

Liverpool House 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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Liverpool House Surgery on 5 November 2014.

This was the second inspection of the practice. We inspected in May 2014 and identified areas for improvement. During our inspection on 5 November we found action had been taken to address these concerns.

Overall we have rated the practice overall as good. Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services.

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
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Feedback from patients was overwhelmingly positive, they told us staff treated them with respect and kindness.
- Staff reported feeling supported and able to voice any concerns or make suggestions for improvement
- The practice was clean and hygienic, and good infection control arrangements were in place.

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?

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 widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Good



Are services effective?

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. NICE guidance is referenced and used routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice could demonstrate that all staff had received an appraisal in which personal development plans were recorded. We saw evidence that staff worked well with other multidisciplinary teams.

Good



Are services caring?

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

Good



Are services responsive to people's needs?

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. 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 issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Good



Summary of findings

Are services well-led?

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



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

The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst 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. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for all patients.

Good



People with long term conditions

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. Longer appointments and home visits were available when needed. All these patients had a named GP and structured annual reviews to check 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.

Good



Families, children and young people

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. There were two young people who were part of the PPG.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group.

Good



Summary of findings

People whose circumstances may make them vulnerable

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. Annual health checks for people with learning disabilities were offered. Patients had the option to book longer appointments as necessary.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector 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 and out of hours.

Good



People experiencing poor mental health (including people with dementia)

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

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations including MIND and SANE. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for people with mental health needs and dementia.

Good



Summary of findings

What people who use the service say

We reviewed 36 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 NHS England GP Patients Survey completed in 2013 showed the large majority of patients were satisfied with the services the practice offered. The results were amongst the best when compared with GP practices nationally.

The results were:

- The proportion of patients who would recommend their GP surgery – 97.8%

- GP Patient Survey score for opening hours – 93.6%
- Percentage of patients rating their ability to get through on the phone as very easy or easy – 94%
- Percentage of patients rating their experience of making an appointment as good or very good – 89.8%
- Percentage of patients rating their practice as good or very good – 100%.

We looked at some websites which capture patient feedback. We saw all responses were very positive about the practice.

Liverpool House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team also included a GP specialist advisor.

Background to Liverpool House Surgery

Liverpool House Surgery is situated in the town centre of Barrow-in-Furness, Cumbria. The practice provides primary medical services to 5,373 people in the town and surrounding villages, from one location, 69 Risedale Road, Barrow in Furness, Cumbria, LA13 9QY. We visited this address as part of the inspection.

Surgery opening times at the practice are between 0800 and 1830 Monday to Friday. The practice offers extended services so is open from 0730 on Mondays and Wednesdays.

There are three doctors working at the practice, supported by two practice nurses, a healthcare assistant and administration team. Out of hours provision is provided by Cumbria Health On Call (CHOC).

Liverpool House Surgery is housed in an older building and former commercial premises. We saw that the outside of the building needed attention and the sign with the name of the surgery was missing.

Services are provided over two floors, there is limited access for people with mobility difficulties as they cannot access the upper floor. We saw that there were plans to relocate the practice to a modern spacious building in 2016.

There is a visiting midwife service and access to a community matron who covers three practices. A podiatrist and Improving Access to Psychological Therapies (IAPT) staff also provide treatment sessions within the practice.

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.

This provider had been inspected in May 2014 when we identified areas for improvement. This inspection was undertaken to review what improvements the practice had made. In addition a full inspection was performed to enable us to give a current rating for the service.

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 that time.

How we carried out this inspection

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

- Is it safe?

Detailed findings

- 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
- The working-age population and those recently retired (including students)
- 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 also spoke with two members of the practice's Patient Participation Group (PPG).

We carried out an announced visit on 5 November 2014. We spoke with five members of staff from the practice. We spoke with and interviewed the practice manager, one GP, a practice nurse and two staff carrying out reception and administrative duties. We observed how staff received and spoke with patients as they arrived at or telephoned the practice. We reviewed 36 CQC comment cards where patients and members of the public had shared their views and experiences of the service. We looked at results from the NHS England GP survey and the survey carried out by the practice's PPG. We also looked at records the practice maintained in relation to the provision of services.

