

Chadsmoor 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	Requires improvement	
Are services safe?	Requires improvement	
Are services effective?	Requires improvement	
Are services caring?	Good	
Are services responsive to people's needs?	Good	
Are services well-led?	Inadequate	

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 Chadsmoor Medical Practice on 11 March 2016. We revisited the practice on 4 April 2016 to clarify information around record keeping, monitoring of patients with certain medical conditions and emergency medicines. Overall the practice is rated as requires improvement.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, the practice did not have a robust system in place for reporting and recording significant events, and there was no evidence of learning and communication with staff.
- The practice did not have robust arrangements for identifying, recording and managing risks and implementing mitigating actions. For example: the risk to reception staff from handling samples or clinical

waste had not been assessed or their immunisation status recorded and a risk assessment had not been carried out to explain the rationale why a DBS check had not been completed for all members of staff.

- Data showed patient outcomes were low compared to the locality and nationally. There was little evidence to support that Quality and Outcomes Framework (QOF) data was monitored and discussed and it was not clear if any member of staff took responsibility for monitoring QOF outcomes.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- Patients told us they could usually get an appointment when they needed one, with urgent appointments available the same day. Patients could also access urgent appointments via the Cannock Network Project.
- The practice had no clear leadership structure and limited formal governance arrangements.

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

Summary of findings

Importantly, the provider must:

- Introduce a robust system for reporting, recording, reviewing and learning from significant events.
- Assess the risk to reception staff from handling samples or clinical waste.
- Implement a system to monitor the use of prescription stationery.
- Implement a system to ensure that the practice nurses and phlebotomists have indemnity insurance in place.
- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision.

In addition the provider should:

- Ensure that all the Disclosure and Barring checks for staff relate to their current employment.
- Implement a system to ensure regular meetings are held within the practice and information discussed at meetings is minuted and shared with the appropriate staff members.

- Implement a robust recall system for patients with long term conditions.
- Introduce a system to record verbal/informal complaints.

Where, as in this instance, a provider is rated as inadequate for one of the five key questions or one of the six population groups it will be re-inspected no longer than six months after the initial rating is confirmed. If, after re-inspection, it has failed to make sufficient improvement, and is still rated as inadequate for any key question or population group, we will place it into special measures. Being placed into special measures represents a decision by CQC that a service has to improve within six months to avoid CQC taking steps to cancel the provider's registration.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services.

- The process for recording, investigating and learning from incidents that may affect patient safety had weaknesses. The practice did not have a policy for significant events in place for staff to refer to. Although the practice carried out investigations when there were unintended or unexpected safety incidents, lessons learned were not communicated and so safety was not improved. There was a lack of recognition as to what constituted a significant event.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from the risk of abuse.
- The practice did not have robust arrangements for identifying, recording and managing risks and implementing mitigating actions. For example: the risk to reception staff from handling samples or clinical waste had not been assessed or their immunisation status recorded and a risk assessment had not been carried out to explain the rationale why a DBS check had not been completed for all members of staff.
- Systems were not in place to monitor the use of prescription stationery.

Requires improvement



Are services effective?

The practice is rated as requires improvement for providing effective services.

- Data showed patient outcomes were low compared to the locality and nationally. local Clinical Commissioning Group (CCG) average and 11.2% below the national average. The percentage of patients at the practice with diabetes, on the register, who had had influenza immunisation in the preceding 1 August to 31 March was 79.54% compared with the national average of 94.45% and the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (practice 45.45% / national 88.47%).

Requires improvement



Summary of findings

- The practice did not have a structured system in place to invite patients for a review of any long terms conditions, or identify patients who did not attend for reviews, or screening tests, for example cervical smears.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for staff.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.

Are services caring?

The practice is rated as good for providing caring services.

- Data from the National GP Patient Survey published in January 2016 showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Staff acted appropriately when they had concerns about a patient's welfare. A patient who was unwell presented at reception. The receptionist took the patient to sit in a quiet area away from the waiting room. They then spoke with the GP to rearrange the appointment list so the patient could be seen quicker. A patient was asked if they would see another GP so the unwell patient could have the next appointment with the GP they were booked in to see.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- The practice engaged with the local Clinical Commissioning Group (CCG) and had been involved in shaping local services.
- Patients told us that they were able to get appointments when they needed them, with urgent appointments available the same day.
- The practice was equipped to treat patients and meet their needs.

