Caldbeck 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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Outstanding
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Caldbeck Surgery on 6 November 2014.

We rated the practice overall as good.

Our key findings were as follows:

- The practice covered a large geographical and rural area; services had been designed to meet the needs of the local population.
- Feedback from patients was very positive; they told us staff treated them with respect and kindness.
- Staff reported feeling supported and able to voice any concerns or make suggestions for improvement.

We saw some areas of outstanding practice including:

- All staff were aware of and sympathetic to, the particular difficulties faced by the local, rural, population. The practice had taken action to help address some of those issues.
- There was an allocated doctor each morning who solely carried out home visits. Prescriptions were delivered to patients twice a week. In addition, the practice worked with a local community charity to transport patients to and from the practice.
- Clinicians were active within the GP community and had a long and successful history of training new GPs.

There was also an area of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure that prescriptions are checked and signed by GPs before medicines are dispensed and issued to patients.

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?

Requires improvement

The practice is rated as requires improvement for safe. Processes were in place to identify unsafe practices and measures put in place to prevent avoidable harm to people. The practice learned from incidents and took action to prevent a recurrence. Staff were aware of safeguarding procedures and took appropriate action when concerns were identified.

The arrangements for the signing of repeat prescriptions before medicines were dispensed were not robust.

Are services effective?

Good

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

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

Are services caring?

Good

The practice is rated as good for caring. Feedback from patients about their care and treatment was consistently and strongly positive. Several patients commented that staff went 'above and beyond' their level of duty. We observed a patient centred culture and found many positive examples to demonstrate how people's choices and preferences were valued and acted on.

Patients had access to health information and advice when needed, and they received support to manage their own health and illness. Staff demonstrated they understood the support patients needed to cope with their care and treatment.

Are services responsive to people's needs?

Outstanding

The practice was rated as outstanding for responsive. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations.

Patients were able to access appointments in a timely way. They reported good access to the practice and told us urgent same day appointments were always available. The practice made the best

Summary of findings

use of the facilities they had available to enable consistency of services in rural locations. There was an allocated doctor each morning who solely carried out home visits. The practice provided a prescription delivery service twice a week. In addition, the practice worked with a local community charity to transport patients to and from the practice.

Patients over 75 patients had been given a named GP to help promote continuity of care. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to any issues raised. There was evidence of learning from complaints with staff and other stakeholders. The practice had implemented suggestions for improvement and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG).

Are services well-led?

Good

The practice is rated as good for well-led. Staff were clear about the practice's vision and their responsibilities in relation to this. Feedback we received from patients showed they felt valued and well cared for by staff. There was an established management structure within the practice. Staff reported feeling supported and valued by their peers. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and acted on any relevant suggestions.

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.

The practice had a higher proportion of patients over the age of 65 compared to other practices nationally. All patients over the age of 75 had a named accountable GP and had been informed by letter of this. Arrangements were in place to review all patients over the age of 75 every six months, or more frequently if clinically necessary. The practice was responsive to the needs of older people, including offering home visits each day to those who needed them.

The practice provided services for people who cared for others (carers). This included working with local organisations and maintaining a practice register of carers.

The practice had close links with a range of healthcare professionals for patients who required additional support. This included district and Macmillan nurses and health visitors.

There were systems in place to offer vaccinations to older people, including pneumococcal vaccinations and an annual flu vaccination.

People with long term conditions

Good

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

The practice had systems to ensure care was tailored to individual needs and circumstances, this took into account patient's expectations, values and choices. We spoke with GPs and nurses who told us regular patient care reviews took place at six monthly or yearly intervals; for example for patients with chronic obstructive pulmonary disease (COPD) or asthmatic conditions. These appointments included a review of the effectiveness of their medicines, as well as patients' general health and wellbeing.

The most up to date available Quality and Outcomes Framework (QOF) data showed the practice was achieving nearly all of its points. It had achieved 95.37% of the available points for the 'clinical areas'; a significant number of which related to the management of patients with long term conditions.

Summary of findings

The practice ensured timely follow up of patients with long term conditions by adding them to the practice registers. Patients were then recalled as appropriate, in line with agreed recall intervals.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

We saw the practice had processes in place for the regular assessment of children's development. This included the early identification of problems and the timely follow up of these. Systems were in place for identifying and following-up children who were considered to be at-risk of harm or neglect. For example, the needs of all at-risk children were regularly reviewed at practice multidisciplinary meetings involving child care professionals such as school nurses and health visitors.

The practice advertised services and activities available locally to families. Lifestyle advice for pregnant women about healthy living, including smoking cessation and alcohol consumption was given by the GPs and midwives.

Appointments were available outside of school hours and the premises were suitable for children and babies. Arrangements had been made for new babies to receive the immunisations they needed.

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).

Access to services for patients in this population group was in line with that for other patient groups. This included flexible appointment times, same day telephone call-backs from clinicians and home visits, should these be required. Patients also had the facility to book GP appointments online, once they had registered with the practice for this service. Appointments were available up to 18.30 Monday to Friday.

The practice was proactive in offering a full range of health promotion and screening, which reflected the needs of this age group. We saw health promotional material was made easily accessible through the practice's website. This included signposting and links to other websites including those dedicated to weight loss, sexual health and smoking cessation.

