Appleby Medical Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected Appleby Medical Practice on 13 November 2014 and visited the surgery in Appleby. We inspected this service as part of our new comprehensive inspection programme.

Overall, we rated the practice 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 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 visibly clean and tidy.
- The practice learned from incidents and took action to prevent a recurrence of the incident.

We saw the following areas of outstanding practice:

- Staff within the practice knew their local population very well and delivered a service which reflected local needs. For example, the practice was flexible with regard to appointments for patients who worked away or for visitors to the area. We saw many examples where staff had 'gone the extra mile' for their patients.
- The practice had effective arrangements to deliver end of life care.

However, there was also an area of practice where the practice should make improvements.

The practice should:

- Ensure robust arrangements are put into place for the GPs to check any changes made to patients' prescriptions following receipt of hospital letters.
- Ensure medicines reviews are carried out on a timely basis.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated 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.

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. 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.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. We found the practice had initiated many positive service improvements for their patient population that were over and above their contractual obligations, particularly for working age people. Patients reported very good access to the practice. 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.

Summary of findings

Are services well-led?

Good

The practice was rated as good for well-led. The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision was regularly reviewed and discussed with staff. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. We found there was a high level of staff engagement and a high level of staff satisfaction. The practice sought feedback from patients. The practice was in the process of establishing a patient participation group (PPG).

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice 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 personalised care to meet the needs of the older people in its population. The practice had written to patients over the age of 75 years to inform them who their named GP was. The practice was responsive to the needs of older people, including offering home visits and allocated GPs for those living in local care homes.

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. We spoke with GPs and nurses who told us care reviews for patients with long term conditions were tailored individually and took place at three monthly, six monthly or yearly intervals. These appointments included a review of the effectiveness of their medicines, as well as patients' general health and wellbeing. 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.

Summary of findings

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)

Outstanding 

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was aware that patients in work found it difficult to attend appointments at times that suited them. The practice had arrangements in place to overcome this problem. Telephone consultations were available and appointments could be booked on-line. In addition, patients who worked away during the week such as long distance lorry drivers were often seen by a GP or nurse out of usual opening hours. The practice had also continued to provide primary care services to some students from the local area who were lived elsewhere during term time.

The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group. We saw health promotion 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.

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 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 worked with patients being treated for addictions and provided personalised support. New patients were reviewed more regularly and staff took time to get to know them and understand how they could best support them.

Summary of findings

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 population group of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had received an annual physical health check. The practice worked closely with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had care planning in place for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. Information and leaflets about services were made available to patients within the practice.

Summary of findings

What people who use the service say

We spoke with nine patients during our inspection. 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.

They told us the staff who worked there were very helpful and polite. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. Patients were generally happy with the appointments system.

We reviewed 27 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 GP Patients Survey completed in 2014 showed the large majority of patients were satisfied with the services the practice offered. The results were among the best for GP practices nationally. The results were:

- The proportion of patients who would recommend their GP surgery – 81%
- GP Patient Survey score for opening hours – 81%
- Percentage of patients rating their ability to get through on the phone as very easy or easy – 91%
- Percentage of patients rating their experience of making an appointment as good or very good – 86%
- Percentage of patients rating their practice as good or very good – 92%.

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

Areas for improvement

Action the service SHOULD take to improve

- Improve the arrangements for the GPs to ensure changes to medicines records are made correctly.
- Ensure medicines reviews are carried out on a timely basis.

Outstanding practice

Staff within the practice knew their local population very well and delivered a service which reflected local needs. For example, the practice was flexible with regard to appointments for patients who worked away or for visitors to the area. We saw many examples where staff had 'gone the extra mile' for their patients. Patients such as long distance lorry drivers who worked away during the week had been seen by a GP or nurse before the practice opened or after the usual closing time.

Staff gave many specific examples of how they had responded to individual patients' needs. This included, writing information down so patients could understand and arranging transport for those without access to a phone.

The practice had very effective arrangements in place to deliver end of life care. One of the GPs had a professional qualification in palliative care and the team worked closely with district nurses and a hospice at home service.

Appleby Medical Practice

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 Appleby Medical Practice

Appleby Medical Practice is located in the town of Appleby in Cumbria and provides primary medical care services to patients living in the town and surrounding rural areas.

The practice provides services to around 4,900 patients, from one location, The Riverside Building, Chapel Street, Appleby in Westmorland, Cumbria, CA16 6QR. We visited this address as part of the inspection.

