Norton Canes 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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Norton Canes Practice on 26 November 2015. Overall the practice is rated as good.

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

Our key findings were as follows:

- Staff knew how to and understood the need to raise concerns and report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and acted upon.
- Risks to patients were assessed and well managed.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- Best practice guidance was used to assess patients' needs and plan and deliver their care.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patient information, including how to complain was available and easy to understand.
- Patients told us they could get an appointment when they needed one.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.

We saw several areas of outstanding practice including:

- The practice organised evening Health Awareness Sessions, where they invited speakers, for example specialist nurses. Patients registered at the practice were invited to these sessions, and the local community were also made aware via the local village newsletter. The most recent event held on 11 November 2015 was about Stroke Prevention, and

Summary of findings

the guest speaker was the local stroke nurse specialist. Staff told us this was well attended and included people who were not registered at the practice.

There were also areas of practice where the provider needs to make improvements.

The provider should:

- Record clinical audits in a way that clearly identifies the four stages of the audit cycle.

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. There was a system in place for reporting, recording, monitoring and reviewing significant events, Staff understood and fulfilled their responsibilities to raise concerns, and were encouraged to 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 patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. There was a GP lead who oversaw any changes to guidelines. 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. The practice worked closely with the multidisciplinary care team to ensure care plans were in place and were regularly reviewed for patients with complex needs. The practice took part in the avoiding unplanned admissions scheme. The nurse practitioner reviewed all discharge letters for these patients, and contacted the patient to discuss their admission and discharge and to ensure they had everything in place that they required, for example changes to medication.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients were positive about the service they experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. They 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. Systems were in place to support carers and patients to cope emotionally with their health condition. Information to help patients understand the services available was easy to understand. We saw that staff were respectful and polite when dealing with patients, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the

Summary of findings

Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients told us they could get an appointment when they needed one, although two patients told us they sometimes had difficulties getting through on the telephone to make an appointment. This was in contrast to the national GP survey, which indicated that 74.9% of patients found it easy to get through to the practice by telephone. Patients requiring an urgent appointment were offered appointments at the end of surgery if no bookable appointments were available. The practice had good facilities and was well equipped to treat people and meet their needs. Information about how to complain was easy to understand 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 well led. The practice had a clear vision to deliver the best health care to patients. Staff were aware of the vision and mission statement and aware of their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular meetings to discuss performance and any issues that arose. There were systems in place to improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in end of life care and avoidance of unplanned admissions. It was responsive to the needs of older people and offered home visits and telephone consultations as required. Same day appointments were provided if requested. The practice identified if patients were also carers and offered health checks and influenza vaccines and supported referrals to the Carers Hub organised by the Carers Association Southern Staffordshire (CASS) and/or social services. CASS is a voluntary organisation which offers advice and support to people who have a caring role. Information about carer support groups was available in the waiting room and on the practice website.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. We found that the nursing team had the knowledge, skills and competency to respond to the needs of patients with a long term condition such as diabetes and asthma. Longer appointments and home visits were available when needed. The practice maintained registers of patients with long term conditions and all of these patients were offered a review to check that their health and medication needs were being met. The practice reviewed the most vulnerable two percent of the practice population who were at risk of admission to hospital. Written management plans had been developed for these patients and were reviewed at least annually. For those people with the most complex needs, the GPs worked with relevant health and social 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 who were at risk, for example families with children in need or on children protection plans. Appointments were available outside of school hours and the premises were suitable for children and babies. Same day emergency appointments were available for children. There were screening and vaccination programmes in

place and the immunisation rates were comparable or above the local Clinical Commissioning Group average. The practice provided GP led baby clinics, supported by the nursing staff. A family planning service was available, as well as screening kits for chlamydia.

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 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. A range of on-line services were available, including medication requests, booking appointments and access to health medical records. The practice offered extended hours with the GP between 6.30pm and 8pm one evening a week, and with the practice nurse between 7.30am and 8am on Wednesday mornings. Same day telephone consultations were available. The practice offered all patients aged 40 to 75 years old a health check with the nursing team. The practice offered 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 all patients they assessed as being vulnerable, and staff were alerted to this when accessing the patient's notes electronically.

