patients including deteriorating health and medical emergencies. For example, all staff who worked in the practice were trained in cardiopulmonary resuscitation (CPR) and basic life support skills. The practice manager described a recent incident where practice staff had observed a patient in the waiting area was displaying signs of a stroke. They explained how the patient was seen straight away by a GP, who then escalated the matter further to ensure the patient received the required treatment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. The defibrillator and oxygen were accessible and records of regular checks of the defibrillator were up to date. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, loss of IT and access to the building. The practice manager told us this document was in the process of being updated to reflect some changes in contact details and we saw evidence of some changes already made.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE). We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, we were told that patients with long term conditions such as high blood pressure were invited into the practice to have their medication reviewed for effectiveness.

Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. Staff had access to the necessary equipment and were trained in its use; for example, blood pressure monitoring equipment and an electrocardiogram (ECG) machine.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. The practice manager told us care bundles were in the process of being introduced for 44 patients identified to be at risk. For example, for patients with impaired glucose tolerance. The practice also held a care plan register that listed 63 of the practice's most vulnerable patients. For example, palliative care, elderly and patients at high risk of admission to hospital.

We saw referrals were reviewed on a weekly basis at clinical team meetings. Minutes of these meetings were kept, with any action points identified and noted.

Patients we spoke with said they felt well supported by the GPs and clinical staff with regards to decision making and choices about their treatment.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

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

The practice showed us examples of clinical audits that had been undertaken in the last year. For example, one of the GPs we spoke with told us about an audit they had completed that involved patients who were prescribed contraceptive pills. The first audit cycle had been completed and change initiated and they told us they planned to re-audit in 12 months' time to measure any improvements in outcomes for patients. Another GP showed us an audit in progress that aimed to improve outcomes for patients with type two diabetes.

The practice was proactive in the management, monitoring and improving of outcomes for patients. A number of examples were provided by the staff we spoke with to support this. For example, the practice employed a co-ordinator to work with patients who were at risk of falls. The co-ordinator focused on patients who did not have input from other clinical services, for example Community Matrons or District Nurses. These patients were generally housebound and not regular attenders of the practice. The co-ordinator, with the patient's permission, would visit them in their home and complete an assessment of their needs. If it was identified patients could benefit from changes to daily living, for example through the provision of mobility aids, the co-ordinator would facilitate the change by working with other agencies. Re-assessments of patient's need would be completed by the co-ordinator after an agreed time to measure the impact of any changes made.

The practice also used the information they collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. The practice had achieved 80.1% of the points available for clinical results, which was below average compared to the local area. A GP we spoke with said it had been a difficult year for the practice and was aware improvements could be made. The practice manager said there had been some coding issues with the data; however both the GP and practice manager expected this to improve with the electronic system now in use.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by a GP. They also checked that all routine health checks were completed for

Good

Are services effective?

(for example, treatment is effective)

long-term conditions such as diabetes. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up-to-date with attending mandatory courses such as annual basic life support. All GPs were up-to-date with their yearly continuing professional development requirements.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, we found they were trained to administer vaccines. Nurses were responsible for the review of patients with long-term conditions such as asthma and were trained to fulfil this role.

We saw the practice had an induction programme to be used when staff joined the practice. This covered individual areas of responsibility. We spoke with a recently recruited member of staff who said they felt well supported by their colleagues. The practice didn't have an information pack to support locum GPs, although the practice regularly used the same locum GP for one day each week.

The administrative and support staff had clearly defined roles, however they were also able to cover tasks for their colleagues. This helped to ensure the team were able to maintain levels of support services at all times, including in the event of staff absence and annual leave.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, x-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service, were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GPs who reviewed these documents and results were responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary 'primary care meetings' weekly to discuss the needs of patients, for example, those with end of life care needs. These meetings were attended by district nurses, palliative care nurses, health visitors, midwives and others. Both of the practice's GPs attended these meetings. Staff felt this system worked well and commented on the usefulness of the meetings as a means of sharing important information.

Information Sharing

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

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were 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

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. Clinical staff we spoke with demonstrated an understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical

Good

Are services effective?

(for example, treatment is effective)

procedures, a patient's formal written consent was obtained. Verbal consent was taken from patients for routine examinations. Patients we spoke with reported they felt involved in decisions about their care and treatment.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing.