The practice is located in a purpose built two storey building, all patient facilities are situated on the ground floor. It also offers on-site parking, disabled parking, a disabled WC, wheelchair and step-free access.

The practice has one GP partner, three salaried GPs, two practice nurses, a healthcare assistant, a phlebotomist, a practice manager, and eight staff who carry out reception and administrative duties.

Surgery opening times at the practice are between 0800 and 1830 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 May 2014 we told the provider that they were not compliant with the following regulations:

- Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Management of medicines. We said "Patients were not protected against the risks associated by medicines because the provider did not have sufficiently robust systems in place to manage medicines."
- Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment. We said "Patients were not protected from the risk of unsafe equipment, the emergency trolley."
- Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment. We said "The registered provider did not have effective systems in place which regularly assessed and monitored the quality of the services and protected patients against unsafe care and treatment."

Detailed findings

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.

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 carried out an announced visit on 13 November 2014. We spoke with nine patients and nine members of staff from the practice. We spoke with and interviewed three GPs, the 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 27 CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Safe track record

The practice had a good track record for maintaining patient safety.

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 significant events were appropriately identified and reported. GPs told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development. They showed us examples of significant events which had been reported and the subsequent actions taken.

We saw mechanisms were in place to report and record safety incidents, including concerns and near misses. All of 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.

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. Records of those incidents were kept on the practice computer system and made available to us. We found details of the event, steps taken, specific action required and learning outcomes and action points were noted. There was evidence that significant events were discussed at practice management team meetings and during the daily staff meetings, to ensure learning was disseminated and implemented.

We saw there had been a significant event in relation to some test results. 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 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 General Medical Council (GMC) and the local clinical commissioning group (CCG). Any alerts were reviewed by one of the GP partners and the 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 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. 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. This provided staff with information about safeguarding legislation and how to identify, report and deal with suspected abuse.

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 clinicians and practice manager held monthly meetings to discuss ongoing or new safeguarding issues. 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 children and adults. The lead GP for safeguarding, practice nurse and the practice manager had received the higher level of training for safeguarding children (Level 3). Other clinical staff had received Level 2, whilst all other staff attended Level 1 training sessions.

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. In addition, the practice operated an 'early warning system', whereby any concerns about patients were noted and discussed at the safeguarding meetings.

The practice had a chaperone policy. Staff told us that a practice nurse or healthcare assistant undertook this role. These staff had received chaperone training and were clear about the requirements of the role. There was a notice on the television screen to inform patients of their right to request a chaperone.

A whistleblowing policy was in place. 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.

Medicines management

When we last inspected the practice, in May 2014, we identified some concerns with the medicines management arrangements:

- Vaccines were not stored securely
- The systems for storing, recording and checking controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were not robust

During this inspection we checked vaccines stored in the medicine refrigerators. We found they were stored securely and were only accessible to authorised staff. Maximum and minimum temperatures of the refrigerators were monitored daily. 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.

The practice had standard procedures in place that set out how controlled drugs were managed. Controlled drugs were stored in a designated cupboard and the keys held securely. GPs held, and recorded, individual stocks of controlled drugs. We checked the main stock of controlled drugs and the stock held by one GP and found that appropriate records were kept to enable a complete audit trail of their use.

Processes were in place to check that medicines were within their expiry dates and suitable for use. We saw processes in place for checking medicines stored in GP bags to ensure no expired stock was kept. Systems for storing emergency medicines and checking for expiry dates had been completely reviewed. 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.

The practice was supported by a medicines manager and a practice pharmacist from the North East and Cumbria Support Unit who provided advice and support with prescribing issues. The practice pharmacist provided updates on prescribing data, for example patterns of antibiotic prescribing, and provided advice on quality prescribing.

We saw that regular clinical audits were undertaken to improve the way medicines were managed. For example, we found that audits were being done to review the management of medicines for patients suffering heart failure to ensure that they received the best treatment that was monitored appropriately. The medicines manager and the practice pharmacist told us that processes were in place for managing national alerts about medicines such as safety issues. They said that alerts were discussed and action plans were produced and implemented to promote patient safety.

There was a system in place for the management of high risk medicines that included regular monitoring in line with national guidance. We saw that audits had been undertaken for patients who had been prescribed long term medication. Practice records had been updated as a consequence which helped ensure patients were monitored appropriately.