The practice held a register of patients with a learning disability and had developed individual care plans for each patient. The practice carried out annual health checks and offered longer appointments for patients with a learning disability.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice held registers of patients with poor mental health, depression and

dementia and staff were alerted to this when accessing the patient's notes electronically. Patients experiencing poor mental health were offered an annual physical health check. Home visits were offered to patients with dementia for their annual review. The practice had reviewed 88% of patients who were on the dementia register. Memory clinics for patients were held on site and practice worked closely with the memory clinic co-ordinator. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

Summary of findings

What people who use the service say

We spoke with seven patients during the inspection and collected 39 Care Quality Commission (CQC) comment cards. Patients were positive about the service they experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. Comment cards highlighted that staff were kind, helpful and considerate. Six out of seven patients spoken with told us they felt fully informed and involved in the decisions about their care and treatment. They 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.

The national GP patient survey results published on 2 July 2015 showed that patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was above average for most of its satisfaction scores on consultations with doctors and nurses. For example:

- 87.5% said the GP gave them enough time compared to the Clinical Commissioning Group (CCG) average of 81.7% and national average of 86.6%.
- 98.4% said they had confidence and trust in the last GP they saw compared to the CCG average of 92.9% and national average of 95.3%
- 95.6% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 89.8% and national average of 90.4%.
- 95.6% said the last nurse they saw or spoke with was good at listening to them compared to the CCG average of 91.6% and national average of 91%.
- 100% said they had confidence and trust in the last nurse they saw compared to the CCG average of 96.5% and national average of 97.2%

However the results indicated that the practice could perform better in certain aspects of care when explaining tests and involving patients in decision making. For example:

- 71.5% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81.1% and national average of 86.3%.
- 70.3% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 75.3% and national average of 81.5%.
- 82.5% said that the last time they saw or spoke to a nurse; the nurse was good or very good at involving them in decisions about their care compared to the CCG average and national average of 84.9%.

Areas for improvement

Action the service SHOULD take to improve

Record clinical audits in a way that clearly identifies the four stages of the audit cycle.

Outstanding practice

The practice organised evening Health Awareness Sessions, where they invited speakers, for example specialist nurses. Patients registered at the practice were invited to these sessions, and the local community were also made aware via the local village newsletter. The most recent event held on 11 November 2015 was about Stroke Prevention, and the guest speaker was the local stroke nurse specialist. Staff told us this was well attended and included people who were not registered at the practice.

Norton Canes Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a second CQC inspector, a GP specialist adviser and an Expert by Experience.

Background to Norton Canes Practice

Norton Canes Practice, also known as Dr B K Singh, is situated in Norton Canes, Cannock, Staffordshire. It is part of the NHS Cannock Chase Clinical Commissioning Group (CCG). The practice is located in purpose built health centre and shares the facilities with another two GP practices and NHS community services. At the time of our inspection there were 4,181 patients on the patient list. Fifty-one percent of the practice population are aged between 45 and 85 plus years old, which is higher than the local CCG and national average.

A team of two GP partners (one male and one female), a salaried GP (male), a nurse practitioner, a practice nurse and a health care assistant provide care and treatment to the practice population. They are supported by a director of management, practice manager and a team of reception staff. The practice is open from 8am until 6.30pm from Monday to Friday. Appointment times are staggered between 9.00am and 12.10pm, and 3.30pm and 6pm (4pm to 6pm on a Monday). Extended hours appointments are available with a GP between 6.30pm and 8pm on a Monday. Nurse appointments are available between 8.10am and 1pm, and 2pm and 6pm. Early morning appointments with the nurse are available between 7.30am and 8am on Wednesdays. Patients requiring a GP outside of normal working hours are advised to contract the practice and the telephone is automatically diverted to the NHS 111 service. The practice has a PMS (Personal Medical Services) contract and also offers enhanced services for example: various immunisation schemes and avoiding unplanned admissions.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 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

Detailed findings

- 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 visiting the practice we reviewed information we held and asked key stakeholders to share what they knew about the practice. We did not receive any information from key stakeholders, We also reviewed policies, procedures and other information the practice provided before the inspection day. We carried out an announced visit on 26 November 2015.

