Fusehill 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 carried out an announced comprehensive inspection at Fusehill Medical Practice on 3 September 2015. Overall the practice is rated as good.

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

- There were systems in place to mitigate safety risks including analysing significant events and safeguarding. The premises were clean and tidy. Arrangements in the practice for managing medicines, including emergency drugs and vaccines, kept patient safe. There were appropriate recruitment checks in place.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Feedback from patients and observations throughout our inspection showed the staff were kind, caring and helpful.
- The practice had systems in place to respond to and act on patient complaints and feedback. Services were planned and delivered to take into account the needs of different patient groups and to help provide flexibility, choice and continuity of care.
- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The staff worked well together as a team.
- Results from the National GP Patient Survey showed that some aspects of patients' satisfaction with how they could access care and treatment was lower than local and national averages. The practice had reinstated the patient participation group (PPG) to help them to improve.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider should :

Summary of findings

- Develop and implement an action plan to improve the levels of patient satisfaction, including improving the experience for patients of contacting the practice, making an appointment, feeling involved with decisions about their health and treatment and consulting with doctors and nurses at the practice.
- Increase the percentage of patients with a range of mental health conditions that have a comprehensive care plan documented within the preceding 12 month.
- Ensure blank prescriptions are recorded in accordance with national guidance to reduce the risk of theft or misuse.
- Consider the use of a paginated, bound book for recording controlled drugs to reduce the risk of theft or misuse.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. The practice was able to provide evidence of a good track record for monitoring safety issues. When things went wrong, lessons were learned and improvements were made. The practice could strengthen this process by including review dates for those significant events where changes had been made so that the effectiveness of learning could be evaluated.

The practice could demonstrate they had a safe track record through having risk management systems in place for safeguarding, health and safety including infection control, medicines management and staffing. Although recruitment checks were carried out, the practice should consider their approach to Disclosure and Barring Service checks to ensure where non-clinical staff work with patients who may be vulnerable, they have appropriate background checks carried out to determine their suitability.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were comparable to averages for the locality and nationally. Staff referred to guidance from the National Institute for Health and Care Excellence, other best practice and local guidance. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and relevant training planned. There was evidence of appraisals and personal development plans for some staff, with plans to ensure this was in place for all staff. The practice worked with multi-disciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. Data showed that patients rated the practice either lower or in line with

Summary of findings

comparators for several aspects of care. The practice had recognised this was an area where they needed to make improvements and were working with the Patient Participation Group to improve their performance.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Staff had reviewed the needs of the practice's local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Feedback from patients reported that access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Easy to understand information about how to complain was available and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. They had a clear vision and strategy. 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 held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients, which it acted on. The practice was in the process of reinstating the patient participation group (PPG) to help support the practice to improve. Staff had received inductions and attended team meetings and events. The practice had identified staff appraisals as an area for improvement had had taken action to address this.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

The practice is rated as good for the care of older people. Staff offered proactive, personalised care which met the needs of these patients. Patients living in local care homes received routine GP visits. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits, longer appointment times and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of an emergency hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were similar to local and National averages for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

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

Summary of findings

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 proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

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

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people with poor mental health (including patients with dementia). The practice held a register of patients experiencing poor mental health and there was evidence they carried out annual health checks for these patients. The practice regularly worked with the multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice performed lower than comparators on the percentage of patients with a range of mental health conditions who had a comprehensive care plan documented within the preceding 12 months.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results published on 8th January 2015 showed the practice was mostly performing below local and national averages. There were 298 survey forms distributed for Fusehill Medical Practice and 125 forms were returned. This was a response rate of 41.9% and equated to 1.5% of the practice population of 8,099.