Summary of findings

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.

Systems were in place to identify patients, families and children who were at risk or vulnerable. These patients were offered regular reviews.

The practice communicated with other agencies, for example health visitors, to ensure vulnerable families and children were monitored to make sure they were safe. The practice received letters from services who treated patients for addictions. This helped them to monitor their recovery.

Nationally reported data showed the practice had achieved good outcomes in relation to meeting the needs of patients with learning disabilities and mental health needs. Registers were maintained, which identified which patients fell into these groups. The practice used this information to ensure patients received an annual healthcare review and access to other relevant checks and tests.

The practice sign-posted vulnerable patients to various support groups and other relevant organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of their responsibilities to ensure vulnerable adults and children were safeguarded.

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).

Nationally reported data showed 96% of people with physical or mental health conditions had received an offer of support and treatment within the last 15 months. 100% of patients with dementia had their care reviewed within the preceding 12 months. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had signposted patients experiencing poor mental health to support groups, including Mind.

Summary of findings

What people who use the service say

We spoke with 13 patients, including three members of the practice's Patient Participation Group. We spoke with people from different age groups, who had varying levels of contact and had been registered with the practice for different lengths of time.

Everyone told us they were happy with the care they received. They said they were treated with respect and were generally positive about staff. However, some patients felt the standards at the practice had not been as high recently. Patients reported that most staff treated them with dignity and respect and always allowed them time, they did not feel rushed.

We reviewed 18 CQC comment cards which had been completed by patients prior to our inspection. All were complimentary about the practice, staff who worked there and the quality of service and care provided.

The latest National GP Patient Survey completed in 2014 showed that most patients were satisfied with the services the practice offered. All of the results were among the best for GP practices nationally. The results were:

- The proportion of patients who would recommend their GP surgery – 94% (nationally 78%);
- GP Patient Survey score for opening hours – 92% (nationally 77%);
- Percentage of patients rating their ability to get through on the phone as very easy or easy – 98% (nationally 73%);
- Percentage of patients rating their experience of making an appointment as good or very good – 91% (nationally 75%);
- Percentage of patients rating their practice as good or very good – 96% (nationally 86%).

Areas for improvement

Action the service MUST take to improve

Ensure safe systems are in place for updating medicines records following hospital discharge, and prescriptions are checked and signed by GPs before medicines are dispensed and issued to patients.

Outstanding practice

The practice was considered to be outstanding in terms of their responsiveness. Many patients lived in rural areas with limited access to public transport. There was an allocated doctor each morning who solely carried out home visits. The practice provided a prescription delivery service twice a week. In addition, the practice worked with a local community charity to transport patients to and from the practice.

Caldbeck Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team also included a GP, a practice manager and a CQC pharmacy inspector.

Background to Caldbeck Surgery

Caldbeck Surgery is located in the village of Caldbeck in Cumbria and provides primary medical care services to patients living in the village and surrounding rural areas. The practice provides services to around 4,400 patients, spread over approximately 700 square miles within the Lake District National Park.

The practice provides services from one location, Friar Row, Caldbeck, Wigton, Cumbria, CA7 8DS. We visited this address as part of the inspection.

The practice is located within a purpose built single storey building. It also offers on-site parking, a disabled WC, wheelchair and step-free access.

The practice has five GP partners, (4 female and 1 male) one training doctor (GP registrar), two practice nurses, a healthcare assistant, a practice manager, an assistant practice manager and six staff who carry out reception and administrative duties. There is a dispensary within the practice; this is supported by a practice medicines manager and staffed by eight dispensing staff.

Surgery opening times at the practice are between 8:30am and 6:30pm Monday to Friday.

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

Why we carried out this inspection

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

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

When we previously inspected the practice in April 2014 we told the provider that they were not compliant with Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Management of Medicines. We said "Service users were not protected against the risks associated with unsafe use and management of medicines because appropriate arrangements were not in place for the use, safe administration and recording of medicines used".

The provider told us they would take steps to ensure the information was available. During this inspection we checked that improvements had been made.

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

Detailed findings

How we carried out this inspection

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

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

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

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

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. 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 also spoke with three members of the practice's Patient Participation Group (PPG).

We carried out an announced visit on 6 November 2014. We spoke with 13 patients and 10 members of staff from the practice. We spoke with and interviewed three GPs, the practice manager, the assistant practice manager, the medicines manager, two members of the nursing team and two staff carrying out reception and administrative duties. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 18 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.

Requires improvement

Are services safe?

Our findings

Safe track record

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how the practice operated. Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards reflected this.

Information from the Quality and Outcomes Framework (QOF), which is a national performance measurement tool, showed that in 2013-2014 the practice appropriately identified and reported incidents. Where concerns arose they were addressed in a timely way.

We saw mechanisms were in place to report and record safety incidents, including concerns and near misses. The staff we spoke with demonstrated an understanding of their responsibilities and could describe their roles in the reporting process. They told us there was an individual and collective responsibility to report and record matters of safety. Where concerns had arisen, they had been addressed in a timely manner. We saw outcomes and plans for improvement arising from complaints and incidents were discussed and recorded within staff meeting minutes.