Good



Summary of findings

- Patients could get information about how to complain in a format they could understand. The practice did not have a system in place for recording minor issues which were dealt with by reception staff and not escalated. There were no written records relating to these issues, so it was not possible to say if any themes could have been identified or any learning points identified and shared with the staff team.

Are services well-led?

The practice is rated as inadequate for being well-led and improvements must be made.

- The practice did not have a vision or values that were shared with staff and patients, although all staff worked towards providing the best care they could.
- The practice did not have a business plan in place to support any forward planning for the business.
- Staff told us the GPs were visible in the practice, approachable and took the time to listen to all members of staff.
- The practice did not have an effective overarching governance framework which supported the delivery of good quality care. This included a lack of formal meetings which were minuted, oversight of performance and identifying learning from significant events and complaints.
- The practice did not have robust arrangements for identifying, recording and managing risks, and implementing mitigating actions.
- The practice received feedback through the NHS Friends and Family Test and the national GP survey and had a Patient Participation Group.

Inadequate



Summary of findings

The six population groups and what we found

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

Older people

The practice was rated as good for caring and responsive overall and this includes for this population group. The practice was rated as requires improvement for safe and effective and inadequate for well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The practice offered 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 as required. Continuity of care was provided for patients living a local care as one of the GP partners carried out the visits and reviews.
- The practice identified if patients were also carers and offered them the annual influenza vaccination and discussed their needs.

Requires improvement



People with long term conditions

The practice was rated as good for caring and responsive overall and this includes for this population group. The practice was rated as requires improvement for safe and effective and inadequate for well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The nursing staff had the knowledge, skills and competency to respond to the needs of patients with a long term condition such as diabetes.
- The practice maintained registers of patients with long term conditions. Although these patients were offered a review to check that their health and medication needs were being met, the practice did not have a structured system in place for inviting patients for their review or identifying patients who did not attend.
- The practice reviewed the most vulnerable of the practice population who were at risk of admission to hospital. 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.

Requires improvement



Summary of findings

Families, children and young people

The practice was rated as good for caring and responsive overall and this includes for this population group. The practice was rated as requires improvement for safe and effective and inadequate for well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- 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. However, the immunisation rates
- The practice's uptake for the cervical screening programme was 70.7%, which was below the national average of 81.83%.
- The practice offered family planning and contraception services including implant/coil fitting.

Requires improvement



Working age people (including those recently retired and students)

The practice was rated as good for caring and responsive overall and this includes for this population group. The practice was rated as requires improvement for safe and effective and inadequate for well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The practice offered extended hours with the GPs on Tuesday evenings
- The practice could book patients into the Cannock Network Project for appointments outside of normal opening hours.
- The practice was proactive in offering online services.
- The practice offered all patients aged 40 to 75 years old a health check with the nursing team.
- The practice offered a range of health promotion and screening that reflected the needs for this age group.

Requires improvement



People whose circumstances may make them vulnerable

The practice was rated as good for caring and responsive overall and this includes for this population group. The practice was rated as requires improvement for safe and effective and inadequate for well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Requires improvement



Summary of findings

- The practice held a register of patients with a learning disability. Seventeen patients had been identified and of these, nine (53%) had received an annual health review. Longer appointments were available for patients with a learning disability.
- 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)

The practice was rated as good for caring and responsive overall and this includes for this population group. The practice was rated as requires improvement for safe and effective and inadequate for well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- 80.95% of patients diagnosed with dementia who had had their care reviewed in a face to face meeting in the last 12 months, which was line with the national average of 84%.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record was 45.45% when compared with the national average of 88.47%.
- The practice held registers of patients with poor mental health and dementia. Patients experiencing poor mental health were offered an annual physical health check.
- Patients with a suspected diagnosis of dementia could be referred to the Memory Clinic.

