Heath Hayes Health Centre

Quality Report

Gorsemoor Road
Heath Hayes
Cannock
WS12 3TG
Tel: 01543 278461
Website: www.heathhayeshealthcentre.nhs.uk

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Heath Hayes Health Centre on 4 May 2017. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they were usually able to get an appointment with a GP when they needed one. Urgent appointments were available the same day and patients had access to appointments through the Cannock Practice Network Surgery.
- 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. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

However, there were areas of practice where the provider should make improvements.

The provider should:

- Ensure that up to date blood results for high risk medicines are available to clinicians to assist with safe prescribing.

Summary of findings

- Carry out a risk assessment to support the rationale for not stocking injectable medicines to treat nausea and vomiting or severe pain.
- Formalise and record clinical supervision which takes place between the nurse practitioner and GP.
- Introduce a system to record any audits of patient notes for consent to procedures.
- Review the issues around confidentiality in the waiting area at Heath Hayes Health Centre and consider ways to improve confidentiality.
- Ensure information regarding interpretation services is easily accessible to patients at both sites.
- Adopt a more proactive approach to identifying and meeting the needs of carers.

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.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Clinicians did not always have access to the most up to date blood results prior to prescribing high risk medicines.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents. However, the practice did not stock injectable medicines to treat nausea and vomiting or severe pain.
- The nurse practitioner received mentorship and support and the lead GP reviewed a random sample of their consultations and provided feedback. However the feedback was not recorded.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were comparable to the national average.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff. Staff said they were supported to develop their skills by the practice.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Summary of findings

- Although patient consent was recorded for specific procedures, audits had been undertaken to ensure that consent was always obtained where required.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice lower than others for satisfaction on consultations with GPs but were comparable for consultations with nurses.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment when they were seen by nursing team but less so when they were seen by GPs.
- Information for patients about the services available was accessible. However, information about the availability of interpreting services was not on display at both sites.
- We saw staff treated patients with kindness and respect. However, a number of patients spoken with told us that not all reception staff were helpful or responsive to their needs.
- We saw that maintaining confidentiality in the waiting area at Heath Hayes Health Centre was a challenge due to the layout of the building.
- There was scope to adopt a more proactive approach to identifying and therefore meeting the needs of carers.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. The practice was part of the Cannock Practice Network Surgery which provided additional appointments for patients when appointments at the practice were not available.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they could usually make an appointment with a GP and urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- Information about how to complain was available and evidence from two examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Not all staff were aware of the practice vision and values. However, it was clear from discussion that everyone was working towards the same aim of high quality healthcare.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour. In two examples we reviewed we saw evidence the practice complied with these requirements.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients.

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.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice provided a service to patients in six care homes and carried out regularly weekly visits at one home. The same GP visited to provide continuity of care. The GPs visited patients in all of the care homes on request.
- The nurse practitioner and practice nurse carried out reviews for house bound patients.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was similar to the CCG and national averages. For example, the percentage of patients on the diabetes register, in whom a specific blood test to get an overall picture of what a patients average blood sugar levels had been over a period of time was recorded as 71% compared with the CCG and national average of 78%.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.

Summary of findings

- There was a system to recall patients for a structured annual review to check their health and medicines needs were being met. The practice had a structured system for inviting patients for their review or identifying patients who did not attend.
- For those patients with the most complex needs, the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives and health visitors to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.

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 practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- Patients could book appointments up to five weeks in advance.
- The practice offered extended hours appointments with the GPs and nurses were offered at Chase Medical Practice between 6.30pm and 8pm on Mondays and on Saturdays between 9am to 12 noon.
- The practice offered all patients aged 40 to 75 years old a health check with the nursing team.

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.

Summary of findings

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice had identified 89 patients on the learning disability register, 12 of which had attended for an annual review this year.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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 carried out advance care planning for patients living with dementia.
- 80% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia. Patients were invited for an annual review of their physical health needs.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The percentage of patients experiencing specific mental health conditions with an agreed care plan documented in the preceding 12 months was 92% compared to the local CCG average of 90% and national average of 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.