We reviewed significant event reports completed by practice staff, and the minutes of meetings where these had been discussed over the previous 12 months. These showed the practice had dealt with such events consistently.

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

Learning and improvement from safety incidents

The practice was open and transparent when there were near misses or when things went wrong. There was a system in place for reporting, recording and monitoring significant events. We spoke with the practice manager about the arrangements in place. They told us that all staff had responsibility for reporting significant or critical events. There was a folder on the practice computer system in which records were kept of significant events. These records were made available to us. We looked at four significant or critical events records. We found details of the event, key risk issues, specific action required and learning outcomes and action points were noted. There was evidence that significant events were discussed at clinical and general staff meetings, to ensure learning was disseminated and implemented.

We saw there had been a significant event where a patient had not been recalled on a timely basis. We saw evidence that a thorough investigation had taken place. This had identified some key learning points, which had been shared with the relevant staff. The changes were implemented and the practice told us they would be reviewed at a later date to confirm they remained effective.

We discussed the process for dealing with safety alerts with the assistant practice manager. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. They told us alerts came into the practice from a number of sources, including the NHS England and the local clinical commissioning group (CCG). Any alerts were reviewed by one of the GP partners and the assistant practice manager, information was then disseminated to relevant members of staff. For example, medicines related safety alerts were forwarded to the medicines manager for action. The assistant practice manager was able to give examples of recent alerts and how these had been responded to. A record had been kept to indicate when alerts had been reviewed and found not to be relevant to the practice. We were told where safety alerts affected the day-to-day running of the practice; all staff would be advised via an email or in a practice meeting.

Reliable safety systems and processes including safeguarding

We saw the practice had safeguarding policies in place for both children and vulnerable adults. There were identified members of staff with clear roles to oversee safeguarding within the practice. This role included reviewing the procedures used in the practice and ensuring staff were up to date and well informed about protecting patients from potential abuse. The GPs discussed ongoing or new safeguarding issues during their daily meetings.

The staff we spoke with had a good knowledge and understanding of the safeguarding procedures and what action should be taken if abuse was witnessed or suspected. We saw records which confirmed all staff had

attended training on safeguarding. All practice staff had attended Level 1 safeguarding for adults and children. Clinical staff had, in addition, completed Level 2 training and the safeguarding lead had attended Level 3 training. A Level 3 training event had been scheduled for the near future so other GPs could attend.

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

The practice did not have a formal whistleblowing policy in place. However, staff we spoke with were all able to explain how, and to who, they would report any such concerns. They were all confident that concerns would be acted upon.

The practice had a chaperone policy. A notice was displayed in the patient waiting area and in all of the consultation rooms to inform patients of their right to request a chaperone. We asked staff about how the role of chaperone was fulfilled within the practice. They told us that a practice nurse or healthcare assistant undertook this role. Staff we spoke with were clear about the requirements of the role.

Medicines management

When we last inspected in April 2014 we found out of date medication in three of the doctors' bags. There were no systems in place to check the contents of the bags. The practice told us they had taken action to address our concerns.

During this inspection we found all of the medication in the bags was in date and robust systems to carry out regular checks had been introduced.

We checked medicines and vaccines stored in the medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Maximum and minimum temperatures of the refrigerators were checked daily. The practice manager told us that there was a power cut during the night prior to the inspection. The temperature readings showed that for a period of time the refrigerator that contained the vaccines was too warm for safe storage. This could affect the quality of vaccines resulting in their not being fully effective. The practice nurse contacted the appropriate authorities for advice on action to take such as quarantining the vaccines to prevent further use. The procedure for managing failure of vaccines fridges was being reviewed.

Medicines storage in the dispensary was secure. However, we saw that medicines that were awaiting collection were not stored in the locked dispensary when the practice was shut. 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. Blank prescription forms were handled in accordance with national guidance and these were kept securely.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of directions that were signed by the nurses who used them.

We saw that regular clinical audit was done to improve the way medicines were managed. For example, audits of the prescribing of antibiotics were done to promote safe and effective use. We saw processes in place for managing national alerts about medicines such as safety issues. Records showed that the alerts were distributed to relevant staff for implementation. Alerts were discussed and action plans were produced and implemented to promote patient safety.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had standard procedures in place that set out how they were managed. Controlled drugs were stored in a controlled drugs cupboard and the keys held securely. There were arrangements in place for the destruction of controlled drugs. The records for the receipt and supply of controlled drugs were incomplete because the register being used did not allow suppliers' and patients' addresses to be recorded. The medicines manager was looking to order an appropriate register so that all the legally required information could be recorded.

There were protocols for medicines management that were followed in practice and covered all required areas, for example, the generation of repeat prescriptions by staff. Protocols were regularly updated and staff were familiar with them.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the

Requires improvement

Are services safe?

Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. We saw records showing members of staff involved in the dispensing process had received appropriate training and had regular checks of their competence.

Staff told us how patient requests for repeat prescriptions were checked for evidence of an up-to-date medication review and patient compliance with taking medicines based on the frequency of requests. They said that if they had concerns these would be raised with the GPs before prescriptions were issued.

We found some areas where the practice must improve the way it manages medicines.