Requires improvement



Summary of findings

What people who use the service say

We spoke with seven patients during the inspection and collected eight Care Quality Commission (CQC) comment cards. All of the comment cards we received were positive 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. Patients told us that they were able to get appointments when they needed them, although a number of patients commented that they did not always get to see the GP of the choice as they were unavailable.

We spoke with one member of the patient participation group. They also told us they were satisfied with the service and care provided by the practice and that staff were friendly and welcoming. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey published in January 2016 from 111 responses showed patients felt

they were treated with compassion, dignity and respect. Results were in line with local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 80% said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 82% and national average of 88.6%.
- 82.7% said the GP gave them enough time (CCG average 82.7%, national average 86.6%).
- 94.3% said they had confidence and trust in the last GP they saw (CCG average 93.8%, national average 95.2%).
- 84% said the last GP they spoke to was good at treating them with care and concern (CCG average 80%, national average 85%).
- 94% said the last nurse they spoke to was good at treating them with care and concern (CCG average 90%, national average 91%).

Areas for improvement

Action the service **MUST** take to improve

Introduce a robust system for reporting, recording, reviewing and learning from significant events.

Assess the risk to reception staff from handling samples or clinical waste.

Implement a system to monitor the use of prescription stationery.

Implement a system to ensure that the practice nurses and phlebotomists have indemnity insurance in place.

Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision.

Action the service **SHOULD** take to improve

Ensure that all the Disclosure and Barring checks for staff relate to their current employment.

Implement a system to ensure regular meetings are held within the practice and information discussed at meetings is minuted and shared with the appropriate staff members.

Implement a robust recall system for patients with long term conditions.

Introduce a system to record verbal/informal complaints.

Chadsmoor Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team included a second CQC inspector, GP specialist adviser, a practice manager specialist adviser and an expert by experience.

Background to Chadsmoor Medical Practice

Chadsmoor Medical Practice is situated in Chadsmoor, Cannock. The practice is part of the NHS Cannock Chase Clinical Commissioning Group. At the time of our inspection there were 4081 patients on the patient list. The practice population has a higher number of younger patients; 41.1% aged 18 years and under and a lower than average percentage of patients aged 65 years and over (practice 23.9% / national 27.2%).

A team of two GP partners (one male / one female), a salaried GP (female) an advanced nurse practitioner (ANP) and two practice nurses provide care and treatment to the practice population. They are supported by a practice manager and a team of reception staff. Two members of reception staff are also trained to take blood samples. The practice is open every week day from 8.30am until 6.30pm, and the telephones are answered from 8am. Appointments are available every day except Thursday afternoons. Consultation times vary depending which GP is working, the earliest at 8.40am and the latest at 5.30pm. Extended hours appointments are available with the GPs on Tuesday evenings.

The practice does not provide an out-of-hours service to its own patients but has alternative arrangements for patients

to be seen when the practice is closed through Staffordshire Doctors Urgent Care, the GP out-of-hours service provider. The practice has a Personal Medical Services (PMS) contract and also offers enhanced services for example: various immunisation schemes, hospital admission avoidance scheme and minor surgery.

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
- People with long-term conditions
- Families, children and young people

Detailed findings

- 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 also reviewed policies, procedures and other information the practice provided before the inspection day. We carried out an announced visit on 11 March 2016 and an additional visit on 4 April 2016.

We spoke with a range of staff including the GPs, the advanced nurse practitioner, a practice nurse, practice manager and members of reception staff during our inspection. We spoke with patients, one member of the patient participation group who was also a patient, looked at comment cards and reviewed survey information. We also spoke with representatives from two local care homes who cared for patients who received a service from the practice.

Are services safe?

Our findings

Safe track record

The practice did not have a robust system in place for reporting and recording significant events.