One of the tools the practice was using was 'Deciding Right', which is an initiative to integrate the principles of making advance care decisions for all ages. It brings together advance care planning, the Mental Capacity Act, cardiopulmonary resuscitation (CPR) decisions and emergency healthcare plans. It identifies the triggers for making care decisions in advance, complying with both current legislation and the latest national guidelines. It aims to ensure that care decisions are centred on the individual and minimise the likelihood of unnecessary or unwanted treatment.

Health Promotion & Prevention

The practice offered all new patients a consultation. Clinicians completed the 'new patient assessment' which involved explaining the service to the patient, reviewing their notes and medical history, and the recording of basic information about the patient. For example, confirming any medicines they were currently taking. The patient's needs were assessed and where appropriate, they were placed into the relevant monitoring service. For example, children would be placed within the immunisation programme at the appropriate point.

We found patients with long term conditions were recalled to check on their health and review their medications for effectiveness. The practice's electronic patient records system was used to flag when patients were due for review. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively. The practice wrote to patients to invite them to attend. Medicine reviews were done in the presence of the patient. Processes were in place to ensure the regular screening of patients was completed, for example, cervical screening.

Some of the patients we spoke with told us they were on regular medicines. They confirmed they were asked to attend the practice to review their conditions and the effectiveness of their medicines.

There was a range of information on display within the practice reception area. This included a number of health promotion and prevention of illness leaflets. In addition there were noticeboards dedicated to smoking cessation, information for carers and the promotion of pancreatic cancer awareness month.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

All of the seven patients we spoke with said they were treated with respect and dignity by the practice staff. Comments left by patients on CQC comment cards reflected this. Words used to describe the approach of staff included caring, attentive and professional. None of the CQC comment cards completed raised any concerns in this area.

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was considerate, understanding and caring, while remaining respectful and professional.

The reception area fronted directly onto the patient waiting area. We saw staff who worked in these areas made every effort to maintain people's privacy and confidentiality. Voices were lowered and personal information was only discussed when absolutely necessary. Phone calls from patients were taken by administrative staff in an area where confidentiality could be maintained.

People's privacy, dignity and right to confidentiality were maintained. The practice offered a chaperone service for patients who wanted to be accompanied during their consultation or examination. A private room or area was also made available when people wanted to talk in confidence with the reception staff. This reduced the risk of personal conversations being overheard.

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. For example, we observed one of the reception staff take a call from a family member who asked for some test results. The member of staff asked to speak with the patient the results were for to verify their identity and seek permission to inform them of their result before doing so.

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

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. For example, the survey showed 81% of practice respondents said the GP was good at involving them in care decisions and 80% felt the GP was good at explaining treatment and results. These results were in line with the local area and national averages.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Staff told us that translation services were available for patients who did not have English as a first language. This service was used infrequently by patients due to the small numbers of patients involved.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were generally satisfied with the emotional support provided by the practice. For example, patients commented the GPs and staff knew them well and were caring, reassuring and supportive.

Some support and signposting was provided to patients during times of bereavement. The practice manager told us the practice didn't routinely undertake bereavement visits at these times. They said this was an approach they needed to review. The practice did offer details of bereavement services to patients. They also had a pack they could give to families from MacMillan Nurses when their relatives were recognised as approaching the end of life. Staff we spoke with in the practice recognised the importance of being sensitive to people's wishes at these times.

We saw notices in the patient waiting areas also signposted patients to a number of support groups and organisations.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

As part of our pre-inspection preparation we looked at the latest demographic population data available for the practice from Public Health England, published in 2013. The practice had a lower percentage of patients under the age of 18 than the England average and a higher percentage of patients aged 65+ than the England average. The majority of the practice's population were of working age.

Patients we spoke with and those who filled out CQC comment cards all said they felt the practice was mostly meeting their needs. This included being able to access repeat medicines at short notice when this was required.