- In the survey 79.2% described their overall experience as good and 67% said they would recommend the surgery to family and friends. This was below local averages (88.4% and 80.5% respectively).
- 54.2% found it easy to get through to this surgery by phone compared with a CCG average of 77.7% and a national average of 71.8%.
- 77.9% said they found the receptionists at the practice helpful compared to the CCG average of 90% and national average of 86.9%.
- 46.8% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 52.3% and a national average of 53.5%.
- 76.9% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 88.2% and a national average of 85.4%.
- 91.8% say the last appointment they got was convenient compared with a CCG average of 93.5% and a national average of 91.8%.
- 54.7% describe their experience of making an appointment as good compared with a CCG average of 78.6% and a national average of 73.8%.
- 73.6% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 65.9% and a national average of 65.2%.
- 59.9% feel they don't normally have to wait too long to be seen compared with a CCG average of 61.3% and a national average of 57.8%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received four comment cards, two of which were positive about the standard of care received. These patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. Negative feedback on the cards related to difficulties in making appointments.

Areas for improvement

Action the service SHOULD take to improve

- Develop and implement an action plan to improve the levels of patient satisfaction, including improving the experience for patients of contacting the practice, making an appointment, feeling involved with decisions about their health and treatment and consulting with doctors and nurses at the practice.
- Increase the percentage of patients with a range of mental health conditions that have a comprehensive care plan documented within the preceding 12 month.
- Ensure blank prescriptions are recorded in accordance with national guidance to reduce the risk of theft or misuse.
- Consider the use of a paginated, bound book for recording controlled drugs to reduce the risk of theft or misuse.

Fusehill Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector. The team included an additional CQC inspector, a GP and a specialist adviser with a background in practice management.

Background to Fusehill Medical Practice

Fusehill Medical Practice is within walking distance of the centre of Carlisle, near the University of Cumbria. The practice provides services to just over 8099 patients of all ages.

The area covered by the practice is within the city boundaries of Carlisle. The catchment area for the practice covers the city east of the River Caldew and north of the River Eden and as far as Rockcliffe to the north, Warwick Bridge to the east and Wreay to the south.

The practice is located at Fusehill Medical Centre, Fusehill Street, Carlisle, Cumbria, CA1 2HE, which we visited during this inspection:

The branch surgery associated with the practice at Scotland Road, Carlisle, has been closed for approximately two years and no services are delivered through this location. The practice intends to remove this from their CQC registration and is in discussions with NHS England to remove this from their contractual obligations.

The practice provides services to patients of all ages based on a General Medical Services (GMS) contract agreement for general practice.

Fusehill Medical Centre is accessible for people with disabilities. Limited onsite parking is available and as such the practice encourages patients to reserve this for patients with disabilities.

The practice is a training practice with five GP partners (two of which are male and three female). There is also one salaried GP (who is female), three practice nurses, five healthcare assistants and a team of administrative support staff. The practice is open Monday to Friday between 8am and 6:30pm. On alternating weeks the practice is open one night a week, either a Tuesday or Thursday until 8:15pm.

They serve an area with lower levels of deprivation affecting children and people aged 65 and over, when compared to the England average. The practice area is within the fifth most deprived decile in England. There were lower numbers of people in paid work or full time employment at 55% (compared to an England average of 60.2%). The unemployment rate in the area is the same as the national average at 6.2%. There were a higher proportion of disability allowance claimants (at 58.7 per 1000 population, compared to an England average of 50.3 per 1000 population).

There are a higher proportion of patients over the age of 65, 75 and 85 when compared to England averages. The average male life expectancy is 79 years, which is the same as the England. The average female life expectancy is 82 years, which is one year lower than the England average at 83.

The percentage of patients reporting with a long-standing health condition is slightly lower than the national average (practice population is 53.7% compared to a national average of 54.0%). The percentage of patients with health-related problems in daily life is higher than the national average (65.8% compared to 48.8% nationally). There are a higher percentage of patients with caring responsibilities at 23.5% compared to 18.2% nationally.

Detailed findings

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

Why we carried out this inspection

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

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.

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)

The inspector:

- Reviewed information available to us from other organisations, for example, NHS England.
- Reviewed information from CQC intelligent monitoring systems.
- Carried out an announced inspection visit on 3 September 2015.
- Spoke to staff and patients.
- Looked at documents and information about how the practice was managed.
- Reviewed patient survey information, including the NHS GP Patient Survey.
- Reviewed the practice's policies and procedures.