We spoke with a range of staff including the GPs, the nurse practitioner and practice nurse, the practice manager and members of reception staff during our visit. We sought the views from the representatives of the patient participation group and looked at comment cards and reviewed survey information.

Good

Are services safe?

Our findings

Safe track record and learning

The practice had a system in place for reporting, recording and monitoring significant events and near misses. Patients affected by significant events received a timely and sincere apology and were told about actions taken to improve care. There was an electronic system in place for recording significant events. Staff told us they were encouraged to report any significant events and near misses and were aware of the process for doing so. The practice carried out an analysis of the significant events.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared between the GP and staff to make sure action was taken to improve safety in the practice. Staff were able to recall the most recent significant event that was discussed at the last practice meeting. For example, two prescriptions were generated for the same medication for a patient but with different doses. This was identified by the GP when checking the prescriptions prior to signing / authorising. Following investigation staff were reminded not to change the dosage of medication at the patient's request and to check with the GP before any changes were made. They were also reminded to check when the prescription had last been issued.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and 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 separate lead members of staff for safeguarding children and vulnerable adults. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. Contact details for external agencies were on display around the practice, including the consultation and treatment rooms.
- The practice held registers for children at risk, and children with protection plans were identified on the electronic patient record. We were shown two examples where the GP had acted appropriately and made referrals to social services to safeguard children. The practice had recently commenced monthly meetings with the health visitor, where they discussed children on the register and shared any concerns.
- A chaperone policy was available to all staff. Nursing and reception staff acted as chaperones if required and notices in the waiting room and consulting rooms advised patients the service was available should they need it. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There were procedures in place for monitoring and managing risks to patient and staff safety. The practice employed the services of an external company to carry out a health and safety risk assessment and the annual visit was carried out in October 2015. As the practice rented their part of the building, the landlord was responsible for a number of the risk assessments and ongoing work. We saw that the practice had obtained these or chased them up when overdue. The practice had up to date fire risk assessments and staff confirmed that fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical 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 and legionella. We noted that the annual testing of the water and the review of the legionella risk assessment were overdue and the practice had contacted the landlord requesting updates.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The nurse practitioner was the infection control clinical lead. There was an infection control protocol in place and staff had received up to date training, including hand washing techniques. An infection control audit had been undertaken in November 2015 which identified areas that needed attention and an action plan had been developed to address these.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing,

Good

Are services safe?

recording, handling, storing and security). Regular medication audits were carried out with the support of the local Clinical Commissioning Group (CCG) pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. We saw that by following the CCG antimicrobial prescribing guidelines the practice had reduced the number of prescriptions and the prescribing performance was below the CCG average. Prescription pads were securely stored and there were systems in place to monitor their use. The GPs told us they did not take the full range of emergency medicines that may be required on a home visit, for example antibiotics to be given in the event of suspected meningitis. They told us they contacted the patient prior to leaving the practice to assess their condition and what medication may be required and they would contact the emergency services if required.

- Recruitment checks were carried out and the five files we reviewed 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 the appropriate checks through the Disclose and Barring Service. Written statements regarding staff conduct in their role was on file for staff who were employed prior to registration with the Care Quality Commission.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all grades of staff. Staff worked additional hours to cover holidays and sickness.

Arrangements to deal with emergencies and major incidents

There were systems in place in the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. 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 power failure or building damage. The plan had been discussed at team meetings so that all staff were aware of what action to take.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff routinely referred to guidelines from the National Institute for Health and Care Excellence (NICE) when assessing patients' needs and treatments. The salaried GP had the lead role of NICE guidelines and was responsible for sharing changes to guidance with the GP partners and nursing staff. Staff had access to the NICE website via their computers. The practice monitored that these guidelines were followed through risk assessments and audits.