Staff showed us how patients' requests for repeat prescriptions were managed and issued. A system was in place to raise concerns with GPs such as requests for the issue of medicines that were not on the patients repeat medicines record. Patients were able to choose to receive their medicines by Repeat Dispensing if they wished (this is a national scheme that allows pharmacies to dispense regular medicines to suitable patients without the direct involvement of the GP on each occasion that the medicine is needed).

Most repeat prescriptions for regular medicines were issued to pharmacies electronically and GPs checked and signed them using an electronic signature. We found in

many cases that there was no limit to the number of repeat prescriptions that could be issued. This meant that prescriptions could continue to be issued even if medication reviews were overdue.

We saw that prescriptions stated the date that patients' next medication reviews were due. The prescribing system also included a diary for each patient; this recorded when a medication review had been carried out and when it was next due. We looked at ten diaries for patients on repeat medicines and saw that two did not have a medication review recorded and did not state when it was next due, and one medication review was recorded as 15 months overdue. Patients could continue to receive medicines without a timely medication review to ensure medicines continued to be appropriate.

We looked at the system for managing hospital letters. The patients' usual GPs received letters and reviewed them. Where letters included instructions relating to medicines, these were shared with the medicines manager. The medicines manager informed GPs of the changes needed to patients' medicines records and GPs authorised the changes if appropriate. Once authorised, the medicines manager then made the changes. However, there was no system to ensure that 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 nurse was the 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. Infection control training was provided for all staff annually. Staff we spoke with confirmed they had received the training.

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 were impermeable, and easy to clean. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels. The privacy curtains in the consultation rooms were disposable. We saw the curtains were clearly labelled to show when they were due to be replaced.

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 records confirming recent checks had been carried out on the sharps bins and the patient toilet areas.

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.

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 wore PPE when emptying the box and transferring 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 throughout the building.

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).

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.

Good

Are services safe?

When we last inspected in April 2014 we found several items on the emergency trolley were out of date. The practice said they had taken action to address our concerns.

During this inspection we saw a new emergency trolley had been purchased. Robust systems to monitor and check equipment were in place. For example, there was a log on the computer system which detailed each piece of equipment and there were new systems in place for stock rotation. In addition, regular, documented checks were carried out by the practice nurse.

Staffing and recruitment

We saw the practice had an up to date recruitment policy in place that outlined the process for appointing staff. These included processes to follow before and after a member of staff was appointed. We looked at a sample of personnel files. Most staff had worked at the practice for many years but we reviewed the records for the two most recently appointed members of staff. We found the appropriate recruitment checks had been completed.

The practice manager and all clinical staff that were in contact with patients 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. Procedures were in place to manage absences. For example, the practice manager said when a GP was on leave or unable to attend work, another GP from the practice or a locum GP provided cover.

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 told us they checked the registration status for nurses every month. 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 demonstrated 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 manage explained how the appointments system was adjusted on the days following bank holidays as these days tended to be busier than usual.

The practice had developed clear lines of accountability for all aspects of patient care and treatment. The GPs and nurses had lead roles such as safeguarding and infection control lead. Each clinical lead had systems for monitoring their areas of responsibility, such as routine checks to ensure staff were using the latest guidance and protocols.

The practice had well established systems in place to manage and monitor health and safety. The fire alarms were tested on a weekly basis and the emergency lights were checked monthly. The practice manager told us fire drills were carried out every six months. We saw records confirming these checks had been carried out.

The practice manager showed us a number of risk assessments which had been developed and undertaken; including a fire and a health and safety risk assessment. 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.

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 and medication available for managing medical emergencies. Arrangements were in place to check

Good

Are services safe?

emergency medicines were within their expiry date and suitable for use. All of the staff we spoke with told us they had attended CPR (resuscitation) training. 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. GPs demonstrated an up to date knowledge of clinical guidelines for caring for patients. There was a strong emphasis on keeping up to date with clinical guidelines, including guidance published by professional and expert bodies. The practice undertook regular reviews of their referrals to ensure current guidance was being followed.

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

We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, 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 review appointments. This ensured people had routine tests, such as blood or spirometry (lung function) tests to monitor their condition.

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 meetings.

All staff had undertaken training on equality and diversity. Interviews with three GPs and two practice nurses 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

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 monthly practice meetings, and/or the daily 'all staff' meetings as required.