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, which is a national performance measurement tool, showed that in 2012-2013 the practice appropriately identified and reported incidents. Where concerns arose they were addressed in a timely way.

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.

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.

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

We reviewed safety and incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term. The practice could also demonstrate that learning and improvement had resulted from safety incidents.

The practice had a system in place for the reporting, recording and monitoring of significant events. Records were kept of events that had occurred during the last year and these were made available to us. A slot for significant events was on the monthly practice meeting agenda to review actions from past events and complaints. 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 and felt encouraged to do so.

We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager. The practice manager showed us the system they used to manage and monitor incidents. We tracked eight incidents and saw records were completed in a comprehensive and timely manner. None of these incidents had resulted in a formal complaint made to the practice. We saw evidence of action taken as a result, for example, the practice reviewed its relationship and communication methods with the local safeguarding team.

National patient safety alerts were also reviewed by the practice manager then disseminated to practice staff as appropriate. Staff we spoke with were able to give examples of recent alerts relevant to their role within the team.

Reliable safety systems and processes including safeguarding

We found that the practice had a strong safeguarding process, with comprehensive policies and procedures in place to protect vulnerable patients. There was a named clinical lead in the practice, all staff had undergone training and were aware of the safeguarding process. Staff had a good understanding of safeguarding and knew how to recognise risks and respond appropriately.

The practice had a dedicated GP appointed as the lead in safeguarding. They had been trained at a higher level of training (Level 3), and could demonstrate they had the necessary knowledge to enable them to fulfil this role. We saw that all other staff had attended Level 1 training sessions. All staff we spoke with were aware who these lead was and who to speak to in the practice if they had a safeguarding concern. A health visitor was based at the practice which enabled staff to contact them easily to share information related to children.

Are services safe?

We saw that there were regular meetings held in the practice with the safeguarding lead, health visitors, district nurses, children's nurse, midwives and a nurse with key responsibilities for looked after children.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff, including health care assistants. If nursing staff were not available to act as a chaperone then reception staff would be utilised.

Four receptionists had undertaken training and understood their responsibilities when acting as a chaperone, including where to stand to be able to observe the examination.

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

The practice held a register of frail and elderly, and housebound patients. This highlighted which of their patients were at risk.

Medicines Management

Liverpool House Surgery had processes in place to regularly review and monitor the prescribing of medication. The practice had a pharmacy optimising manager attached to the surgery with whom they worked closely to address concerns around prescribing. We saw that they had quarterly meetings to address concerns and action plans were developed and agreed.

The provider had been identified as being an outlier in some prescribing areas. Examples of those were high prescribing of antibiotics and benzodiazepine prescribing. Benzodiazepines are used in the treatment of anxiety, panic attacks, insomnia, seizures and muscle spasms. The pharmacy optimising manager had established clinics in the practice to work with patients to reduce the use of benzodiazepines. The prescribing trends in the practice were benchmarked with other practices in the Cumbria area. This meant that the practice could see how their prescribing compared to other practices and identify any differences or concerns.

We saw that practice used electronic prescribing and people could order repeat prescriptions at the surgery or by telephone. The practice had introduced a system for monitoring the use and issuing of prescription pads to prevent their loss of within the practice.

In May 2014 we found that medicines stored in the practice were not kept safe and secure nor was their usage monitored.

At this inspection we saw improvements had been made and processes had subsequently been implemented to check the storage, use and expiry of medication. We saw that there were now systems in place to check and monitor the contents of the doctor's bags carried on home visits.

We saw that checks were in place to ensure medication was stored at the correct temperature. The practice had contracts in place to ensure the safe disposal of unwanted medicines.

We looked at how vaccines were ordered and checked on receipt and stored. We saw that regular checks were in place to ensure vaccines were stored appropriately.

When we inspected in May 2014 we saw that the keys were left in fridge door which held the vaccines and the room was left unattended at times. During this inspection we saw the practice had a system for safe storage of the keys and was in the process of fitting new locks to all consulting and treatment room doors. This enabled the practice to maintain safety when not these rooms were not in use.