Staff told us that repeat prescriptions were signed by GPs at the end of the day. This meant that some medicines were dispensed before the GP checked and signed to confirm that the prescription was correct

We saw there was a system in place for reviewing hospital discharge letters. These were scanned and sent to the GP on duty. We were told that sometimes the GP would make any necessary changes to patients' medication records. However, sometimes the task of updating medication records was delegated to the medicines manager. There was no system to ensure that these changes to medicines records were made correctly.

Cleanliness and infection control

We looked around the practice and saw it was clean, tidy and well maintained. Patients we spoke with told us they were happy with the cleanliness of the facilities. Comments from patients who completed CQC comment cards reflected this.

The practice had a nominated infection control lead. We saw there was an up to date infection control policy and detailed guidance for staff about specific issues. For example, action to take in the event of a spillage. All of the staff we spoke with about infection control said they knew how to access the practice's infection control policies.

The risk of the spread of infection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment (PPE), such as aprons and gloves, were available for staff to use. The treatment room had walls and flooring that was impermeable, and easy to clean. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels. The privacy curtains in the consultation rooms were cleaned monthly. We saw records confirming this had taken place.

The practice employed its own domestic staff. We saw the domestic staff completed cleaning schedules, on a daily, weekly, monthly and annual basis. One of the practice nurses carried out regular infection control audits.

We saw there were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We looked at some of the practice's clinical waste and sharps bins located in the consultation rooms. All of the clinical waste bins we saw had the appropriately coloured bin liners in place and all of the sharps bins we saw had been signed and dated as required.

The practice carried out regular checks of the water system for legionella (a type of bacteria found in the environment which can contaminate water systems in buildings).

Staff were protected against the risk of health related infections during their work. We asked the reception staff about the procedures for accepting specimens of urine from patients. They showed us there was a box for patients to put their own specimens in. The nursing staff then used PPE to empty the box and transfer the specimens. We confirmed with a practice nurse that all clinical staff had up to date hepatitis B vaccinations. We saw there were spillage kits (these are specialist kits to clear any spillages of blood or other bodily fluid) located in the treatment room.

Equipment

Staff had access to appropriate equipment to safely meet patients' needs. The practice had a range of equipment in place that was appropriate to the service. This included medicine fridges, patient couches, access to a defibrillator and oxygen on the premises, sharps boxes (for the safe disposal of needles), electrocardiogram (ECG) machines and fire extinguishers. We looked at a sample of medical and electrical equipment throughout the practice. We saw regular checks took place to ensure the equipment was in working condition.

Staffing and recruitment

We saw the practice had recruitment policies in place that outlined the process for appointing staff. These included

processes to follow before and after a member of staff was appointed. We reviewed the records for the two most recently appointed members of staff and found the appropriate recruitment checks had been completed.

All clinical staff that were in contact with patients and the practice managers had been subject to Disclosure and Barring Service (DBS) checks, in line with the recruitment policy.

The practice employed sufficient numbers of suitably qualified, skilled and experienced staff. The practice manager said when a GP was on leave or unable to attend work, another GP from the practice provided cover. Some of the administrative staff worked 'annualised hour's, which meant they were flexible and could provide additional cover when needed.

We asked the practice manager how they assured themselves that GPs and nurses employed by the practice continued to be registered to practice with the relevant professional bodies (For GPs this is the General Medical Council (GMC) and for nurses this is the Nursing and Midwifery Council. They said the practice paid for GPs GMC registration, which assured them of their registration status. They told us they checked the registration status for nurses every six months. We saw records which confirmed these checks had been carried out.

Monitoring safety and responding to risk

Feedback from patients we spoke with and those who completed CQC comment cards indicated they would always be seen by a clinician on the day if their need was urgent.

Appropriate staffing levels and skill-mix were provided by the practice during the hours the service was open. Staff we spoke with were flexible in the tasks they carried out. This meant they were able to respond to areas in the practice that were particularly busy. For example, within the reception on the front desk receiving patients or on the telephones.

The practice had well established systems in place to manage and monitor health and safety. The assistant practice manager carried out daily checks of the premises. The fire alarms and emergency lights were tested on a monthly basis. The practice manager told us fire drills were carried out every six months.

The assistant practice manager showed us a number of risk assessments which had been developed, including the security of the building, clinical rooms and work stations. Risk assessments of this type made sure the practice was aware of any potential risks to patients, staff and visitors and planned mitigating action to reduce the probability of harm.

Arrangements to deal with emergencies and major incidents

The practice had detailed plans in place to ensure business continuity in the event of any foreseeable emergency, for example, fire or flood. The practice manager told us these plans had been successfully put into place during power failures.

Each of the doctors had their own 'on-call' bag. This meant if they were called to a rural area some distance from the practice they would have the appropriate equipment available without having to return to the practice.

Staff had sufficient support and knew what to do in emergency situations. The practice had resuscitation equipment, oxygen and medication available for managing medical emergencies. All of the staff we spoke with told us they had attended CPR (resuscitation) training. The practice manager told us clinical staff attended CPR training every 18 months and administrative staff every three years. We looked at records which confirmed this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. We found all of the GPs had a good level of knowledge and there was a strong emphasis on keeping up to date with clinical guidelines, including guidance published by professional and expert bodies. This was monitored by regular reviews of referrals.