- The practice did not have a significant event policy and procedure. It was not clear how significant events were managed within the practice. Staff spoken with were not clear about what a significant event was or how to report it.
- The practice had recorded four significant events since April 2015. Three of the records related to events that were external to the practice. Practice staff told us about a recent occasion when the electronic computer system had been unavailable. This has not been recognised or recorded as a significant event, even though it had impacted on the running of the practice.
- The senior GP told us that if there were unintended or unexpected safety incidents, patients would receive an apology.
- Although significant event meetings took place, they were on an ad hoc basis rather than planned on a regular basis, and there was no record of who attended the meetings. Not all practice staff attended the significant meetings and minutes of the meetings were not kept. There was no overview of significant events to identify themes or trends, or to review whether any learning had been embedded into practice.
- Medicine and equipment alerts were disseminated to the GPs and the practice nurses by the practice manager. The practice had taken appropriate action on receipt of the most recent medicines and equipment alerts. We saw that the practice had identified those patients who were prescribed the medicines in the most recent alerts, and taken appropriate action. For example, arranged blood monitoring for those patients on a specific combination of medicines.

Overview of safety systems and processes

Although the practice had some systems, processes and practices in place to keep patients safe, these were not always robust.

- Arrangements were in place to safeguard children and vulnerable adults from the risk of 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. One of the GP partners was the lead member of staff for safeguarding. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs were trained to Safeguarding level three.

- The practice held registers for children at risk, and children with protection plans were identified on the electronic patient record. Although the practice did not meet regularly with the health visitor, they told us they contacted them by telephone to share any concerns.
- Notices around the practice advised patients that chaperones were available if required. All except one patient spoken with knew that chaperones were available, although no one had requested one.
- Members of the nursing team and reception staff acted as chaperones if required and staff who acted as chaperones were trained for the role and understood their responsibilities. However one member of staff told us they had stood outside of the curtain on one occasion at the request of the patient. All staff who acted as chaperones had received a disclosure and barring check (DBS). However, the DBS on file for one member of staff was a copy of the certificate obtained by a different organisation. (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).
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. One of the practice nurses was the infection control lead for the practice. Staff spoken to told us they had completed infection control training and this was supported by records. However, we noted that the cleaner had not received any infection control training and there was no record of whether reception staff had been offered or received immunisation towards Hepatitis B. An infection control audit had been undertaken in February 2015 by the NHS Trust which identified areas that needed attention. The practice had produced an action plan which demonstrated that the issues identified had been addressed following an internal audit carried out in April 2015.
- The arrangements for managing medicines, including emergency medicines and vaccinations, in the practice

Are services safe?

kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Prescription stationery was securely stored although the practice did not have systems in place to monitor their use.

- The advanced nurse practitioner had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- We reviewed seven personnel files and found appropriate recruitment checks had been undertaken prior to employment for staff employed since 2012 (registration with the Care Quality Commission). For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. However, one member of staff had a DBS that had been obtained by a different organisation. The cleaner (although employed since 2008) did not have a DBS certificate in place and a risk assessment had not been carried out to explain the rationale why DBS checks had not been completed. The practice was unable to demonstrate that the practice nurses or reception staff who also worked as phlebotomists had indemnity insurance in place.
- We saw that the GPs used a combination of paper records and electronic systems to record information about patients during / following consultations. We saw that information recorded on the paper notes was also recorded electronically.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representative. The practice had up to date fire risk assessments and the last fire drill was carried out in May 2015. 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 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 (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice had recently recruited an advanced nurse practitioner to the staff team. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Staff provided cover for holidays and sickness.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Staff spoken with told us they had received basic life support training and this was supported by training records.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks.
- The emergency medicines available during the first inspection were adrenaline, aspirin, Ventolin and GTN. The practice did not have a supply of atropine even though staff carried coil fitting and minor surgery. A risk assessment had not been completed to support the rationale for stocking the limited range of emergency medicines. The senior partner told us that up until recently they had stocked additional emergency medicines but they had been removed as clinical staff were concerned about administering them. When we revisited the service we saw that an appropriate range of emergency medicines were available for staff use.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- Alerts were cascaded electronically by the practice manager and a hard copy printed off and retained in a folder. Staff were required to sign to say that they had read the alert.