The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register, learning disabilities and palliative care register. The practice took part in the avoiding unplanned admissions scheme. Care plans had been developed for these patients and were reviewed annually or on change. The nurse practitioner reviewed all discharge letters for these patients, and contacted the patient to discuss their admission and discharge and to ensure they had everything in place that they required, for example changes to medication.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and performance against the national screening programmes to monitor outcomes for patients. The practice achieved 95.3% of QOF points which was above the local Clinical Commissioning Group (CCG) average of 91.9% and national average (94.2%). This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2013 – 2014 showed:

- Performance for diabetes related indicators was comparable to other local practices and similar or above the national average.
- The percentage of patients with hypertension whose blood pressure was within the recommended range was comparable to other local practices (89.65%) and above the national average (83.1%).
- The dementia diagnosis rate was comparable to other local practices (76.92%) although slightly below the national average (83.8%).

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and patients' outcomes. We saw a record of audits going back to 2008. We reviewed two clinical audits carried out during the last two years, one of which was a completed audit looking at antibiotic prescribing where the improvements made were implemented and monitored. The completed audit related to antibiotics prescribed and the first cycle identified that although 74% of patients were prescribed antibiotics appropriately, only 42% of the antibiotics were prescribed in accordance with the local guidelines and 10% of patients had no information in their notes about why the antibiotics prescribed. The clinicians were reminded of the local antibiotics prescribing guidelines and the importance of record keeping. The second audit cycle carried out after two months demonstrated an improvement with 96% of patients being prescribed antibiotics appropriately, of which 70% of antibiotics were prescribed in accordance to local guidelines and only 4% of patients with no information recorded in their notes about why the antibiotics were prescribed. The clinical audits would benefit from being recorded in a way that clearly identified why the audit was carried out, the findings and the conclusions.

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 safeguarding, fire safety, health and safety and confidentiality.
- Structured induction programmes were in place for newly appointed members of clinical member of staff.
- The learning needs of staff were identified through appraisals, discussions and meetings. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support during sessions, monthly protected learning time either in house or organised by the CCG, and facilitation and support for the revalidation of doctors

and nurses. Each member of staff was given feedback forms to hand out to colleagues to comment on their performance prior to their appraisal and learning and development needs / objectives were agreed. All staff had had an appraisal within the last 12 months. One member of staff told us the practice was supporting them through further training in Information Technology. They told us this had increased their confidence when using the computer.

- Staff received training that included: safeguarding, mental capacity act, fire procedures, basic life support, infection control and equality and diversity.

Coordinating patient care and information sharing

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 record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. All relevant information was shared with other services in a timely way, for example when patients were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patient's needs and to assess and plan ongoing care and treatment. This included when patients moved between services, when they were referred, or after they are discharged from hospital. The practice held multidisciplinary team meetings bi-monthly to discuss the needs of complex patients, for example those with end of life care needs. Nursing staff told us that the care plans for patients who were identified as part of the admission avoidance scheme were reviewed at least annually or when any changes occurred. The nurse practitioner reviewed all discharge letters for these patients, and contacted the patient to discuss their admission and discharge and to ensure they had everything in place that they required, for example changes to medication. Nursing staff also told us they work closely with specialist nurses, such as the community respiratory nurse, diabetic nurse specialist as well as the community matrons and district nurses.