Examples of clinical audits included an audit of referrals of patients with suspected cancer. An initial audit was carried out. This demonstrated that most patients had been referred correctly (18 out of 20). Some changes to procedures were implemented, then the audit was repeated to assess the effectiveness of these changes. We saw the audit was due to be repeated again to continually monitor the practice's performance.

An audit on the use of lithium (this is a type of medicine used to treat a number of mental health problems) identified some actions which could lead to improvements in patient care. We found the practice had responded to the issues identified. For example, ensuring patients received regular monitoring tests. 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 (63%) had received the seasonal vaccination compared to the national average (52%).

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support. 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, the CCG had recently delivered a session on domestic abuse.

Role specific training was also provided. The practice nurses had been trained to administer vaccines and some of the GPs had attended end of life care training. In addition, one GP was spending some time at a specialised genito-urinary medicine (GUM) clinic each week to increase their skills and knowledge in that area.

Good

Are services effective?

(for example, treatment is effective)

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation (every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All other staff had received an annual appraisal. During the appraisals, training needs were identified and personal development plans put into place. Staff told us they felt supported. For example, a recently qualified GP was offered extended appointments and had access to a senior GP throughout the day for support.

The patients we spoke with were complimentary about the staff. Staff we spoke with and observed were knowledgeable about the role they undertook.

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.

A number of health care services were based in the same building as the practice. This included health visitors, district nurses and a counsellor. In addition, there was an Age UK day-care centre, a drug and alcohol treatment service and a cancer support group. Staff told us they had developed strong links with these services. Although formal arrangements were in place to meet and share information, informal discussions were often held. Staff described many instances where they were able to discuss patient matters with other colleagues when they saw them within the building, rather than always having to send out formal letters. This enabled the practice to provide a more efficient service for their patients.

We saw various multi-disciplinary meetings were held. For example, a monthly mental health team meeting was held, which involved practice staff and the community psychiatric nurse. The practice safeguarding lead had good relationships with social services, health visitors and school nurse services.

The practice was a member of a group of GP practices located in the Eden area who met regularly to build relationships and share learning with the aim of improving patient care. There were well established links with local Macmillan nurses. This helped to share important information about patients including those who were most vulnerable and high risk.

We found appropriate end of life care arrangements were in place. The practice maintained a palliative care register. We saw there were procedures in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out of hours provider and the ambulance service. One of the GPs has completed a postgraduate certificate in palliative care and was the lead on this area within the practice. Each patient on the palliative care register had a lead GP, and a second named GP to ensure continuity of care. The team worked closely with district nurses and a hospice at home service to give patients a choice in how their care was delivered.

Correspondence such as blood results, X-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service, was received both electronically and by post. Information was scanned and passed on to the person who had requested the test (or whoever was covering for them if they were not available). Any urgent correspondence was passed to the duty doctor to deal with. The GP who reviewed these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

Information sharing

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

The practice used electronic systems to communicate with other providers. For example, making referrals to hospital services using the Choose and Book system (the Choose and Book system enables patients to choose which hospital they will be seen in and allows them to book their own outpatient appointments). Staff reported this system was easy to use.

Good

Are services effective?

(for example, treatment is effective)

Regular meetings were held throughout the practice. These included all staff meetings, clinical meetings and multi-disciplinary team meetings. Information about risks and significant events were shared openly at meetings. Patient specific issues were also discussed to enable continuity of care.

The management team produced a monthly staff newsletter. This was sent to all staff and gave them information about any issues which would affect the practice, new policies and information from the CCG where necessary. The weekly electronic GP newsletter was also shared with all staff.

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. There was a practice policy on consent, this provided guidance for staff on when to document consent.

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.

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. One of the GPs had carried out some personal research on Gillick competencies to enhance their understanding.

We found that staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. Some staff had recently received specific training on consent and the MCA. 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 MCA. The GPs described the procedures they would follow where people lacked capacity to make an informed decision about their treatment.

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.

New patients were offered a 'new patient check', with one of the nurses, 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).

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. Staff told us about some of the services offered to patients. These included 'exercise on prescription' and access to a local health and wellbeing service. The practice's website also provided some further information and links for patients on health promotion and prevention.

The practice offered a full range of immunisations for children, as well as travel and flu vaccinations, in line with current national guidance. The percentage of patients in the 'influenza clinical risk group', 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 nine 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 27 CQC comment cards we received also reflected this. Words used to describe the approach of staff included caring, friendly, kind, discreet, polite, helpful and supportive.