Summary of findings

- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice was involved in a pilot of a well being assessment worker programme. This pilot was funded by the local CCG and provided a counselling service for patients. Patients with low level mental health needs were seen within the practice.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. 251 survey forms were distributed and 111 were returned. This represented 1% of the practice's patient list:

- 79% of patients described the overall experience of this GP practice as good compared with the CCG average of 84% and the national average of 85%.

However, 63% of patients described their experience of making an appointment as good which was lower than the CCG and national average of 73%. In addition, 62% of patients said they would recommend this GP practice to someone who has just moved to the local area, which was also lower than the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 13 comment cards which were all positive about the standard of care received. Patients commented that the doctors and nurses listened to what they had to say, and staff were friendly and efficient.

We spoke with 14 patients during the inspection. All patients said they were satisfied with the care they received and thought the majority of staff were approachable, committed and caring. However, they told us that not all members of reception staff were helpful or responsive to their needs, particularly when appointments were not available. Five patients told us some reception staff did not offer any alternatives, such as an appointment with the nurse practitioner or an appointment at the network.

Areas for improvement

Action the service SHOULD take to improve

Ensure that up to date blood results for high risk medicines are available to clinicians to assist with safe prescribing.

Carry out a risk assessment to support the rationale for not stocking injectable medicines to treat nausea and vomiting or severe pain.

Formalise and record clinical supervision which takes place between the nurse practitioner and GP.

Introduce a system to record any audits of patient notes for consent to procedures.

Review the issues around confidentiality in the waiting area at Heath Hayes Health Centre and consider ways to improve confidentiality.

Ensure information regarding interpretation services is easily accessible to patients at both sites.

Adopt a more proactive approach to identifying and meeting the needs of carers.

Heath Hayes Health Centre

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 GP specialist adviser, a Practice Manager specialist advisor and an expert by experience.

Background to Heath Hayes Health Centre

Dr Hirendra Choudhary is registered with the Care Quality Commission (CQC) as an individual provider operating a GP practice in Cannock. Staffordshire. The practice is part of the NHS Cannock Chase Clinical Commissioning Group. The practice holds a General Medical Services (GMS) contract with NHS England. A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract. At the time of our inspection the practice had 10,214 patients.

The provider operates from two sites. The main site is Heath Hayes Health Centre, with a branch site in Cannock. The practice sites are located as follows:

- Heath Hayes Health Centre, Gorsemoor Road, Heath Hayes, Cannock, WS12 3T
- Chase Medical Practice, 65 Church Street, Cannock, WS11 1DS

The staffing across the two sites consists of:

- Five male GPs, of which four work as salaried GPs, and a part time female locum.
- A nurse practitioner, a practice nurse and a health care assistant (all female)
- A practice manager supported by secretarial staff, reception staff, and two apprentices.

Both Heath Hayes Health Centre and Chase Medical Practice are open between 8am and 6.30pm Monday to Friday and 9am to 12 noon on Saturdays. GP and nurse appointments are available Monday to Friday from 9am to 12.30pm and 2pm and 6pm at both practice sites. Extended hours appointments with the GPs and nurses are offered at Chase Medical Practice between 6.30pm and 8pm on Mondays, and on Saturdays between 9am to 12 noon.

The provider is also part of the Cannock Practice Network Surgery, based in the GP Suite at Cannock Hospital. Reception staff can offer patients appointments at the Network Surgery after 1.30pm when the practice's own weekday appointments have been booked. Appointments are available at the Network between 3.30pm and 7.40pm. There are also pre-bookable appointments at the Network on Saturdays and Sundays between 9am and 1pm.