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, palliative care register or part of the avoiding unplanned admissions to hospital scheme. Care plans had been developed for these patients and were reviewed annually or on change. The practice had identified 72 patients as part of the avoiding unplanned admissions to hospital scheme, and 64 of these patients agreed to have a care plan.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed that the practice achieved 83.5% of the total number of points available (which was 10% below the local Clinical Commissioning Group (CCG) average and 11.2% below the national average), with 4.3% clinical exception rate (which was 5.9% below the CCG average and 4.9% below the national average). (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This practice was an outlier for four of QOF (or other national) clinical targets. These were:

- The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March (practice 79.54% / national 94.45%)
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (practice 45.45% / national 88.47%)
- The percentage of women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding 5 years (practice 70.7% / national 81.83%)
- The percentage of patients with physical and/or mental health conditions whose notes record smoking status in the preceding 12 months (practice 86.97% / national 94.1%)

The senior GP partner was aware that the practice was an outlier in these four areas and told us this was due to a reduction in practice nurse hours due to long term sickness over the last two years. They told us the data was improving as a new practice nurse had been employed. The practice had also recently employed an advanced nurse practitioner (ANP) who would be able to assist with patient reviews. We could not be assured that QOF data was monitored and discussed at formal practice meetings because minutes were not held, and it was not clear if any member of staff took responsibility for monitoring QOF outcomes. The practice manager told us they reviewed the long term condition registers around October each year and then concentrated on calling patients for reviews from January onwards. The practice recognised that the system was not robust and planned to introduce reviews during the birth month for patients. We saw that staff recorded when reviews took place, patients declined to attend a review, or they were under the care of a specialist nurse.

Clinical audits demonstrated some quality improvement.

- There had been five clinical audits completed in the last two years, two of these were completed audits where the improvements made were implemented and monitored.
- One of these was the use of anticoagulation therapy (prevent the clotting of blood) in patients with a particular heart condition which increase the risk of patients' having a stroke. The first audit cycle identified 14 patients with the condition who were not on

Are services effective?

(for example, treatment is effective)

anticoagulation therapy. These patients were reviewed by a consultant cardiologist and offered the opportunity to start anticoagulation therapy. The second audit cycle demonstrated an increase in the number of patients receiving the therapy, and a subsequent reduction (50%) in patients not receiving the therapy.

We reviewed the system in place to handle high risk medicines and saw that the necessary monitoring was being done to keep patients safe. We identified 26 patients receiving methotrexate (used in the treatment of rheumatoid arthritis) and we examined the records of four patients. Two of these patients had their bloods taken by the practice staff and two by the hospital. We saw that the practice acted promptly and appropriately when they had been informed that a patient had not attended their appointments for blood tests. We also checked the record for a patient who was receiving lithium and saw that the necessary monitoring was also taking place.

Effective staffing

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

- The newly appointed practice nurse and ANP had both completed an induction programme. It covered such topics as safeguarding, infection prevention and control, fire safety and information governance.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff for example, for those reviewing patients with long-term conditions. Staff administering vaccinations and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccinations could demonstrate how they stayed up to date with changes to the immunisation programmes, for example attending training sessions provided by the local CCG.
- The learning needs of clinical staff were identified through a system of appraisals and personal development plans. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. Clinical staff attended the monthly protected learning time sessions organised by the CCG. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support, infection prevention and control, manual handling, equality and diversity and

information governance awareness. Staff had access to and made use of e-learning training modules and in-house training. However, we saw that one member of staff (the cleaner) had not received any training.

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 investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services, or with the out of hour's service for patients with complex care needs.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared with the local out of hours service so they were aware of the patient's wishes and treatment choices when the practice was closed. We saw evidence that multi-disciplinary team meetings took place every six weeks to discuss patients identified on the palliative care register. These meetings were attended by the palliative care team, the community matron and community nurses. Regular meetings were held to discuss patients identified on the hospital admission avoidance register. The practice also worked closely with other community based specialist nurses to support patients with long term conditions, for example the respiratory nurse and heart failure nurse.

Consent to care and treatment

Staff sought patients' consent to care and treatment 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, the GPs carried out assessments of capacity to consent in line with relevant guidance.

Are services effective?

(for example, treatment is effective)

- Not all of the clinical staff had attended training on the Mental Capacity Act and Deprivation of Liberty Safeguards. None on the non clinical staff had received training on the Mental Capacity Act or consent.
- Written consent was obtained for minor surgery and joint injections. Parents or legal guardians provided written consent for childhood immunisations.