We looked at data from the National GP Patient Survey, published in July 2014. This demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the practice was above national and local average scores on the overall experience and the helpfulness of reception staff. We saw that 92% of patients said they had confidence and trust in their GP and 86% said their GP was good at treating them with care and concern.

Staff told us they had a good knowledge of their practice population and so were able to provide personalised care. All the practice staff proactively followed up information received about patients. We were shown examples where clinical and reception staff had used their initiative when they had escalated a concern or passed on information which had led to a positive outcome for the patient. Information available at the time had been as little as a passing comment about a patient in the waiting room, to a concern by a member of staff about a patient who did not attend their appointment.

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. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in those rooms could not be overheard.

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 patients' 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 27 completed CQC comment card, patients felt they were involved in their care and treatment. One person commented that they understood their health issues as staff explained everything to them. Another person said the doctors always listened and responded to their needs.

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 and explained the need for any tests or treatment. Scores for both doctors and nurses were well above both the national and local averages.

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

The appointment system was designed so that all patients were able to speak with a medical professional within a short time of them contacting the practice. An 'on the day' appointment was always offered when this was appropriate. This contact gave patients assurance that their needs would be met on the day they requested it. Staff were also able to give us examples of where they had gone over and above what was expected of them. This included offering appointments outside of the usual opening hours when it was felt the need was urgent.

We saw there was a variety of patient information on display throughout the practice. This included information on mental and emotional health and support groups.

The practice routinely asked patients if they had caring responsibilities. They were offered additional support and GPs informed them of a local carer support group.

Good

Are services caring?

Support was provided to patients during times of bereavement. The practice manager told us a visit to those who had lost a loved one was offered once the practice had been notified. 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.

There was a system in place to enable staff to easily identify who was in hospital or who had recently been discharged. This ensured staff were able to provide appropriate and timely support to those patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to the needs of the local population.

Staff told us they had reviewed their appointments system and had introduced longer standard appointment times. Appointment times were increased from 10 to 15 minutes. Patients we spoke with told us they felt they had sufficient time during their appointment. Results of the national GP patient survey from 2014 confirmed this. 95% of patients felt the doctor gave them enough time, 88% felt they had sufficient time with the nurse. These results were well above the national averages (86% and 81% respectively).

Due to the rural location, local hospital services were difficult to access for many patients living in the practice area. The practice had therefore arranged for some services to be provided at the practice itself. Some of the GPs had been trained to carry out joint injections and some minor surgical procedures were carried out. This reduced the number of referrals to other services and meant patients did not have to travel as far to receive care and treatment.

Some patients did not want to travel to the nearest accident and emergency department or minor injury clinic as these were 45 and 25 minutes away. Staff told us this meant that these patients presented at the practice instead. They gave several examples of where patients had received treatment for minor injuries at the practice, rather than accessing other services.

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. Staff gave many specific examples of how they had responded to individual patients' needs. This included, writing information down so patients could understand and arranging transport for those without access to a phone.

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

The practice was in the process of establishing a Patient Participation Group (PPG) to enable patients to have further opportunities to share ideas and any concerns. At the date of our inspection, six patients had volunteered to be part of the PPG. We saw the practice was responsive to comments from patients. For example, during a recent patient survey one person had commented that they would like the practice to remind them of any follow-up appointments. The practice reviewed the system and amended the monitoring procedure to include text message reminders to patients.

Tackling inequity and promoting equality

The practice had recognised the needs of the different groups in the planning of its services. For example, there was a large travellers' fair each year in the town. During this time, arrangements were put into place to ensure travellers were able to access GP and nursing services.

Nationally reported data showed the practice had achieved good outcomes in relation to meeting the needs of patients whose circumstances may make them vulnerable. 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. One of the nurses specialised in this area, they explained how patients were also offered longer appointment times.

The practice had access to local drug and alcohol support services for patients. Some of these teams were based within the same premises, so staff had good working relationships with the specialists.

Free parking was available in a car park directly outside the building. We saw there marked bays for patients with mobility difficulties. The practice building was accessible to patients with mobility difficulties. 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.

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

Access to the service

The practice is open between 0800 and 1830 Monday to Friday.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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

The practice was flexible with regard to appointments. We saw many examples where patients had been seen by a GP or nurse before the practice opened or after the usual closing time. Staff told us how they arranged telephone appointments with patients who worked away at a time that was convenient to the patient.