All clinicians we interviewed were able to describe and demonstrate how they access guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners (Cumbria Clinical Commissioning Group (CCG)).

The clinicians we interviewed demonstrated evidence based practice. New guidelines and the implications for the practice's performance and patients were discussed at the daily GP meetings. Whilst there was no formal policy for ensuring clinicians remained up-to-date, all the GPs interviewed were aware of their professional responsibilities to maintain their knowledge.

The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. We spoke with staff about how the practice helped people with long term conditions manage their health. They told us that there were regular clinics where people were booked in for recall appointments. This ensured people had routine tests, such as blood or spirometry (lung function) tests to monitor their condition.

Interviews with three GP partners and the practice nurse demonstrated that the culture within the practice was to refer patients onto other services on the basis of their assessed needs, and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Delivery of care and treatment achieved positive outcomes for people. We reviewed the most recent Quality and Outcomes Framework (QOF) results for the practice for the year 2013/2014. The QOF is part of the General Medical Services (GMS) contract for general practices. Practices are rewarded for the provision of quality care. We saw the practice had scored high on clinical indicators within the QOF. They achieved 95.3%, which was better than the England average of 92.3%.

The practice had a system in place for completing clinical audit cycles, which led to improvements in clinical care. We saw a number of clinical audits had recently been carried out. The results and any necessary actions were discussed at the weekly primary healthcare meetings. Examples of clinical audits included an audit of the anticoagulation service (anticoagulation medicines are most commonly prescribed for people who have had a condition caused by blood clots or who are at risk of developing one) and of medicines wastage. We saw both audits had been completed earlier this year; plans were in place to repeat the audits to measure the impact of any changes made.

An audit on patients diagnosed with cancer identified some actions which could lead to improvements in patient care. We found the practice had responded to the issues identified. For example, having a named GP in each case to co-ordinate care and increased use of the practice information system to monitor dates for blood tests and patient reviews. These changes had recently been implemented, so the practice had not yet reviewed whether this initiative had been successful.

We reviewed a range of data available to us prior to the inspection relating to health outcomes for patients. These demonstrated that the practice was performing the same as, or better than average, when compared to other practices in England. There were no areas of risk identified from available data. For example, a higher proportion of patients defined as 'at risk' from influenza (61%) had received the seasonal vaccination compared to the national average (52%). There were no emergency hospital admissions for cancer patients; this was well below the national average.

Complete, accurate and timely performance information was published by the practice on their website. This included the results of the patient survey and the subsequent action plan.

Effective staffing

Staff were appropriately qualified and competent to carry out their roles safely and effectively.

Good

Are services effective?

(for example, treatment is effective)

All staff received an annual appraisal which identified their learning and development needs and goals that had been agreed. The staff we spoke with confirmed the practice was proactive in providing training and funding for relevant courses.

There was a strong emphasis on training. The practice was a designated training practice for GP registrars and had a long history of training new GPs. One of the GP partners was a designated trainer, two of the other GP partners had previously been trainers and another was a former postgraduate tutor.

We reviewed staff training records for a selection of staff, and saw that they had attended mandatory training, such as annual basic life support. Staff had their training needs assessed and were supported to update their skills and knowledge, The staff we spoke with confirmed this. The nurses in the practice were registered with the Nursing and Midwifery Council (NMC). To maintain their registration they must undertake regular training and updating of their skills. The GPs in the practice were registered with the General Medical Council (GMC) and were also required to undertake regular training and updating of their skills.

Staff had opportunities for professional development beyond mandatory training. One of the nurses told us they had been supported to go on other courses when training needs were identified. For example, they said they had requested and been given the opportunity to attend a course on allergies. Monthly open forums were held for all staff, during which there was the opportunity to review educational needs.

Once a month the practice closed for an afternoon for Protected Learning Time (PLT). Some of the time during these afternoons was dedicated to training. Some training was also delivered by external experts, for example, a Macmillan nurse delivered a session on palliative care.

We saw evidence which confirmed that all GPs undertook annual appraisals and that they had all 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 with the GMC).

Working with colleagues and other services

The practice worked closely with other health and social care providers, to co-ordinate care and meet people's needs. We saw various multi-disciplinary meetings were arranged. This included a weekly primary healthcare meeting, which involved practice staff and district nurses. The practice safeguarding lead had good relationships with social services, health visitors and school nurse services. We found regular, both formal and informal, information sharing meetings were held. There were well established links with a local hospice and Macmillan nurses. This helped to share important information about patients including those who were most vulnerable and high risk. We saw a clinical meeting had recently been arranged to co-ordinate care for a patient with complex needs who was in hospital.

We found appropriate and effective 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 and the ambulance service.

Information sharing

The practice had systems in place for recording information from other health care providers. This included out of hours services and secondary care providers, such as hospitals.

We spoke with clinical staff about the how information was shared with the out of hours services in the local area, 111 and Cumbria Health On Call. Staff told us that patient information received from the out of hours service was of good quality and received on time in the morning. The practice manager confirmed that all faxed information from the out of hours provider, was passed to one of the GPs to review. The GP then identified any action needed and passed the information to an administrator to scan and attach to the electronic clinical patient notes. Staff told us that this normally happened on the same day the information was received.