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

Good

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. Staff told us they would inform the lead GP or practice manager of any incidents and there was also a recording form available on the practice's computer system. A record of complaints was maintained, and where appropriate these were also considered as significant events. The practice carried out an analysis of the significant events and this also formed part of the GPs' individual revalidation process.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, the practice had an incident where a refrigerator for storing vaccines was switched off overnight in error. This meant all the vaccines and medicines which had been in it were no longer safe to use and as such were disposed of. To reduce the risk of this happening again the practice installed plug covers for all refrigerators. They also improved their temperature monitoring systems to allow them more easily to identify the time period for which vaccines and other medicines were stored in refrigerators at either below or above optimum temperature ranges.

Overall, the sample of records we looked at, and evidence obtained from interviews with staff, showed the practice had managed such events consistently and appropriately. However, the practice could strengthen this process by including review dates for those significant events where changes had been made so that the effectiveness of learning could be evaluated.

Safety was monitored using information from a range of sources, including National Patient Safety Alerts (NPSA) and National Institute for Health and Care Excellence (NICE) guidelines. This enabled staff to understand risks and gave a clear, accurate and current picture if safety.

Overview of safety systems and processes

The practice could demonstrate they had a safe track record through having risk management systems in place for safeguarding, health and safety including infection control, medicines management and staffing. The practice should consider some further improvements to ensure adequate safeguards were in place in some areas.

- There were arrangements in place to safeguard adults and children from abuse, which reflected relevant legislation and local requirements. Safeguarding policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There were lead members of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. However, the practice could improve their approach to ensuring all staff had recently undertaken training in the safeguarding of vulnerable adults and children at the right level to do their job.
- A notice was displayed in the waiting rooms, advising patients of the availability of a chaperone service. Staff told us it was normally the practice nurses or healthcare assistants who were asked to act as chaperones. However, if none were available reception staff had been asked to undertake this role. Although some newer non-clinical staff had been subject to a criminal records check, known as a Disclosure and Barring Service (DBS) check, others had not. These checks identify whether a person has a criminal record or is on the official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. We raised this with the practice and they told us they would review their approach to this to ensure it reflected national guidance.
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The practice was implementing improvements following the health and safety risk assessment they undertook in August 2015. The practice had an up-to -date fire risk assessment. The practice had undertaken an evacuation in response to a fire alarm. However, it had not recently undertaken a fire drill. All electrical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. A practice nurse was the infection control clinical lead and liaised with the local infection control prevention teams to keep up to date with best practice.

Good

Are services safe?

There were infection control protocols in place and staff had received up-to-date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. The practice carried out regular monitoring for the risk of legionella. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal).

- Arrangements in the practice for managing medicines, including emergency drugs and vaccines, kept patient safe (this included obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out, with the support of the local Clinical Commissioning Group (CCG) pharmacy team. This ensured the practice was prescribing in line with best practice guidelines. Prescription pads were stored securely. However, there were no systems in place to monitor their use.
- The practice temporarily held a small quantity of controlled drugs returned to the practice by a registrar. (Controlled drugs are medicines that are liable to misuse and as such have extra controls in place). The practice had in place written standard operating processes relating to controlled drugs. The practice recorded controlled drugs in a bound book. However, this was not paginated. The practice should consider the use of a paginated, bound book for recording controlled drugs to reduce the risk of theft or misuse.
- Routine recruitment checks were carried out and the three staff files we sampled showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and appropriate checks through the DBS. The practice had implemented checks for all new staff recruited and all clinical staff had been subject to a DBS check. However, some existing non-clinical staff had not been subjected to a DBS check. The practice manager confirmed they would review their policy on chaperoning and would review the need for non-clinical staff to have a DBS based on whether they would provide a chaperone service in the future.
- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure there were enough staff on duty.