We spoke with two representatives from local care homes. They told us that they the GPs discussed end of life care as appropriate with patients and relatives, taking into account the patient's capacity to make decisions.

Supporting patients to live healthier lives

Patients who were 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, smoking and alcohol cessation. Staff told us patients could be referred to Together For Health for support with weight loss and smoking cessation programmes and One Support for support with alcohol intake. Exercise on referral was also available. Staff told us 70% of patients identified as smokers had received smoking cessation advice. Patients spoken with told us they had been offered support and advice on how to manage their long term condition or how to live a healthier life, for example support with weight loss and referral for pain management.

The practice's uptake for the cervical screening programme was 70.7%, which was below the national average of 81.83%. The practice did not have a robust system for

recalling patients who did not attend for their cervical screening test. Chlamydia screening kits were available in the practice. Twelve patients had been screened for chlamydia between April and December 2015.

Representatives from a local care home told us that all eligible patients were invited into the national screening programmes regards of their physical or mental health, although often the patients chose not to attend. The practice identified patients who were living with dementia, or a mental health condition. These patients were offered an annual review of their medication and physical health needs.

Childhood immunisation rates for the vaccinations given to under two year olds were all below the CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 72.9% to 97.9% (CCG rate 79.7% to 98.8%). The majority of the childhood immunisation rates for the vaccinations given to five year olds were above the CCG averages. For example the practice rates ranged from 84.8% to 100% (CCG rate 88.9% to 98.2%).

Patients had access to appropriate health assessments and checks. New patients were asked to complete a health questionnaire and would be offered a blood pressure checks. NHS health checks for people aged 40–74 were offered although staff told us the uptake was low. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

The practice nurses had supplies of leaflets relating to health promotion and support groups. However limited information was available for patients in the waiting room.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect. Staff knew many patients by their first names and asked about their wellbeing when they presented at the desk.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.

All of the eight patient Care Quality Commission comment cards we received were positive 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.

We spoke with one member of the patient participation group. They also told us they were satisfied with the service and care provided by the practice and that staff were friendly and welcoming. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey published in January 2016 showed patients felt they were treated with compassion, dignity and respect. Results were in line with local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 80% said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 82% and national average of 88.6%.
- 82.7% said the GP gave them enough time (CCG average 82.7%, national average 86.6%).
- 94.3% said they had confidence and trust in the last GP they saw (CCG average 93.8%, national average 95.2%).
- 84% said the last GP they spoke to was good at treating them with care and concern (CCG average 80%, national average 85%).
- 94% said the last nurse they spoke to was good at treating them with care and concern (CCG average 90%, national average 91%).
- 92.7% said they found the receptionists at the practice helpful (CCG average 87.1% and national average 86.8%)

Care planning and involvement in decisions about care and treatment

We spoke with seven patients and they told us 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. However, one patient commented that when they were referred to see a consultant they were not asked with which hospital they wished to be referred to, although another patient commented that they had been asked about their preference.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were above the local and national averages. For example:

- 87.7% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81.4% and national average of 86%.
- 81% said the last GP they saw was good at involving them in decisions about their care (CCG average 76%, national average 82%)
- 91% said the last nurse they saw was good at involving them in decisions about their care (CCG average 86%, national average 85%)

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a carers advise line and staff told us Care UK booklets were available.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 66 patients who were also carers, and these patients were offered the annual influenza vaccine, and their health needs were also discussed. The practice's carers' policy was not being used as it had not been updated since it had been written in 2013, and the information contained within it was out of date.

We saw that staff had acted appropriately when they had concerns about a patient's welfare. A patient who was unwell presented at reception. The receptionist took the patient to sit in a quiet area away from the waiting room. They then spoke with the GP to rearrange the appointment

Are services caring?

list so the patient could be seen quicker. A patient was asked if they would see another GP so the unwell patient could have the next appointment with the GP they were booked in to see.

One patient we spoke with told us that they had been supported by the practice during their spouse's illness and following their death. Patients could be referred to the local counselling service for support following bereavement.