Consent to care and treatment

Patients' consent to care and treatment was 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 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 assessed the patient's capacity. The practice also carried out dementia screening and one of the GP partners was the lead for dementia and worked closely with the memory clinic and the care co-ordinator to ensure patients and families received the additional support that they required. The practice told us that 88% of the patients identified on the dementia register had received an annual review. Clinical staff had attended training on the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLs) as part of their protected learning time with the local Clinical Commissioning Group. Other staff had received in house training delivered by one of the GPs. Staff told us that written consent was obtained when required, for example, immunisations, travel vaccinations and minor surgery.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition (disease prevention) and those requiring advice on their diet and smoking cessation. The practice offered in house smoking cessation support, and 99% of patients identified as smokers had received advice, and 38.2% had been assisted to stop smoking.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 77.95% which was slightly below the national average of 81.8%. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable or above the national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 80.4% to 100% and five year olds from 94.4% and 100%. Weekly baby clinics were held at the practice when mothers and babies could be seen by the lead GP and the practice nurse. Flu vaccination rates for the over 65s were 71.1% and for at risk groups 51%, both of which were in line with national averages.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and

Good

Are services effective?

(for example, treatment is effective)

NHS health checks for patients aged between 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

The practice organised Health Awareness Sessions in an evening, where they invited in speakers, for example specialist nurses. Patients registered at the practice were invited to these sessions, and the local community were also made aware via the local village newsletter. The most recent event held on 11 November 2015 was about Stroke Prevention, and the guest speaker was the local stroke nurse specialist. Staff told us this was well attended and included people who were not registered at the practice.

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 attending at the reception desk and that people were treated with dignity and respect.

We spoke with seven patients during the inspection and collected 39 Care Quality Commission (CQC) comment cards. Patients were positive about the service they experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. Comment cards highlighted that staff were kind, helpful and considerate.

Consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. Consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. Patients told us where appropriate they had been offered a chaperone for intimate examinations.

Results from the national GP patient survey published in July 2015 from 101 responses showed that patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was above average for most of its satisfaction scores on consultations with doctors and nurses. For example:

- 87.5% said the GP gave them enough time compared to the Clinical Commissioning Group (CCG) average of 81.7% and national average of 86.6%.
- 98.4% said they had confidence and trust in the last GP they saw compared to the CCG average of 92.9% and national average of 95.3%
- 95.6% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 89.8% and national average of 90.4%.
- 95.6% said the last nurse they saw or spoke with was good at listening to them compared to the CCG average of 91.6% and national average of 91%.
- 100% said they had confidence and trust in the last nurse they saw compared to the CCG average of 96.5% and national average of 97.2%

However performance in some areas was slightly lower than local and national averages for example:

- 73.5% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 78.3% and national average of 85%.

Care planning and involvement in decisions about care and treatment

Six out of seven patients we spoke with told us they felt fully informed and involved in the decisions about their care and treatment. They 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. Patients' comments on the comment cards we received were also positive and supported these views.

Data from the National GP Patient Survey July 2015 showed from 101 responses that performance in some areas was slightly lower than local and national averages for example:

- 71.5% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81.1% and national average of 86.3%.
- 70.3% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 75.3% and national average of 81.5%.
- 82.5% said that the last time they saw or spoke to a nurse; the nurse was good or very good at involving them in decisions about their care compared to the CCG average and national average of 84.9%.

Staff told us that translation services were available for patients who did not have English as a first language. In addition the GPs spoke a number of different languages. The practice website could also be translated into different languages.

The practice had a zero tolerance to violent or abuse patients. Staff told us they had not experienced any potentially difficult situations with patients. Staff were not aware of any local practices within the locality that would accept violent and abusive patients should the need arise to remove patients from the practice list.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

Notices in the waiting room and information on the practice website told patients how to access a number of support groups and organisations.

The practice's computer system alerted clinical staff if a patient was also a carer. There was a practice register of all patients who were carers, and offered health checks and influenza vaccinations. Staff advised carers who were not registered at the practice to request influenza vaccines from their own GP. Written information for carers was provided by the practice with the option of a referral to the Carers Hub organised by the Carers Association Southern Staffordshire (CASS) and/or social services. Information about CASS was available on the practice website. CASS is a voluntary organisation which offers advice and support to people who have a caring role.

The practice worked closely with the Care Co-ordinator linked to the memory clinic. Patients and their families were referred to the care co-ordinator if they required additional support or services.