Arrangements to deal with emergencies and major incidents

- There was an instant messaging system on the computers in all the consultation and treatment rooms, which alerted staff to an emergency. All staff received basic life support training. The practice had a defibrillator and oxygen with adult and children's masks. The practice held three oxygen cylinders and on the day of our inspection there was a malfunction with one, which emptied the cylinder. The practice told us they would take action to replace this. Emergency medicines were easily accessible to staff in a secure area of the surgeries and all staff knew the location of these. All the medicines we checked were in date and fit for use.
- The practice had a comprehensive business continuity plan in place for major incidents, such as a power failure or damage to premises. The plan included emergency contact numbers for staff. However, a copy was only stored at the practice. The practice manager told us following the visit copies would also be kept by her and all partners to mitigate risks if they were unable to access the practice premises.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment and consent

The practice carried out assessments and treatments in line with National Institute for Health and Care Excellence (NICE) best practice guidelines and had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. For example, the practice used the NICE guidance on the prescribing of warfarin (a blood thinning medicine) to patients with known Atrial fibrillation for stroke prevention. The practice monitored the implementation of these guidelines by carrying out risks assessments, audits and random checks of patient records.

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed this and, where appropriate, recorded the outcome of the assessment.

Protecting and improving patient health

New patients were offered a 'new patient check'. The initial appointment was scheduled with one of the healthcare assistants, to ascertain details of their past medical histories, social factors including occupation and lifestyle, medications and measurements of risk factors (for example smoking, alcohol intake, blood pressure, height and weight). The patient was then offered an appointment with a GP if there was a clinical need, for example, a review of medication.

Patients who may need extra support were identified in the practice. These included patients in the last 12 months of their lives, those at risk of developing a long term-condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were sign posted to relevant services.

The practice's uptake for cervical screening programme was 79.5%, which was comparable to the national average of 81.9%.

The practice performed similar to other practices within the local CCG area, on rates for a number of child hood vaccinations. For example, Mumps, Measles and Rubella (MMR) vaccination rates for five-year-old children were 64.7% compared to an average of 70.1% in the local CCG area. Infant Men C vaccination rates for two-year-old children were 96.9% compared to 97.6% across the CCG; and for five-year-old children were 97.1%, compared to 96.6% across the CCG. The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination, was higher at 56.1% than the England average of 52.3%. The seasonal flu vaccination rates for over 65s were lower at 69.4% compared to a national average of 73.2%.

Patients had access to appropriate health assessments and checks. These included NHS health checks for people aged 40 to 74 years. Appropriate follow-up on the outcomes of health assessments and checks were made, where abnormal results or risk factors were identified.

Coordinating patient care

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way, through the practice's patient records system and intranet. This included care and risk assessments, care plans, medical records and test results. Information, such as NHS Patient information leaflets, were also available.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs. Also to assess and plan ongoing care and treatment. This included where people moved between services, including when they were referred to other services or after they were discharged from hospital. We saw evidence multi-disciplinary team meetings took place on a monthly basis and care plans were routinely reviewed and updated.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This system is intended to improve the quality of general practice and reward good practice. The practice used the information collected for QOF and performance against national screening programmes to monitor outcomes for patients. The most recent results showed the practice had achieved 87.8% of

Good

Are services effective?

(for example, treatment is effective)

the total number of points available. This was 6.1 percentage points below CCG Average, 4.5 below the England Average. The practice was an outlier on two indicators:

- The percentage of patients with a range of mental health conditions who have a comprehensive care plan documented within the preceding 12 months.The practice performance on this indicator was 56.9%, compared to a national average of 86.1%. The practice did not know the reason for this below average performance. They told us they would investigate this and look at ways they could improve their performance.
- The percentage of patients with physical or mental health conditions whose notes record the smoking status in the preceding 12 months. The practice performance on this indicator was 90.2%, compared to a national average of 95.3%. The practice knows there is a recording issue with this indicator. They showed us an example where the patient notes stated the patient was an 'ex-smoker for five years' but this was not clinically coded. The practice told us they would investigate ways they could improve their recording in this area.

Clinical audit were carried out and all relevant staff were involved to improve care and treatment and outcomes for patients. There had been five clinical audits carried out in the last two years, of which four were completed audit cycles where improvements were checked and monitored. For example the practice had audited new cancer diagnosis; the prescribing of hypnotics, such as benzodiazepines which are a class of psychoactive drugs used to treat anxiety, insomnia, and a range of other conditions; and results of inadequate specimen for cervical screening tests.