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

The practice also had links with the local Citizens Advice Bureau (CAB), which until recently visited the practice every week for two hours. Patients were able to call in without an appointment to seek advice and support from the staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The senior partner attended the local CCG meetings and clinical staff attended the protected learning time events organised by the CCG. The practice was involved in the Cannock Network Project, a group of ten local GP practices that had developed a service whereby patients could book an on the day appointment through their own practice with a GP or nurse between 3.30pm and 8pm at the Network if appointments were not available at their own practice.

Patients could also pre-book appointments on Saturday mornings between 9am and 12 noon. The project had been set up using Prime Minister's Challenge Fund monies and with support from the CCG.

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.
- Annual review visits were carried at home for patients who were unable to visit the practice.
- One of the GP partners visited patients who lived in a local care home, to provide continuity of care.
- Patients aged 75 years and over and / or with long term conditions had direct telephone access to the practice via a separate mobile telephone number.
- The practice used the Acute Visiting Service (AVS) to carry out home visits between 2.30pm and 5.30pm. Care home staff were able to contact this service directly if a patient required to be seen by a GP. AVS was provided GP First, a federation of the GP practices in the local CCG area.
- Extended hours were offered with the GPs on Tuesday evenings.
- Same day appointments were available for children as well as patients requesting an urgent appointment.
- There were longer appointments available for patients who needed them.
- Telephone consultations/advice were available to all patients but especially for working age patients.
- All patients on the hospital admission avoidance register were reviewed on discharge following admission to hospital or accident and emergency.

- The practice referred patients with memory loss to the care co-ordinator at the memory clinic.
- There were disabled facilities, a hearing loop and translation services available.

Access to the service

The practice was open every week day from 8.30am until 6.30pm, although the telephones were answered from 8am. Appointments were available every day except Thursday afternoons. Consultation times varied depending which GP was working, the earliest at 8.40am and the latest at 5.30pm. Extended hours appointments were available with the GPs on Tuesday evenings.

Appointments could be booked in person, over the telephone and on line. The practice offered a number of appointments each day with the GPs and the advanced nurse practitioner (ANP) for patients who needed to be seen urgently, as well as pre-bookable appointments. Once the same day appointments had been taken, a small number of patients requiring an urgent appointment were seen at the end of surgery. Appointments were available on the day of the inspection. Once the same day appointments had been taken, patients requiring an urgent appointment were referred to the Cannock Network Project from 3.30pm until 8pm on weekdays. Pre-bookable appointments could also be made for Saturday mornings between 9am and 12 noon. The practice was also part of a cluster containing four GP practices. The GPs provided cover for each other for home visits, emergency and occasionally routine appointments.

Patients told us on the day of the inspection that they were able to get appointments when they needed them. However a number of patients commented that they did not always get to see the GP of the choice as they were unavailable. We observed patients making appointments with reception staff at a time and date that suited them.

Results from the national GP patient survey published in January 2016 showed that patients' satisfaction with how they could access care and treatment was above the local and national averages in some areas. For example:

- 82% of patients said they could get through easily to the practice by phone compared to the CCG average of 72.5% and national average of 73.3%.
- 80% 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 64.8%.

Are services responsive to people's needs?

(for example, to feedback?)

Patients' satisfaction with how they could access care and treatment was comparable to the local and national averages in some areas. For example:

- 83% 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 86.1% and national average of 85.2%.
- 64.1% of patients felt they did not normally have to wait too long to be seen on time compared to the CCG average of 61.6% and national average of 57.7%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Staff told us they investigated, discussed and responded to formal and informal complaints, although we could not be assured that this occurred as records were not kept for informal complaints.

- The 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 information to help patients understand the complaints procedure was available on the website, posters displayed in the waiting area and a patient information leaflet available from the reception.
- Not all of the patients we spoke were aware of the complaints procedure or how to make a complaint.

We looked at the one complaint that had been received during 2014 – 2015 and found that it had been satisfactorily handled and demonstrated openness and transparency. We looked at the minutes from the annual complaints review meeting held in September 2015, which indicated that minor issues raised by patients about appointments and prescriptions were dealt with by reception staff. There were no written records relating to these issues, so it was not possible to say if any themes could have been identified or any learning points identified and shared with the staff team.