The practice understood the different needs of the population and acted, where possible, on these needs in the planning and delivery of its services. For example, patients could access appointments face-to-face in the practice, receive a telephone call back from a clinician or be visited at home. Patients could also make appointments with the GP of their choice and could see a male or female GP. The practice had two female GP partners and employed a regular male locum GP who ran a surgery once a week. Practice staff told us they deliberately used a male locum GP to ensure patients had the choice to see a male or female GP. Staff and some patients we spoke with said it was difficult at times to get an appointment with the male locum GP or the GP of their choice as their appointments were frequently fully booked. For example, the male locum GPs' next planned surgery was in four days time on the Monday following our visit. This surgery was already fully booked, meaning patients who wanted to see this specific GP had a wait of at least 11 days for an appointment with them. Patients would be seen on the same day by a GP if their need was urgent.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families' care and support needs. The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment.

The practice had carried out its own survey of patients in April 2014 and a number of actions had been identified as a result of the feedback received. We saw some of these actions had been completed and some were still in the process of being acted upon.

The practice had recently started up a patient participation group (PPG). The practice manager told us they knew patient engagement could be improved. They had recently contacted some patients who had agreed to join the group to ask their opinions on the length of patient appointment times. Feedback was still in the process of being gathered on this.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, the regular GP consulting rooms in the practice were accessed via a short flight of stairs and the main treatment room was on the first floor. Patients were able to be seen in a small consulting room that led directly from the waiting area on the ground floor. We observed this happening during the morning surgeries. This helped to improve access for those patients who had mobility difficulties. The practice also had access to telephone translation services if required, for those patients whose first language was not English.

The premises and services had been reasonably adapted to meet the needs of people with disabilities. Access via the main entrance was suitable for patients with mobility difficulties. The patient toilet could be accessed by patients with disabilities and disabled parking bays were provided directly in front of the main entrance. We saw the height of the main reception desk counter made it difficult for patients who used a wheelchair to speak with the reception staff face-to-face.

The practice provided staff with equality and diversity training. Staff we spoke with confirmed that they had completed the training.

Access to the service

Patients we spoke with and those who filled out CQC comment cards all said they were satisfied with the appointment systems operated by the practice. They said they could see a doctor on the same day if they needed to and could see another doctor if there was a wait to see the doctor of their choice. This was reflected in the results of the most recent national GP Patient Survey (2013/14). This showed 90% of patients who responded were able to get

Good

Are services responsive to people's needs?

(for example, to feedback?)

an appointment to see or speak to someone the last time they tried and 95% said the last appointment they received was convenient. These results were based on the responses of 98 patients and were above the weighted CCG (local area) averages.

Appointments were available from 9.00am to 5.30pm on weekdays. The practice did not offer extended opening hours. We asked the practice manager about this and they told us extended hours used to be offered. They said this part of the service was withdrawn as it was felt it was not sustainable. Practice staff we spoke with told us some appointments were kept for urgent matters. We looked at the practice's electronic appointments booking system, which confirmed this. Patients we spoke with told us they had been able to access these appointments at times of urgent need.

Information was available to patients about appointments on the practice website. This included how to arrange appointments and home visits. Consultations were provided face-to-face at the practice, over the telephone, or by means of a home visit by the GP. This helped to ensure patients had access to the right care at the right time.

There were also 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 giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The practice's contracted out of hours provider was Cumbria Health on Call (CHoC).

Feedback from a number of sources suggested the practice had problems with patients being kept waiting well beyond their allotted appointment times on a regular basis. Patients we spoke with, CQC comment cards completed by patients, patient surveys and staff we spoke with all indicated this was an issue. For example, the most recent GP patient survey showed only 40% of respondents usually waited 15 minutes or less after their appointment time to be seen and only 43% felt they didn't normally have to wait too long to be seen. Both of these results were well below the weighted CCG (local area) averages.

Patients we spoke with also said they did not feel they were always kept informed of any delays to their appointments.

Some of the patients we spoke with said they had been kept waiting up to an hour beyond their allotted appointment times in the past. We spoke with the practice manager about the concerns raised and they confirmed it was a problem the practice needed to resolve. We saw some actions had already been taken in an attempt to resolve the problem. These included notices to inform patients if GPs were running late, reminders to staff to keep patients informed, asking patients if they would prefer longer appointments and contacting other practices for advice. The practice manager said improvements were still required.

The practice was situated at ground and first floor levels and services for patients were provided from both. We saw that the ground floor waiting area was large enough to accommodate patients with wheelchairs and prams. Accessible toilet facilities were available for all patients attending the practice.