The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered topics such as fire safety, health and safety and confidentiality.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included on-going support during sessions, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. The practice had not yet undertaken appraisal sessions, within the last year, for all staff. Some staff had not received an appraisal session within the last three years. The practice had identified this as an area for improvement and was making progress. We saw a number of appraisal sessions had taken place for non-clinical staff and dates were set for clinical staff such as practice nurses. All GPs were up-to-date with their yearly continuing professional development requirements and all either had 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 can the GP continue to practice and remain on the performers list). Staff received training that included, safeguarding, fire procedures, basic life support and information governance. Staff had access to and made use of e-learning modules and in-house training.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a designated privacy area to discuss their needs.

Four patient CQC comment cards were returned, of which two were positive and two were negative about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. Negative feedback on the cards related to difficulties in accessing appointments, and did not raise concerns about staff attitudes towards patients. We also spoke with four patients on the day of our inspection, two of whom were members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. The patients we spoke to highlighted that staff responded compassionately when they needed help and provided support when required.

Overall, results from the national GP patient survey showed that patients were happy with how they were treated and that this was with compassion, dignity and respect. However, the practice was below both national and CCG averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 85.4% said the GP was good at listening to them compared to the CCG average of 90.1% and national average of 87.2%.
- 81% said the GP gave them enough time compared to the CCG average of 88.6% and national average of 85.3%.
- 92.7% said they had confidence and trust in the last GP they saw compared to the CCG average of 94.3% and national average of 92.2%
- 77.4% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85.6% and national average of 82.7%.
- 75.6% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 82.3% and national average of 78%.
- 77.9% said they found the receptionists at the practice helpful compared to the CCG average of 90% and national average of 86.9%.

The registered manager told us the team was aware that some of their National GP Patient satisfaction scores fell below the local CCG and national averages, and were considering what they could do to improve them. However, the practice had not developed an action plan to ensure improvements were made.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on 50% of the comment cards we received was also positive and aligned with these views.

However, results from the national GP patient survey we reviewed showed the number of patients who responded positively to questions about their involvement in planning and making decisions about their care and treatment and results was lower than local and national averages. For example:

- 76.6% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84.1% and national average of 82%.
- 69.1% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 76.9% and national average of 74.6%

The registered manager told us the team was aware that some of their National GP Patient satisfaction scores fell below the local CCG and national averages, and were considering what they could do to improve them. However, the practice had not developed an action plan to ensure improvements were made.

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language, and staff we spoke to knew how to access this service.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. This included information for carers and information about bereavement services offered in the area. The practice had a register of 100 patients registered as carers. This equated to approximately 1.2% of the practice population. The local carer's organisation, Carlisle Carers, was based in the same building as the practice. The practice told us they referred patients with caring responsibilities to this service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local Clinical Commissioning Group (CCG) to improve outcomes for patients in the area.

The practice was in the process of reinstating the Patient Participation Group (PPG). They had recognised this as an area for improvement and meetings had not taken place for some time. They had recruited some new members and were advertising for more via the practice website and newsletter.

Services were planned and delivered to take into account the needs of different patient groups and to help provide flexibility, choice and continuity of care. For example;

- The practice offered appointments outside normal working hours. On alternating weeks the practice was open one night a week, either a Tuesday or Thursday until 8:15pm. There were longer appointments available for people with a learning disability.
- Home visits were available for older patients and other patients who would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities, hearing loop and translation services available. The practice provided large print information on request to those with visual impairment. Practice staff told us they had not made much use of translation services. They often relied on relatives and friends of the patient to interpret. To protect the confidentiality of the patient and to ensure an accurate translation of complex medical terms it is best practice to use a translation service. We spoke with the practice manager about this. She told us they would promote the use of translation services to staff and patients to increase its use.
- Practice staff told us they frequently registered temporary patients to ensure they received timely care and treatment. This included local students and tourists.
- Other reasonable adjustments were made and action was taken to remove barriers when people find it hard to use or access services.
- The practice provided specialist nurse led clinics for patients with long term conditions, to ensure appropriate regular reviews of patient's health took place.