The practice has opted out of providing of providing out of hours services to their own patients. Patients requiring a GP outside of normal working hours are advised to contact NHS 111, who triage the calls for the out of hours service, which is Staffordshire Doctors Urgent Care.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 4 May 2017. We also reviewed policies, procedures and other information the practice provided before the inspection day. During our visit we:

- Visited Heath Hayes Health Centre and Chase Medical Practice.
- Spoke with a range of staff including the GPs, the nurse practitioner, a practice nurse, health care assistant, nursing student, practice manager and members of reception staff.
- Spoke with patients who used the service, including a representative from the patient participation group.
- Reviewed comments cards where patients and members of the public shared their views and experiences of the service, and looked at survey information.
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- The practice had recorded 43 significant events between April 2016 and March 2017. From the sample of three documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- Staff told us that significant events were discussed at the clinical meeting and practice meeting. They told us the discussions were open and transparent, which enabled learning from the incident to take place.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, the door to the branch surgery was left unlocked, although the alarm had been set. A patient was sat in the building waiting for an appointment when staff arrived the following morning. As a consequence a specific member of staff is allocated the task of locking the door on a rota basis, and this is checked by a second member of staff.
- The practice also monitored trends in significant events and evaluated any action taken. The practice reviewed all significant events on an annual basis. The information relating to significant events for 2016/17 had been collated but not yet discussed. We saw evidence of the review undertaken for 2015/16.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There were lead members of staff for safeguarding. Staff had attended external training in respect female genital mutilation (FGM).
- The practice held registers for children at risk, and children with protection plans were identified on the electronic patient record. Regular meetings were held with the health visitors to discuss any child or families at risk.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs and nursing staff were trained to child safeguarding level three.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (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).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The nurse practitioner was the infection prevention and control (IPC) clinical lead. There was an IPC protocol and staff had received up to date training, including handwashing techniques. Annual IPC audits were undertaken and we saw that no action was required following the last audit.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

Good

Are services safe?

- There were processes for handling repeat prescriptions which included the review of high risk medicines. However, sufficient information was not always available for one high risk medicine to demonstrate that patients were prescribed this medicine safely. We spoke to staff who told us that although blood monitoring was done regularly, they did not always have access to these results from the hospital and the patients did not always bring the results to the practice. The lead GP told us that in accordance with NICE guidelines, if a blood result undertaken within the last 70 days was not recorded, they would not issue a repeat prescription.
- The practice carried out regular medicines audits, with the support of the local clinical commissioning group medicine optimisation team, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the medical staff for this extended role. They told us the lead GP reviewed a random sample of their consultations and provided verbal feedback. However the feedback was not recorded. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- One of the practice sites was located within a building owned by a local NHS trust, who were responsible for maintaining the building. The trust had procedures in place for monitoring and managing risk to patients and staff. The Chase Medical Practice building was owned by the practice
- The practice had an up to date fire risk assessments and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments 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).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements 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.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room. However, we noted that the practice did not stock any injectable medicines to treat nausea and vomiting or severe pain. A risk assessment had not been completed to explain the rationale for not stocking these medicines.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems 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.
- Staff told us that changes to guidance was discussed at the clinical meetings.
- Clinical staff had access to templates to assist with the assessment of long term conditions.
- Staff at the practice made use of computer software system to assist them to prescribe in line with best practice guidelines.

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 the practice had achieved 95.9% of the total number of points available compared with the clinical commissioning group (CCG) average of 96.8% and national average of 95.3%. The practice clinical exception rate of 11.6%, which was in line with the CCG average and 1.8% above the national average. Clinical 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 not an outlier for any QOF (or other national) clinical targets. Data from 2015/16 showed:

- Performance for diabetes related indicators was similar to the CCG and national averages. For example, the percentage of patients on the diabetes register, in whom a specific blood test to get an overall picture of what a patients average blood sugar levels had been over a period of time was recorded as 71% compared with the CCG and national average of 78%. The practice exception reporting rate of 11% was lower than the local average of 15% and England average of 12.5%.
- Performance for the percentage of patients with who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale (the degree of breathlessness related tofive specific activities) in the preceding 12 months was 94%. This was comparable to the local CCG average of 92% and the England average of 90%. COPD is a chronic lung disease. The practice exception reporting rate of 20% was higher than the local average of 14.5% and the national average of 11.5%.
- Performance for mental health related indicators was comparable to the local CCG and national averages. For example, the percentage of patients experiencing specific mental health conditions with an agreed care plan documented in the preceding 12 months was 92% compared to the local CCG average of 90% and national average of 89%. The practice clinical exception rate of 6.3% for this clinical area which was lower than the local CCG average of 15% and the England average of 12.7%.
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was comparable to the local CCG average and England averages (80% compared with the CCG average of 83% and England average of 84%). The practice clinical exception rate of 8.9% for this clinical area was slightly above the local CCG average and England average of 6.8%.
- There was evidence of quality improvement including clinical audit:
- Audits were carried in response to medicine safety alerts or changes to guidance. There had been five clinical audits commenced in the last 12 months, all of were completed audits where the improvements made were implemented and monitored.
- The practice completed audits on patients over the age of 75 years who were prescribed specific medicines used in patients with diabetes. Patients were identified and specific blood tests completed. The blood results for three patients were outside of the desired range and their medicine was either reduced, changed or stopped. When the audit was repeated, two patients were identified with blood results outside of the desired range and they were invited in for a medicine review.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- 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 vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by attending update training sessions and discussion at protected learning time events.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support from colleagues and facilitation and support for revalidating GPs and nurses. The nurse practitioner attended the nurse prescriber meetings within the locality. Clinical staff attended protected learning time sessions organised by the local CCG and in house training was provided for other staff. All staff had received an appraisal within the last 12 months.
- Two members of staff told us they had identified areas where they wished to extend their skills and knowledge. They told us their development had been supported by the practice. One member of staff had a training course booked and the other member of staff was currently looking to identify a suitable training course.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house 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.
- Staff worked together and with other health and social care professionals 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 between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a regular basis when care plans were routinely reviewed and updated for patients with complex needs.
- The practice had introduced a referral slip which patients handed to reception staff. The staff then married the referral slip against the referral from the GP to ensure they were carried out in a timely manner.
- The practice identified patients who were at high risk of hospital admission. The care of these patients was managed using care plans. The nurse practitioner was responsible for overseeing these patients and reviewed all information received from secondary care or the out of hours service and contacted patients if required. The lead GP, nurse practitioner and practice nurse met regularly with the community matron and community nursing team to discuss the care of these patients. They told us they also identified and reviewed the patients who most frequently attended the emergency department at these meetings, to see if any additional support was required.
- Staff told us that through these meetings they had identified a patient who rang 999 (the emergency ambulance service contact number) a number of times a day to say they were coming to the practice. The practice worked with the community matron to ensure that additional support was provided at home. The patient now rang the community matron when they needed support or to speak with a professional, rather than ringing 999.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. The clinical staff at the practice met every six to eight weeks with the community nurses and palliative care team to discuss patients identified with palliative care needs.

Good

Are services effective?

(for example, treatment is effective)

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.
- All staff received training on the Mental Capacity Act.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- Written consent was obtained for joint injections and insertion and removal of contraceptive implants. Completed examples of these were seen.
- The process for seeking consent was monitored through patient records audits, although there was no written information to support this.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation, or substance misuse.

The practice's uptake for the cervical screening programme was 80%, which was comparable with the CCG average of 82% and the national average of 81%. (The practice exception reporting rate of 2.2% was lower than the local average of 5.5% and the national average of 6.5%). The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. Data from 2015/16 published by Public Health England, showed that the number of patients who engaged with national screening programmes was comparable to the local and national averages.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given to under two year olds were all above the national expected coverage of 90%, ranging from 94% to 100%. The uptake rates for vaccines given to five year olds were above the national average and ranged from 94% to 99%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

All of the 13 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an good service and staff were helpful, caring and treated them with dignity and respect.