Listening and learning from concerns & 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 the practice had received 10 formal complaints since April 2013 and these had been reviewed as part of the practice's formal review of complaints. Where mistakes had been made, it was noted the practice had apologised formally to patients and taken action to ensure they were not repeated. Complaints and lessons to be learned from them were discussed at staff meetings.

Staff we spoke with were aware of the practice's policy and knew how to respond in the event of a patient raising a complaint or concern with them directly. We saw the practice had a 'suggestion box' in place for patients to use. The practice also encouraged comments and suggestions through their website and made reference to their complaints policy in the practice leaflet.

None of the seven patients we spoke with on the day of the inspection said they had felt the need to formally complain to the practice before. Some patients said they had raised some concerns informally and felt they had been resolved at that time.

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 vision to deliver high quality care and promote good outcomes for patients. This was not formally documented, however it was evident in discussions we had with staff throughout the day that it was a shared vision.

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

Governance Arrangements

At the previous inspection in May 2014 we found the practice had monitoring processes in place, however these were not followed by some members of staff within the practice. The practice sent us an action plan which had been completed following our inspection. This included the action they were going to take to meet the regulation and the timescales within which this would be achieved. At this inspection we reviewed whether the practice had made improvements. We found improvements had been made in this area.

The practice had a number of policies and procedures in place to govern activity and these were available to staff. We asked some of the staff we spoke with to show us how they accessed these and all were able to do so. The practice manager told us some policies had been recently reviewed and updated and others still required review. The policies we looked at confirmed and reflected this statement.

The practice held regular governance meetings where matters such as performance, quality and risks were discussed. We saw minutes of meetings held were recorded and circulated to the appropriate staff. Agenda items at practice meetings included audit activity, significant events and complaints. Weekly clinical meetings were attended by GPs and attached clinical staff and records showed areas such as safeguarding, palliative care and hospital discharges were discussed.

The practice had completed or was in the process of conducting clinical audits, for example for patients prescribed contraceptive pills and for diabetic patients prescribed insulin. The results of these audits had resulted in change being initiated to improve outcomes for patients. This was to be measured at the time of re-audit.

The practice had procedures in place for checking and monitoring the content of the emergency medicines and equipment bags. We saw records of checks completed to demonstrate this was being followed and the sample of emergency drugs and equipment we checked were all in date.

Leadership, openness and transparency

The practice had a leadership structure which had named members of staff in lead roles. For example, the practice manager was the lead for infection control and a GP partner was the lead for safeguarding. We spoke with nine members of staff and they were all clear about their own roles and responsibilities.

We saw from minutes that staff meetings were held regularly. Staff told us that there was an open culture within the practice and they were actively encouraged to raise concerns and suggestions for improvement. Staff reported feeling well supported in their roles and felt they could talk to the practice manager and clinical staff at any time if they had concerns. The practice manager told us they operated an open door policy, which reflected what staff had told us.

Practice seeks and acts on feedback from users, public and staff

Staff we spoke with told us they regularly attended staff meetings. They said these provided them with the opportunity to discuss the service being delivered and to raise any concerns they had. We saw the practice also used the meetings to share information about any changes or action they were taking to improve the service and they actively encouraged staff to discuss these points.

The practice had recently started up a patient participation group (PPG). We saw this was being advertised in the practice waiting areas and on the practice's website. The practice manager said they had a number of patients who had agreed to take part, however they still wanted to recruit more members. We saw the practice had already asked members of the group for their opinions on the length of GP appointments. This was in response to problems the practice had with patients being kept waiting beyond their appointment times.

Are services well-led?

Good

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

We saw the practice had recently trialled some 'Friends and Family' style questionnaires with patients ahead of its proposed launch in December 2014. The practice manager had not formally reviewed the responses received yet.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions on a daily basis. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning & improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was supportive of training and development opportunities.

The practice had completed reviews of significant events and other incidents and shared these with staff via meetings. Staff meeting minutes showed these events were discussed, with actions taken to reduce the risk of them happening again. Staff we spoke with referred to the open and honest culture within the practice and the aim to learn and improve outcomes for patients. The practice had completed reviews of significant events and other incidents and shared with staff via meetings to ensure the practice improved outcomes for patients.

The practice manager met regularly with other practice managers in the area and shared learning and experiences from these meetings with colleagues. GPs met with colleagues at locality and CCG meetings. They also attended learning events and shared information from these with the other GPs in the practice.