Consent to care and treatment

Before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. We asked staff how they ensured they obtained patients' consent to treatment. Staff were all able to give examples of how they obtained verbal or implied consent. We saw where necessary, written consent had been obtained, for example, for minor surgery procedures or contraceptive implants.

Good

Are services effective?

(for example, treatment is effective)

GPs we spoke with showed they were knowledgeable about how and when to carry out Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Decisions about or on behalf of people who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the Mental Capacity Act (MCA). We found the doctors were aware of the MCA and used it appropriately. The doctors described the procedures they would follow where people lacked capacity to make an informed decision about their treatment. They gave us some examples where patients did not have capacity to consent. The doctors told us an assessment of the person's capacity would be carried out first. If the person was assessed as lacking capacity then a "best interest" discussion needed to be held. They knew these discussions needed to include people who knew and understood the patient, or had legal powers to act on their behalf.

One of the GP partners had completed a law degree and had provided training on confidentiality and consent issues during a PLT.

Health promotion and prevention

The practice proactively identified people who needed ongoing support. This included carers, those receiving end of life care and those at risk of developing a long term condition. Patients with long term conditions were reviewed each year, or more frequently as necessary.

We found that new patients were offered a 'new patient check', with one of the GPs, to ascertain details of their past medical histories, social factors including occupation and lifestyle, medications and measurements of risk factors (e.g. smoking, alcohol intake, blood pressure, height and weight). Any new patients who were on repeat medication had to see a GP before the prescription was issued. The practice strictly followed this policy, if necessary any new patients were seen by the duty doctor to ensure medication could be prescribed on a timely basis.

Information on a range of topics and health promotion literature was available to patients in the waiting area of the practice. This included information about screening services, smoking cessation and child health. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. The practice's website also provided some further information and links for patients on health promotion and prevention.

We saw posters on display throughout the building, to inform patients of the availability of chlamydia testing kits in the toilets. The practice was keen to promote use of the tests, so the kits were left in the toilets to ensure anonymity for those patients who wished to use them.

The practice offered a full range of immunisations for children, as well as travel and flu vaccinations. GPs told us they had arranged several dedicated flu clinics and also offered the vaccination to those patients in the 'at risk' clinical groups during consultations. The percentage of patients in these clinical groups, who had received a seasonal flu vaccination, was higher than the overall average for other practices in the local CCG area.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with 13 patients during our inspection. They were all happy with the care they received. People told us they were treated with respect and were positive about the staff. Comments left by patients on the 18 CQC comment cards we received also reflected this. Words used to describe the approach of staff included caring, attentive, courteous, understanding, polite, helpful and sympathetic.

We looked at data from the National GP Patient Survey, published in July 2014. This demonstrated that patients were satisfied overall with the practice. In particular, the practice performed better than national and local average scores on the helpfulness of reception staff, the experience of making an appointment, and on GPs and nurses treating them with care and concern.

Staff were familiar with the steps they needed to take to protect people's dignity. Consultations took place in purposely designed consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. There were signs, both in the waiting room and in the consultation rooms explaining that patients could ask for a chaperone during examinations if they wanted one. Patients we spoke with were aware that chaperones were available.

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

Care planning and involvement in decisions about care and treatment

Patients told us they felt they had been involved in decisions about their care and treatment. They said the clinical staff gave them plenty of time to ask questions and responded in a way they could understand. They were satisfied with the level of information they had been given. We reviewed the 18 completed CQC comment card, all patients commented positively on their experience. One person commented that any problems were thoroughly explained. Another told us that any issues were explained, without them having to ask the doctors.

The results of the National GP Patient Survey from July 2014 showed patients felt the GPs and nurses involved them in decisions about their care. The survey showed 89% of respondents felt doctors involved them in decisions, and 78% said nurses involved them. These results were well above the national averages (doctors 75%, nurses 67%).

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

Patient/carer support to cope emotionally with care and treatment

Many people commented that the staff at the practice 'went the extra mile'. One patient told us the doctors often just called in to see her elderly friend when they were passing. Another patient told us staff from the practice had been very supportive following a family bereavement.

The practice maintained a register of patients who cared for others (carers). Support was provided in partnership with a local community charity (Northern Fells Group).

The practice had good links with palliative care services. The clinical staff within the practice met daily and weekly information sharing meetings were held with district nurses. This helped to ensure patients were supported appropriately. One of the GPs had studied for a diploma in palliative care and told us the practice had a strong ethos of fulfilling patients' wishes. This level of care was reflected in some of the comments made by patients on the CQC comment cards.

Support was provided to patients during times of bereavement. The practice also offered details of bereavement services upon request, with information displayed on notice boards in the patient waiting area. Staff we spoke with in the practice recognised the importance of being sensitive to people's wishes at these times. Support was tailored to the needs of individuals, with consideration given to their preference at all times.

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.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Staff understood the needs of the key population groups living within the area covered by the practice. Systems were in place to address these needs and the practice was responsive to them.