Cleanliness & Infection Control

We saw that the premises were clean and tidy. Patient's told us they always found the practice clean and had no concerns about cleanliness.

The practice had systems and processes in place to monitor cleanliness and infection control. We saw that policies and procedures were detailed and had been reviewed and there were cleaning schedules available for the rooms and offices. This provided the cleaning staff with details of what needed to be cleaned and the frequency. There was a named lead for infection control, they undertook infection control audits, risk assessments and monitoring of the environment.

When we inspected in May 2014 we looked at infection control audits undertaken in 2012 and 2013. We found that a number of actions identified in the 2012 audit had not been completed. Since our inspection the practice risk assessed and addressed these issues. For example, the consulting rooms were wallpapered; this was assessed as low risk and, due to the forthcoming move to the new premises, deemed not to be an infection risk to patients. Splash backs behind sinks, disposable towels, soap

Are services safe?

dispensers had been installed in toilets and clinical areas. New furniture had been purchased for the waiting and consulting areas which was easy to clean. All treatment and consulting rooms were free of clutter.

The floors in the public areas and treatment rooms were carpeted and had been cleaned since our inspection in May 2014 and a protocol was in place to ensure these were cleaned at least annually or as required. In May 2014 we saw that some toilets were being used to store other equipment for example, water cooler bottles and other equipment. These were subsequently removed and stored more appropriately.

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 the fridge thermometer.

Staffing & Recruitment

When we inspected in May 2014 we looked at two staff records. We saw that checks had been made when recruiting staff however the practice manager told us that in some instances that they had taken up verbal references.

The practice manager told us that they had since re-performed the checks and had updated records to reflect these checks. On review of the two staff files we saw this had been the case. Other 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 professional body and where required, 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 we spoke with told us about the arrangements for planning and monitoring the number and skill mix of staff needed to meet patients' needs. There was an arrangement in place for staff to cover each other's annual

leave or other absences. We saw that the practice manager was currently reviewing capacity and demand within the practice. This would help identify the need for extra staff in the future.

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 annual and monthly 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 to see and there was an identified health and safety representative.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For patients with long term conditions there were emergency processes in place to provide support if they became ill. Staff gave us examples of referrals made for patients that had a sudden deterioration in health.

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 oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff we spoke with knew the location of this equipment and there was a notice in each room advising staff of its location. Records we saw confirmed this equipment was checked regularly. In the minutes of one of the practice's significant event meetings, we saw that a medical emergency concerning a patient had been discussed and appropriate learning taken place.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included, for example, those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also now 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. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified

Are services safe?

included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, details of a company to contact in the event of failure of the heating system.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

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.

We were told that each GP had the lead in specialist clinical areas such as diabetes, heart disease and asthma. The practice nurses supported this work. This allowed the practice to focus on specific conditions by staff who had up to date knowledge on the condition. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. The GP we spoke with followed national standards for referrals. We saw minutes from meetings where regular reviews of elective and urgent referrals were carried out, and improvements to practice were shared with all clinical staff. Nursing staff had received the appropriate clinical training which ensured they were able to undertake their designated speciality roles, using the most up to date guidelines. For example one of the practice nurses had received clinical update training in cervical cytology in July 2014 whilst the other nurse had received update training in travel health in April 2014.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with the GP and other staff 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,

child protection alerts management and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The GP told us that clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). The practice showed us a number of clinical audits that had been undertaken. In all of these completed audits the practice was able to demonstrate the changes had been introduced following the audit.

For example, there had been an audit of the management of patients with rheumatology as the GP's were aware that there was a problem with follow up appointments. The audit demonstrated that all referrals to the rheumatology specialism were appropriate. People were seen quickly and there was no problem with first appointments but there was concern over the review appointments, seeing nurses and commencing treatment. The GPs concluded the management issues were due to the secondary care provider rather than their own processes.

The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, the practice had met all the minimum standards for QOF in diabetes, asthma and COPD. This practice was not an outlier for any QOF (or other national) clinical targets.

The team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around audit and quality improvement.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and dementia and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP prescribed medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

Effective staffing

The practice staff team included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with

Are services effective?