Staff told us that if families had suffered bereavement, they were contacted by their usual GP and sent a bereavement leaflet with information about the service available. Information about bereavement support was on display in the waiting room.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was actively engaged with the local Clinical Commissioning Group (CCG) and therefore involved in shaping local services.

The 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.

- Home visits were offered to patients who were unable to or too ill to visit the practice. Health checks were carried out on housebound patients.
- Telephone consultations/advice were available to all patients but especially for working age patients and students.
- Extended hours were offered with a GP on Monday evenings and with the nurse on Wednesday mornings.
- Same day appointments were available for children under 2 years old and over 75 years when requested, as well patients assessed as requiring an urgent appointment.
- All patients on the admission avoidance register were reviewed on discharge following admission to hospital or accident and emergency. These patients were given a dedicated telephone number so they could contact the practice without having to go through the main telephone number.
- The practice engaged with the care co-ordinator and referred patients with memory loss to the memory clinic.
- The practice participated in the Patient Choice Scheme which enabled patients who lived outside of the practice area to be registered, without any obligation on the practice to provide home visits. One patient told us they had recently moved out of area but remained registered at the practice. Patients were advised to contact NHS 111 if they were too ill to attend the practice and telephone advice was not appropriate.
- There were disabled facilities and translation services available. The GPs spoke a number of different languages.

Access to the service

The practice was open from 8am until 7.30pm on Mondays, and 8am until 6.30pm from Tuesday to Friday.

Appointment times were staggered between 9am and 12.10pm, and 3.30pm and 6pm (4pm to 6pm on a Monday). Extended hours appointments were available with a GP between 6.30pm and 8pm on a Monday. Nurse appointments were available between 8.10am and 1pm, and 2pm and 6pm Monday to Friday. Early morning appointments with the nurse are available between 7.30am and 8am on Wednesdays.

The practice offered a number of appointments each day with the GPs and nursing staff for patients who needed to be seen urgently, as well as pre-bookable appointments. Once the same day appointments had been taken, patients requiring an urgent appointment were seen at the end of surgery. Same day appointments were always offered to children under 2 years and patients over 75 years when requested. The practice voluntarily offered flexible Saturday working especially over a prolonged national holiday period, to reduce the burden on the out of hours service and accident and emergency.

Patients told us they could get an appointment when they needed one. Two of the seven patients we spoke with told us they sometimes had difficulties getting through on the telephone to make an appointment. These comments were similar to those made on one comment card. This was in contrast to the result of the national GP patient survey.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages and patients we spoke with on the day were able to get appointments when they needed them. For example:

- 74.9% of patients said they could get through easily to the practice by phone compared to the CCG average of 75.5% and national average of 73.3%.
- 86.9% of patients said they were able to get an appointment or speak to someone the last time they tried, compared to the CCG average of 85.3% and national average of 85.4%.

However performance in some areas was lower than local and national averages for example:

- 42.8% of patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 69.5% and national average of 65.2%.
- 40.3% of patients felt they didn't normally have to wait too long to been seen time compared to the CCG average of 61.9% and national average of 57.8%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice was aware that waiting times were an issue as it had been identified during the 2014 patient survey, although improvements had been noted from the previous year. An action plan had been put in place and patients booked to see the GP who often ran late were offered the opportunity to see another GP if they did not wish to wait.

Listening and learning from concerns and complaints

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

Information on how to complain was available on the website and complaint forms were available in reception. None of the patients we spoke with had any complaints about the practice.

We looked at a summary of two complaints made during the last 12 months and found these had been satisfactorily handled and demonstrated openness and transparency. Although no themes were identified from these complaints, learning points had been identified and shared with the staff team. We saw that the practice also had a system in place for dealing with any verbal / informal complaints as they arose. We saw that the main theme of the complaints was around the telephone access. The practice acknowledged the difficulties around answering the telephone and as a consequence had carried out an audit to see when the telephones were most busy. They had identified the busiest period to be between 9am and 10 am and allocated a dedicated staff member each day to answer the telephone during this period.