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 average male life expectancy for the practice population was 80.30 and female life expectancy was 82.62. The percentage of patients aged 65 years and above (25.4%) was much higher than the England average for practices (16.5%).There were also 23.5% of patients who reported having caring responsibilities, well above the national average of 18.5%.

Staff told us that one the biggest challenge in terms of patient demographics was the rural nature of the practice boundaries and the availability of public transport locally. Some of the outlying villages had only infrequent bus services, which made travelling by public transport difficult. In addition, a relatively high proportion of patients were elderly and/or housebound.

The practice had processes in place to address patients' needs. There was an allocated doctor each morning who solely carried out home visits. The practice provided a prescription delivery service twice a week. In addition, the practice worked with a local community charity to transport patients to and from the practice.

Staff told us that where patients were known to have additional needs, such as being hard of hearing, were frail, or had a learning disability, this was noted on the medical system. This meant the GP or nurses would already be aware of this and any additional support could be provided, for example, a longer appointment time. The clinicians would also always go to the waiting area to escort the patient to the consultation room.

There was information available to patients in the waiting room and reception area, about support groups, clinics and advocacy services.

The PPG members we spoke with before the inspection both told us the practice took notice and responded to requests and concerns the group fed back to them. They said this included simple things, for example, a suggestion had been made to have music in the waiting room. They said this had been done and was welcomed by the PPG and patients in general.

Tackling inequity and promoting equality

The practice was set in a rural location and patients lived in an area of approximately 700 sq. miles. A relatively high proportion of the patients were elderly and/or housebound. We found the practice had good arrangements in place to ensure it met the needs of its patients. Some of the staff told us they also visited patients on their way to or from the practice. This was confirmed by some of the patients we spoke with.

Only a small minority of patients did not speak English as their first language. There were arrangements in place to access interpretation services.

Free parking was available in a car park directly outside the building. The practice building was accessible to patients with mobility difficulties. We saw there were low level pads on the walls at the entrance to the practice, when pressed the doors would open automatically. The consulting rooms were large with easy access for all patients. There was also a toilet that was accessible to disabled patients. There was a large waiting room with plenty of seating; including smaller chairs for children and an orthopaedic high backed chair.

There was a play area in the waiting room with a selection of plastic and easy to clean toys. We saw that this facility was well liked and used by children visiting the surgery.

Access to the service

The practice is open between 8:30am and 6:30pm Monday to Friday.

Patients were able to book appointments either by calling into the practice, on the telephone or using the on-line system. Face to face and telephone consultations were available to suit individual needs and preferences. Due to the rural nature of the area covered by the practice, home visits were also made available every day.

The practice manager told us if a patient wanted an emergency appointment then they could have one the same day. This was confirmed when we observed reception staff taking calls from patients; patients were offered appointments on the same day. If there were no appointments available then a 'task' would be sent via the

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

practice's computer system to one of the GPs (the duty doctor). The duty doctor would then telephone the patient and if necessary ask them to attend the practice later in the day.

All of patients we spoke with, and those who filled out CQC comment cards, said they were satisfied with the appointment systems operated by the practice. Many people commented that they were able to get an appointment or speak to someone at short notice. This was reflected in the results of the most recent National GP Patient Survey (2014). This showed 91% of respondents were satisfied with booking an appointment and 92% were satisfied with the practice's opening hours. These results were 'among the best' for GP practices nationally.

We found the practice had an up to date leaflet which provided information about the services provided, contact details and repeat prescriptions. The practice also had a clear, easy to navigate website which contained detailed information to support patients. This included several 'How do I' guides, for example, 'register at the practice', 'get test results' and 'get help out of surgery hours.'

Listening and learning from concerns and complaints

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

The complaints policy was outlined in the practice brochure and was available on the practice's website. The practice also had a comments box situated in the waiting room to enable patients to provide feedback about the service provided. In addition, there was a large display in the reception area advertising a website where patients could rate the service.

None of the 13 patients we spoke with during the inspection said they had felt the need to complain or raise concerns with the practice. In addition, none of the 18 CQC comment cards completed by patients indicated they had felt the need to make a complaint.

Staff we spoke with were aware of the complaints policy. They told us they would deal with minor matters straight away, but would inform the practice manager of any complaints made to them. This meant patients could be supported to make a complaint or comment if they wanted to.

We saw the practice had received two formal and two informal complaints within the last 12 months. We reviewed these and found the complaints had been recorded and fully investigated. We found the practice listened and learned from the complaints. For example, following one complaint about a patient's long wait for medication, a session was held with clinical staff in relation to sending prescriptions through to the dispensary.

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. We found details of the vision and practice values were part of the practice's statement of purpose. The practice vision and values included providing the highest possible standards of treatment and care and meeting the needs of the population living in a rural area.

We spoke with 10 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. They all told us they put the patients first and aimed to provide person-centred care.

Practice objectives were reviewed during monthly business team meetings and shared with all staff. Six monthly 'strategic' meetings were also held. These focussed on how the practice could maintain service provision in the future. Issues such as staff age and the likelihood of retirement were discussed. Succession planning was an ongoing consideration.