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 88% of respondents were satisfied with booking an appointment and 96% felt the practice was currently open at times that were convenient for them. 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.

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 leaflet and was available on the practice's website. The practice also had a comments box situated in the entrance foyer 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 nine patients we spoke with on the day of the inspection said they had felt the need to complain or raise concerns with the practice. In addition, none of the 27 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. Patients could therefore be supported to make a complaint or comment if they wanted to.

The practice manager told us that all informal, as well as formal complaints were logged. We saw the summary of complaints that had been received in the 12 months prior to our inspection. A summary of the complaint, details of the steps taken, the outcome of the investigation, and details of any contact with the complainant were recorded. The method by which the practice was informed of the complaint was also recorded and we saw that verbal indicators of dissatisfaction were investigated.

The practice had a robust approach to dealing with complaints in that it reviewed all, even ones that were out of their control but involved their patients. We saw the practice manager had dealt with a patient's complaint about a pharmacy and another about a different healthcare provider.

We looked at the most recent complaints the practice had received. We saw these had all been thoroughly investigated and the complainant had been communicated with throughout the process. We found the practice listened and learned from the complaints. For example, following one complaint we saw a review of the process for arranging home visits had been carried out.

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 delivery of the service to a high standard, to understand the expectations of patients and to maintain the highest professional and ethical standards.

We spoke with nine 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. We saw that the regular staff meetings helped to ensure the vision and values were being upheld within the practice.

Governance arrangements

When we last inspected in May 2014 we found there had been significant changes to the leadership of the practice. New ways of working had been introduced but these had not been fully implemented or embedded in staff practice.

During this inspection we found systems were in place for monitoring all aspects of the service such as complaints, incidents, safeguarding, clinical audit and infection control. The practice had a number of policies and procedures in place to govern activity. These were available to staff electronically. In addition, there was a file held in the administration office which contained all of the policies. Staff signed a form to confirm they had read and understood each policy. All of the policies we looked at had been reviewed and were in date. The systems and feedback from staff showed us that strong governance structures were in place.

There was a management team in place to oversee the practice. Monthly practice management team meetings were held, attended by the GPs, lead practice nurse and the practice manager. These sessions were used to discuss any serious incidents, complaints and clinical governance issues in detail. Daily staff meetings were held, this allowed time for any lessons learnt or actions identified to be cascaded.

The practice manager and GPs actively encouraged staff to be involved in shaping the service.

We found that staff 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.

Leadership, openness and transparency

The practice had a clear leadership structure designed to support transparency and openness. There was a well-established management team 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 nine 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.

A monthly staff newsletter was produced. Staff we spoke with appreciated this as they felt they were kept up to date. Daily meetings were held each lunch time. The practice was closed at this time to allow all staff the opportunity to attend. The meetings were not formally minuted but notes of the discussions were maintained.

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

The practice gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff we

Are services well-led?

Good

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

spoke with told us their daily meetings provided them with an opportunity to share information, changes or action points. They confirmed they felt involved and engaged in the running of the practice.

The practice had carried out a recent patient survey and was in the process of establishing a patient participation group (PPG). The results of the practice survey were on display in the waiting room, along with the practice response to the findings.

The practice had robust whistleblowing procedures and a detailed policy in place. Staff we spoke with were all able to explain how they would report any such concerns. They were all confident that concerns would be acted upon.

Management lead through learning and improvement

The practice had management systems in place which enabled learning and improved performance.

Staff told us that the practice was very supportive of training. They said they had received the training they needed, both to carry out their roles and responsibilities and to maintain their clinical and professional development. We saw that regular appraisals took place. Staff from the practice also attended the monthly CCG protected learning time (PLT) initiative. This provided the team with dedicated time for learning and development.

The practice had a robust approach to incident reporting in that it reviewed all incidents The management team met monthly to discuss any significant incidents that had occurred. The practice had completed reviews of significant events and other incidents and shared these with staff. Staff meeting minutes showed these events and any actions taken to reduce the risk of them happening again were discussed.

The practice manager met monthly with other practice managers in the area and shared learning and experiences from these meetings with colleagues. The practice nurse attended a locality Practice Nurse forum with other nurses from the Eden area. GPs met with colleagues at locality and CCG meetings. They also attended learning events and shared information from these with the other GPs in the practice.

This section is primarily information for the provider

Enforcement 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.