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 the best health care to patients and to have all staff fully trained. We saw that the vision and mission statement had been discussed at the staff meeting held in September 2015.

There have been recent changes in the management structure at the practice. Dr R Singh (who was not a GP) had joined the practice in April 2014 as the Director of Management. The practice had been without a practice manager for 12 months, and this role had been filled by a temporary Assistant Manager (an experienced senior receptionist). A new practice manager had been appointed and started their employment the week of the inspection.

The practice was working towards becoming a teaching practice in January 2016, and the salaried GP had undertaken the necessary training to become a GP trainer. The practice was also looking to work with other practices in the locality through the Clinical Commissioning Group. The current strategies were discussed at the management meetings.

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. Changes to policies were emailed to staff so they remained up to date.
- There was a comprehensive understanding of the performance of the practice. Data relating to the Quality and Outcomes Framework was reviewed monthly.
- A system for reporting incidents without fear of recrimination and whereby learning from outcomes of analysis of events actively took place.
- A system of continuous audit cycles which demonstrated an improvement in outcomes for patients.
- Clear methods of communication that involved the whole staff team and other healthcare professionals to disseminate best practice guidelines and other information.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- Confidential information was stored securely.

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure good quality care. The GPs and Director of Management were visible in the practice and staff told us they were approachable and they felt able to raise any issues or ask for help and support. The partners encouraged a culture of openness and honesty.

Staff told us that regular team meetings were held and minutes of meetings were made available to all staff. 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 were confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported. The practice manager planned to hold focus groups to discuss how to run and develop the practice and to discuss new ideas with the staff.

The practice staff told us they worked well together as a team and there was evidence that staff were supported to attend training appropriate to their roles. The reception team told us they worked well together as a team and shared duties when required to cover sickness or holidays. The GPs were involved in revalidation, appraisal schemes and continuing professional development. There was evidence that staff had learnt from incidents and there was evidence of shared learning between staff.

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), NHS Friends and Family Test and complaints received. The practice had a well-established Patient Participation Group (PPG) who met every three months. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. There were also a small number of virtual PPG members who

Are services well-led?

Good

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

contributed to discussions with email. We spoke with two members of the group who told us the practice had been responsive to their suggestions. For example, fitting safety covers to the electrical sockets in the waiting room and notices requesting patients did not smoke directly outside the doors to the building. They told us they had asked the practice to develop an action plan in response to any concerns raised. We saw that the PPG meeting minutes covered any areas of concern, and actions were agreed via an action plan. The members told us they supported the practice with patient satisfaction surveys.

Patients were kept information about changes at the practice via the practice newsletter and information in the local village newsletter. The practice had reviewed the results from the national GP survey and these were on display in the reception area. The practice reviewed all comments made on NHS Choices and responded to each one individually.

The practice gathered feedback from staff via annual appraisals, staff meetings and discussion. The practice told us they planned to set up a 'survey monkey' for all staff to complete and give feedback about the practice.

Innovation

The practice organised Health Awareness Sessions in an evening, where they invited in speakers, for example specialist nurses. Patients registered at the practice were invited to these sessions, and the local community were also made aware via the local village newsletter. The most recent event held on 11 November 2015 was about Stroke Prevention, and the guest speaker was the local stroke nurse specialist. Staff told us this was well attended and included people who were not registered at the practice.

The practice was actively engaged with the local Clinical Commissioning Group (CCG) and therefore involved in shaping local services. The CCG had grouped the practices into three localities, and the practices in the locality were looking to develop the role of GPs with special interests within these practices to reduce the number of referrals into secondary care. The practices were also looking at the feasibility of Saturday opening in rotation to share the workload.

The practice had signed up to a research project looking at patients with cardio vascular disease (heart disease) and the timing of their medication. The focus of the study was to evaluate whether outcomes for patients were improved by taking medication at night rather than in the morning.