Governance arrangements

The practice had a clear corporate structure designed to support transparency and openness. There were a number of policies and procedures in place to govern activity. These were available to all staff electronically on a shared drive. We looked at a range of these policies and procedures and found most covered the relevant areas in sufficient detail and incorporated national guidance and legislation.

The GPs on duty met each morning before the practice opened. In addition, weekly primary healthcare team meetings were held, attended by the GPs and practice nurse team. These sessions were used to discuss any serious incidents, complaints and clinical governance issues in detail. Any lessons learnt or actions identified were then cascaded to the other members of the team.

The practice manager and GPs actively encouraged staff to be involved in shaping the service. The practice held 'open forums' at least twice a month. These sessions gave staff further opportunities to put forward ideas and suggestions. All of the staff we spoke with told us they felt comfortable to challenge existing arrangements and looked to continuously improve the service being offered.

Staff told us they were aware of the decision making process. For example, staff who worked within reception demonstrated to us they were aware of what they could and couldn't do with regards to requests for repeat prescriptions. We also found clinical staff had defined lead roles within the practice, for example, safeguarding and infection control. The purpose of the lead roles was to liaise with external bodies where necessary, act as a point of contact within the practice and ensure the practice remained up to date with any new or emerging guidance. Other staff were aware of who the leads were and told us they would approach them if they had any concerns or queries.

The practice used data from the QOF to measure their performance. The QOF data showed the practice was performing in line with practices nationally. We saw that QOF data was discussed at practice management meetings. This helped ensure all staff were aware of how the practice was performing and to reach consensus about any actions that needed to be taken.

There was a programme of clinical and internal audit in place. For example, annual infection control and health and safety audits. The practice nurse had recently carried out an audit of the cold chain and fridge storage of vaccines. Regular clinical audits were undertaken. One of the GPs told us about an audit on the number of referrals to neurology outpatient services. Records of the audit showed the results had been analysed and there was a note outlining any actions required.

The practice had suitable arrangements in place for identifying, recording and managing risks. For example, an up-to-date fire safety risk assessment was in place, and there were risk assessments to minimise the risks associated with the use of IT equipment.

Leadership, openness and transparency

There was a well-established management structure with clear allocation of responsibilities. The GPs all had individual lead roles and responsibilities, for example, safeguarding, risk management, performance and quality. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. Managers had a good understanding of, and were sensitive to, the issues which affected patients and staff. For example, there was an awareness of how poor weather conditions may impact on people being able to get to the practice. We saw contingency plans were in place to address this.

Are services well-led?

Good

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

We saw all practice staff met regularly and mechanisms were in place to support staff and promote their positive wellbeing. Minutes of team meetings were available and were circulated to staff. Staff told us there was an open culture in the practice and they could report any incidents or concerns they might have. This ensured honesty and transparency was at a high level. We saw evidence of incidents that had been reported, and these had been investigated and actions identified to prevent a recurrence. Staff told us they felt supported by the practice manager and the clinical staff and they worked well together as a team.

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

All of the practice staff met regularly. There were various weekly meetings, including a practice meeting attended by the GPs, nurses and practice management team. In addition, all of the GPs on duty met each morning before the surgery opened.

There were monthly dispensary and reception team meetings and training sessions. Staff told us they felt listened to and were able to raise any concerns they had.

Feedback from the patients was sought in a variety of ways, including comments box and directions to a patient care website. Any comments received were taken to the monthly business team meeting for discussion and decision on any action necessary. Patient feedback was also shared with all staff to ensure they were aware of any concerns or compliments.

The practice had an established Patient Participation Group (PPG). The members represented a cross section of the practice population. The PPG generally met every few months; all minutes were available on the practice website or at reception upon request.

PPG members told us they were fully involved in how the practice operated. They told us they were involved in setting objectives with the practice for the year ahead, and contributed to any changes required following the annual patient survey. They said they were listened to and felt that patient opinion and feedback was always welcomed by the practice and suggestions were acted upon.

Management lead through learning and improvement

The practice had management systems in place which enabled learning and improved performance. They showed us how they made use of the Clinical Commissioning Group (CCG)'s comparative data to analyse performance.

The practice was also taking part in a national programme 'The Productive Practice'. The programme is an 'approach to support practices in their drive to improve productivity. It helps to create improvement capability, engages the whole practice team, improves working life of staff, supports patient involvement and develops safer services'.

We saw practice staff met on a regular basis. Minutes from the meetings showed the team discussed clinical care, audit results, significant events and areas for improvement. Staff from the practice also attended the CCG protected learning time (PLT) initiative. This provided staff with dedicated time for learning and development.

Staff also told us that the practice was very supportive of training. They said had received the training they needed, both to carry out their roles and responsibilities and to maintain their clinical and professional development.

The team met monthly to discuss any significant incidents that had occurred. The practice had a robust approach to incident reporting in that it reviewed all incidents. Staff we spoke with discussed how action and learning plans were shared with all relevant staff and meeting minutes we reviewed confirmed that this occurred. Staff we spoke with could describe how they had improved the service following learning from incidents and reflection on their practice. We were told this was done in an open, supportive and constructive way.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Patients who used the service and others were not protected against the risks associated with the unsafe use and management of medicines because of inadequate arrangements for authorising, prescription forms.**