We spoke with 14 patients including one member of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Patients did comment on the challenges of maintaining confidentiality in the waiting area at Heath Hayes Health Centre. The area was open and conversations at the reception desk between patients and staff could be overheard. This had been overcome at Chase Medical Practice by playing background music in the waiting area.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The survey invited 251 patients to submit their views on the practice, a total 111 forms were returned. This gave at return rate of 44%. With the exception of confidence and trust which was comparable to other practices, satisfaction scores on consultations with GPs were below average. For example:

- 93% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 75% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 85% and the national average of 89%.
- 74% of patients said the GP gave them enough time compared to the CCG average of 84% and the national average of 87%.
- 74% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG 82% national average of 85%.

However, the satisfaction scores consultations with nurses were comparable to other practices. For example:

- 91% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 92% and the national average of 91%.
- 93% of patients said the nurse gave them enough time compared with the CCG average of 93% and the national average of 92%.
- 97% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 89% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG and national average of 91%.

The survey showed that 86% of patients said they found the receptionists at the practice helpful compared with the CCG and the national average of 87%. However, on the day five patients told us that not all reception staff were helpful, and in particular staff at the Heath Hayes Medical Practice needed to be more compassionate.

The practice had reviewed the results of the GP survey and developed an action plan to address the areas where the scores were below the national average. For example, staff attitude was discussed at each staff meeting, and significant events and complaints had been reviewed to identify any relevant to staff attitude. The results of the GP survey and action plan had been shared with the patient participation group.

The views of external stakeholders were positive and in line with our findings. We spoke with staff from three of the six local care homes where the practice had registered patients. One of these care homes received a weekly visit by the same GP, which provided continuity of care. The member of staff told us that the GPs will also visit on request. All three representatives told us the practice responded positively to requests for visits, and were supportive of staff and provided guidance and advice when required.

Good

Are services caring?

Care planning and involvement in decisions about care and treatment

Patients 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. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

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 for GPs were below local and national averages. For example:

- 71% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 82% and the national average of 86%.
- 64% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG 77% and national average of 82%.

However, the results for nursing staff were comparable to the CCG and national averages. For example:

- 89% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 90% and the national average of 90%.
- 82% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG 86% national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception area at Heath Hayes Health Centre informing patients this service was available. However, this information was not on display at Chase Medical Practice.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 55 patients as carers (0.5% of the practice list). These patients were offered an annual heath check and flu vaccination. The practice completed annual health checks on eight carers identified on the register. Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support.

Staff told us that if families had experienced bereavement, the practice sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours appointments with the GPs and nurses at Chase Medical Practice between 6.30pm and 8pm on Mondays and on Saturdays between 9am to 12 noon, for working patients who could not attend during normal opening hours.
- The provider was part of the Cannock Practice Network Surgery, based in the GP Suite at Cannock Hospital. Reception staff offered patients appointments at the Cannock Practice Network Surgery after 1.30pm when no appointments were available at the practice. Appointments were available between 3.30pm and 7.40pm. Pre-bookable appointments at the Cannock Practice Network Surgery were available on Saturdays and Sundays between 9am and 1pm.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- There were longer appointments available for patients with a learning disability.
- A separate telephone number was made available to patients over 75 years old and those with serious / long-term medical conditions so they could access medical advice promptly.
- All patients identified as at risk of unplanned admissions to hospital were reviewed on discharge following admission to hospital.
- The practice had a number of registered patients who lived in six local care homes. The home with the greatest number of patients received a weekly visit by the same GP, as well as on request. The GPs visited patients in the other care homes on request.
- The nurse practitioner and the practice nurse carried out annual reviews and visits to patients who were housebound.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- The practice co-hosted services such as orthopaedic assessment, counselling services and community ear, nose and throat clinics.