(for example, treatment is effective)

mandatory training such as annual basic life support. A good skill mix was noted amongst the doctors and the GPs were up to date with their yearly continuing professional development requirements. All had either been revalidated or had a date for revalidation (every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals. These 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, on administration of vaccines and cervical cytology. Those with extended roles for example seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease and people with learning disabilities were also able to demonstrate they had appropriate training to fulfil these roles.

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 and discharge summaries from the local hospital, out of hour's 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, reading, passing on and addressing any issues arising from communications with other care providers on the day they were received. The GP saw these documents and results was responsible for taking necessary action to address any concerns.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients for example those with end of life care needs or children on the 'at risk' register. These meetings were attended by district nurses, social workers and palliative care nurses. Any decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals.

The practice had systems in place to provide staff with the information they needed. An electronic patient record system was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. 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 the Children's and Families Act 2014 and their duties in fulfilling it. All of 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.

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. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make certain decisions. All clinical staff demonstrated a clear 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 procedures, a patient's verbal consent was documented in the electronic patient notes, along with a record of the relevant risks, benefits and complications of the procedure. The practice had not had an instance where restraint had been required in the last 3 years but staff were aware of the distinction between lawful and unlawful restraint.

Health Promotion & Prevention

The practice had met with the Public Health team from the Local Authority and the CCG to discuss the implications and share information about the needs of the practice

Are services effective?

(for example, treatment is effective)

population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer all new patients a health check with the health care assistant or practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. Patient treatment records were used to highlight any concerns.

Information on a range of topics and health promotion literature was available to patients in the waiting area of the practice. The practice also used a television screen in the waiting area to provide information and health promotion messages to patients. 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.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. The practice had mechanisms in place to identify at risk groups for example patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

A counsellor from mental health services held a session in the practice each week to support people with mental health problems.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data on patient satisfaction. This included information from the national patient survey and a survey of patients undertaken by the practice's Patient Participation Group (PPG). The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients rating the practice as good or very good. The practice was also higher than average for its satisfaction scores on consultations with doctors and nurses with over 80% of respondents saying the GP was good at involving them in decisions about their care and that their experience at the surgery was very good.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 36 completed cards and all were very positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

Staff told us that all consultations and treatments were carried out in the privacy of a consulting room. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Telephones were located in a separate room away from the reception desk. In the national GP survey results there was a higher than average percentage of patients who felt that in the reception area other patients could not be overheard.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. We were told that there had been no reported incidents for the breach of confidentiality in the last 12 months.

We looked at data from the National GP Patient Survey data, published in July 2013. The data demonstrated that patients were satisfied overall with the practice. In particular, the practice performed better than comparators on the helpfulness of reception staff, the experience of making an appointment, and on GPs and nurses treating them with care and concern.

The practice had an active PPG, with representatives from a cross section of patient population groups. We spoke with two patient participation group members, they both told us that the practice valued their contribution to the operation of the service and listened to their insights into the patient experience. One member told us how they felt the PPG was a two way bridge between the practice and the patients. Another said they felt listened to and that action was taken to address any issues identified. We saw from the review of minutes from PPG meetings these claims were supported.

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.

Patient feedback on the comment cards we received told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. Patients told us they were 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.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The practice's computer system alerted GPs if a patient was also a carer. The patients we spoke to on the day of our inspection and the CQC comment cards we reviewed were also consistent with this survey information. For example, these highlighted staff responded with care and concern when they needed help and provided support when required.

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

Are services caring?

on health conditions, health promotion and support groups. Notices in the patient waiting room, on the TV screen and patient website also signposted people to a number of support groups and organisations.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs.

There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). The members of the group we spoke with voiced their concerns about the move to the new practice site. They did confirm that the practice kept them informed.

The practice had achieved and implemented the gold standards framework for end of life care. The gold standards framework (GSF) enables generalist frontline staff to provide a good quality of care for people nearing the end of life. There was a palliative care register in place.

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

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. We asked staff how they made sure that people who spoke a different language were kept informed about their treatment. Staff told us they had access to an interpretation service, however they could not recall ever having a need to use it.