Access to the service

The practice was open Monday to Friday between 8am and 6:30pm. On alternating weeks the practice was open one night a week, either a Tuesday or Thursday until 8:15pm. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available.

Results from the National GP Patient Survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. For example:

- 72.4% of patients were satisfied with the practice's opening hours compared to the CCG average of 79.7% and national average of 75.7%.
- 80.5% said the GP surgery was open at times that were convenient, compared to a CCG average of 79.5% and a national average of 73.8%.
- 73.6% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 65.9% and national average of 65.2%.
- 91.8% said their last appointment was convenient, compared to a CCG average of 93.5% and a national average of 91.8%.

However, satisfaction results relating to the experience of making an appointment were lower than local and national averages. For example:

- 54.2% patients said they could get through easily to the surgery by phone compared to the CCG average of 77.7% and national average of 71.8%.
- 54.7% patients described their experience of making an appointment as good compared to the CCG average of 78.6% and national average of 73.8%.
- 76.9% were able to get an appointment to see or speak to someone the last time they tried, compared to the CCG average of 88.2% and the national average of 71.8%.

The practice manager told us she was aware some of their National GP Patient satisfaction scores fell below the local CCG and national averages, and were considering what they could do to improve them. Dissatisfaction with appointment making was a recurring theme in complaints and other patient feedback. They planned to involve the

Good

Are services responsive to people's needs?

(for example, to feedback?)

reinstated patient participation group in generating ideas on how the practice could improve in this area. However, the practice had not developed an action plan to ensure improvements were made.

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. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. The complaints policy was outlined in the practice leaflet and was available on their website.

The practice had received nine complaints in the last year, of which six were upheld. We looked at a couple of the complaints received in the last 12 months and found the practice had responded with openness and transparency when dealing with the compliant. The practice approached complaints as a learning opportunity and identified where they could improve as a result. For example, a complaint about the attitude of a clinician was used to as part of the continuing professional development to help them improve.

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. Staff had prepared a statement of purpose which set out their aims and objectives. The statement described the practice's commitment to providing:

- Comprehensive Primary Care General Medical Services to patients in the local community. Providing services from purpose built premises which were well-maintained and provided a safe, pleasing environment for staff and patients.
- Fostering an atmosphere of courtesy, mutual respect and understanding regardless of personal characteristics or the nature of the problems presented to them.
- Staff and patients working together to prevent disease or poor outcomes by promoting healthy lifestyle choices through education, information and encouragement.
- Striving to reduce inequalities brought about by socioeconomic and other external factors through encouragement and recognition of individual circumstances. Staff who were mindful of the most vulnerable in the community and regarded safeguarding as a component of every interaction.
- Appropriately trained staff working to diagnose, treat, manage or refer patients with illness in the most timely manner. Where cure is not possible, to work with allied colleagues in health and social care to provide the best support -physical, psychological and social - to allow patients dignity and control over their lives.

Although there was no formal business plan in place, we found the practice had a clear plan as to how they would continue to operate and improve the service offered. It was evident in discussions we had with staff throughout the day that it was a shared vision and was fully embedded in staff's day-to-day practice. They had made appropriate succession plans to provide continuity where staff were due to retire or left employment with the practice.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities
- Practice specific policies were implemented and were available to all staff
- There was a comprehensive understanding of the performance of the practice
- A programme of continuous clinical and internal audit which is used to monitor quality and to make improvements
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions

Leadership, openness and transparency

The partners in the practice have the experience, capacity and capability to run the practice and ensure high quality care. They prioritise safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. The partners encouraged a culture of openness and honesty.

Staff told us that regular team meetings were held. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. They described the relationships between leaders and staff as positive, open and based on respect. Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through surveys and complaints received. The practice was in the process of reinstating their patient participation group and had plans for those areas where they thought the PPG could add value by generating ideas for improvement.

The practice had also gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussion. Staff told us they would not

Are services well-led?

Good

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

hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Innovation

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was engaged with other organisations locally to improve health inequalities and efficiencies in primary care. For example, the practice was a partner in the emerging local GP federation. They were participating in discussions as to how the federation could help to improve primary care in the area. Discussions were at early stages and no key strategy had yet been developed.