Are services well-led?

Inadequate 

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

Our findings

Vision and strategy

The practice did not have a vision or values that were shared with staff and patients, although all staff told us they worked towards providing the best care they could. The practice did not have a business plan in place to support any forward planning for the business, including any succession planning.

Governance arrangements

We found that governance arrangements were not supported by the necessary management infrastructure and leadership and the governance processes and systems were not operated effectively or were applied inconsistently.

- The practice did not always have specific policies in place and available to all staff to support the safe running of services. For example; there was no significant event policy and procedure in place. Not all policies and procedures were up to date, although the practice manager was in the process of reviewing these.
- Clinical staff told us significant issues would be recorded in the patient's notes, and if not identified as a significant event that the individual practitioner would deal with it. The practice manager told us the significant events tended to be dealt with by the GP or practice manager at the time but were not always recorded.
- The practice was unable to demonstrate that the practice nurses or reception staff who also worked as phlebotomists had indemnity insurance in place.
- The practice did not have robust arrangements for identifying, recording and managing risks and implementing mitigating actions. For example, the risks associated with handling specimens or cleaning up spillages had not been assessed and systems were not in place to monitor the use of prescription pads and blank computer prescription forms.
- We could not be assured that a comprehensive understanding of the performance of the practice was maintained. Quality and Outcome Framework (QOF) data was not routinely monitored and discussed as formal practice meetings with minutes were not held. The practice did not have a robust system in place to invite patients for a review of any long term conditions, although there were plans to introduce a new system from April 2016.

- There were no written records relating to informal complaints, so it was not possible to say if any themes could have been identified or any learning points identified and shared with the staff team.

Leadership, openness and transparency

The GPs were visible in the practice and staff told us that they were approachable and took the time to listen to all members of staff. The GPs told us they encouraged a culture of openness and honesty and information sharing and learning from events. However, the system in place to support this was not robust, for example; the failure to share learning from significant events and complaints with staff.

Staff told us the practice did not hold regular meetings. They told us there was an open culture within the practice and they were able to raise any issues with the management team and felt confident in doing so and felt supported if they did. One member of staff discussed changes that had taken place following their suggestion regarding the storage of prescription requests.

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

The practice received feedback through the NHS Friends and Family Test and the national GP survey. The results from the NHS Friends and Family Test for 2015 had been analysed and were generally positive, as was feedback from the GP survey. However, the results had not been shared with the patients.

The practice had an active Patient Participation Group (PPG) which met with the practice on a regular basis. We spoke with a representative from the PPG. The representative told us that the practice had discussed the changes in primary and secondary care with them, and provided any information that they asked for. Information about the PPG was on display in the waiting room.

The practice had gathered feedback from staff generally through appraisals and informal discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

We did not see any evidence of continuous learning and improvement at all levels within the practice. For example: the lack of training provided to the cleaner and

Are services well-led?

Inadequate 

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

the failure to learn from significant events and complaints to drive forward improvements within the service. However, the practice was involved in local projects such as the Cannock Network Project.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity

Diagnostic and screening procedures
Family planning services
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

A clearly defined system for the handling and investigation of significant events was not in place.

The risk to reception staff and the cleaner from handling samples or clinical waste had not been assessed or their immunisation status recorded.

Systems were not in place to monitor the use of prescription stationery.

Regulation 12(1)(2)(a)(g)(h)

Regulated activity

Diagnostic and screening procedures
Family planning services
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

People using the service were not protected against the risks of inappropriate or unsafe care and treatment because of the lack of systems to assess, monitor and mitigate the risks relating to health, safety and welfare of patients.

The system for reporting significant events was not robust and did not support that learning from outcomes of analysis of significant events actively took place or was shared with staff.

There was no overview of significant events to identify themes or trends, or to review whether any learning had been embedded into practice.

A system was not in place to ensure that the practice nurses and phlebotomists had indemnity insurance in place.

Regulation 17(1) (2)(a)(b)(d)(i)(ii)(f)