There was patient car parking available for staff and patients on the road outside. There was no hearing loop available in the building however staff told us they always tried to be aware of people's needs and assist them. We saw that the reception staff were always monitoring the

entrance and asking people if they required help. We saw the practice had a dedicated toilet for disabled patients. A baby changing facility had recently been installed as a result from feedback from patients.

The ground floor consulting rooms were accessible for patients with mobility difficulties, however there was no screen around the couch or the ability to raise or lower the couch. The practice manager confirmed that risk assessments had been performed to ensure patients remained safe and their dignity and privacy respected.

Access to the service

Surgery opening times at the practice are between 0800 and 1830 Monday to Friday. The practice offers extended services so is open from 0730 on Mondays and Wednesdays. The service for patients requiring urgent medical attention out of hours is provided by Cumbria Health on Call (CHOC).

The practice had a process in place to ensure that people could access services offered by the practice. We saw that the practice used a telephone system that monitored the number of calls and the practice's responsiveness. We saw that it was not always possible for patients to see a doctor of their choice on the same day but that the GPs were very responsive to ensuring all patients were seen when needed. Patients could also book to have a telephone consultation with a doctor. We received 36 CQC comment cards. Patients told us they were able to access appointments and prescriptions easily in the practice but that if they wanted to see a particular doctor they may need to wait.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. 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.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they 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 NHS GP Survey (2013). This showed 96.4% of respondents were

Are services responsive to people's needs?

(for example, to feedback?)

satisfied with booking an appointment and 93.6% were satisfied with the practice's opening hours. These results were 'among the best' in comparison with GP practices nationally.

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. The practice had a duty doctor telephone system so patients could receive telephone advice from a GP without initially visiting the practice. Repeat prescriptions could also be ordered either over the telephone, in person or on the practice's website.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. There were information leaflets around the practice and information was also available in the practice handbook and on the web site.

The practice had a comments and suggestions box in the waiting area; however the practice manager told us that this was rarely used. None of the 36 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 looked at the three complaints received in the last twelve months and found that these were satisfactorily handled, dealt with in a timely way and feedback was provided to the complainant.

The practice reviewed complaints on an on-going basis to detect themes or trends. We were told, and review of the complaints data, confirmed that no themes had been identified, however lessons learnt from individual complaints had been acted upon.

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 aims and objectives. The practice vision and values included the provision of good quality primary care services, proactive management of long term conditions and liaison with other agencies and NHS colleagues to focus on what is best for the patient.

We spoke with four 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.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at four of these policies and procedures and saw most staff had completed a cover sheet to confirm when they had read the policy. All the policies and procedures we looked at were up to date.

The practice held monthly governance meetings. We looked at minutes from the last meeting and found that performance, quality and risks had been discussed. The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with or above national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had completed a number of clinical audits, for example, the use of certain medications being prescribed by the practice. Audits were also conducted in response to specific triggers, such as the use of specific medication.

The practice had also reviewed the management of patients receiving anticoagulation therapy in line with NHS Cumbria requirements. An action plan was developed at the end of the review because findings highlighted that the service should be offered to more patients, staff required update training and the review of reporting facilities within the practices software. We found that all the above actions had been addressed.

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.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. We spoke with four members of staff and they were all clear about their own roles and responsibilities. They all told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

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

The practice had gathered feedback from patients through comments cards and the practice survey. We looked at the results of the annual patient survey and 100% of respondents were either very or fairly satisfied with the care they received from the practice.

The practice's patient participation group (PPG) had steadily increased in size. The PPG contained representatives from various population groups; including a wide variety of age groups across the practice population. PPG members told us they were fully involved in how the practice operated. They told us they were fully 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.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they

Are services well-led?

Good 

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

would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files and saw that regular appraisals took place and staff had personal development plans. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended. Monitoring documents held by the practice manager demonstrated that all staff had received an appraisal in 2014.

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.

The practice 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 even ones that were out of their control but involved their patients. The practice manager shared one such incident with us relating to a member of the community healthcare team. The practice communicated this to the community matron who responded to the staff member and the patient concerned.

The team discussed if anything, however minor, could have been done differently at the practice. All staff were encouraged to comment on the incidents. All of the staff we spoke with told us this was done in an open, supportive and constructive way.