Access to the service

Both Heath Hayes Health Centre and Chase Medical Practice were open between 8am and 6.30pm Monday to Friday and 9am to 12 noon on Saturdays. GP and nurse appointments were available Monday to Friday from 9am to 12.30pm and 2pm and 6pm at both practice sites. Extended hours appointments with the GPs and nurses were offered at Chase Medical Practice between 6.30pm and 8pm on Mondays, and on Saturdays between 9am to 12 noon. In addition to pre-bookable appointments that could be booked up to five weeks in advance, on the day appointments and telephone consultations were also available for patients that needed them.

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 in the following areas.

- 81% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG and national average of 85%.
- 92% of patients said their last appointment was convenient, the same percentage as the CCG and national average.
- 71% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 62% and the national average of 58%.
- 69% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 76% and the national average of 76%.
- 69% of patients said they could get through easily to the practice by phone compared to the CCG and national average of 73%

Good

Are services responsive to people's needs?

(for example, to feedback?)

However the percentage of patients who described their experience of making an appointment as good was 63%, which was lower than the CCG and national average of 73%.

Patients told us on the day of the inspection that they were usually able to get appointments when they needed them. However, five patients told us that not all members of reception staff were helpful or responsive to their needs, particularly when appointments were not available. These patients told us some reception staff did not offer any alternatives, such as an appointment with the nurse practitioner or an appointment at the network.

The practice had reviewed the results of the GP survey and developed an action plan to address the areas where the scores were below the national average. For example, the appointment system had been amended to include more book on the day appointments and less pre-bookable. The results of the GP survey and action plan had been shared with the patient participation group.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

All patients who request a home visit will be seen. Urgent requests were passed to the GPs by reception staff. The GPs telephone the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system 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 responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. A poster and complaints leaflets were available in reception.
- The majority of patients spoken with knew how to make a complaint. Those patients who had made a complaint said it had been resolved satisfactorily.

The practice had recorded 33 complaints during the previous 12 months. We looked at two complaints in detail and found these were satisfactorily handled, dealt with in a timely way and with openness and transparency. The patients had received a written response and apology. Lessons were learned from individual concerns and complaints and also from analysis of trends. The main themes related to the attitude of one of the GPs and the reception staff. We saw evidence to support that the practice had spoken to the members of staff concerned and ongoing monitoring was in place. Complaints were discussed at the clinical meetings and administration meetings. Complaints were also discussed at the patient participation group meetings.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- Not all staff were aware of the practice vision and values. However, it was clear from discussion with staff that everyone was working towards the same aim of high quality healthcare.
- The GP described their plans for the future and areas for development, for example, care of dementia patients and those living with a learning disability.

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 and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. The GPs had lead roles for safeguarding, minor surgery and joint injections and long term conditions. The nurse practitioner
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. Clinical meetings and administration meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice. staff who were not in attendance to update themselves.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.medicines and equipment alerts issued by external agencies were actioned appropriately and risk assessments including infection control audits had been completed.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. From the sample of two documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses, community matron and palliative care nurses to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Are services well-led?

Good

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

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly and submitted proposals for improvements to the practice management team. For example, the PG had suggested altering the appointments on Mondays, so there were more book on the day and less pre-bookable. The practice had implemented this suggestion and staff told us this had enabled them to usually meet patient demand for appointments on Mondays.
- the NHS Friends and Family test, complaints and compliments received.
- staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run. We saw that staff had been asked for 'ideas for positive change.'

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The nurse practitioner worked as the practice nurse facilitator for the local CCG, and was involved in supporting practices with nurse appraisals, training and recruitment. She also supported practices where improvements were required. The nurse practitioner also had a facilitator role for the Fundamentals in General Nursing Practice course.

The practice was involved in a pilot of a wellbeing assessment worker programme. This pilot was funded by the local CCG and provided a counselling service for patients. Patients with low level mental health needs were seen within the practice, reducing the need to travel for appointments.

The practice was also a teaching and training practice for medical students and GP registrars, as well as a placement for nursing students.

We saw that learning opportunities were provided at clinical meetings. A local cardiologist attended a recent meeting to discuss deep vein thrombosis and pulmonary embolism (blood clots) and electrocardiographs (ECG / heart tracing).