

The Spires Practice

Quality Report

St Chad's Health Centre,
Dimbles Lane
Lichfield
WS13 7HT

Tel: 01543 412980

Website: www.spires-practice.co.uk

Date of inspection visit: 22 February 2016

Date of publication: 07/04/2016

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	3
The six population groups and what we found	5
What people who use the service say	8
Areas for improvement	8

Detailed findings from this inspection

Our inspection team	9
Background to The Spires Practice	9
Why we carried out this inspection	9
How we carried out this inspection	9
Detailed findings	11

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Spires Practice on 22 February 2016. Overall the practice is rated as Good.

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

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Information about safety was recorded, monitored, reviewed and addressed.
- Risks of infection had not been completed in some treatment rooms.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.

- Patients said they were treated with dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients told us they could get an appointment when they needed one. Urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff understood their roles and responsibilities.

We saw a number of areas where the practice should make improvements.

The practice should:

- Perform a risk assessment on the use of handwashing sinks in clinical rooms with screw top taps. Complete and maintain a risk log for the premises.

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 good for providing safe services.

Good



- There was a system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When there were unintended or unexpected safety incidents, the practice recorded, reviewed and held a meeting for all staff where learning could be shared.
- The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded patients from the risk of abuse.
- Risks to patients were assessed and well managed with the exception of carpets in clinician's rooms and sinks with screw top taps in some treatment rooms.
- The practice had facilities and equipment that was well maintained and regular infection prevention control audits were carried out and benchmarked against nationally recognised guidelines.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality Outcomes Framework (QOF) showed that the practice performed above both local and national averages.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Regular clinical audits were completed and repeated cycles 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 all staff.
- Staff had regular meetings with other healthcare professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

The practice is rated as good for providing caring services.

Good



- Data showed that patients rated the practice comparable to local and national averages in most aspects of care.

Summary of findings

- Patients said they were treated with compassion, dignity and respect and were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- Patients said they could get an urgent appointment on the same day.
- Same day appointments were available for children and those with serious medical conditions.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- The practice showed an awareness of health problems specific to the local population.

Good



Are services well-led?

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

- It had a clear vision and strategy to deliver high quality care and promote good outcomes for patients and their families. Staff were clear about the vision and their responsibilities in relation to this.
- There was a clear leadership structure and staff felt supported by the management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the Duty of Candour. The GP encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents.
- The GP partners and the management team were aware of the practice performance and the specific requirements of their patients.

Good



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 is rated as good for the care of older people. Every patient over the age of 75 years had a named GP and all hospital admissions were reviewed. This included patients that resided in nursing and care homes. Each care home had a named, designated GP partner who performed regular visits. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, risk profiling and case management. All over 75 year olds were assessed for the need to have a care plan following an unplanned admission. The practice was responsive to the needs of older people and offered home visits and offered longer appointments as required. A community practice nurse was employed by the practice to provide chronic disease management to housebound patients. The practice had identified and supported patients who were also carers.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Patients were reviewed in nurse led chronic disease management clinics. We found that the nursing staff had the knowledge, skills and competency to respond to the needs of patients with long term conditions such as diabetes and asthma. Longer appointments and home visits were available when needed and reviews were coordinated to minimise the required number of patient visits. Written management plans had been developed for patients with long term conditions and those at risk of hospital admissions. 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. The practice used the gold standards framework (GSF) to provide end of life care. The practice community nurse provided domiciliary care services to housebound patients.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children who were at risk, for example, children and young people who had protection plans in place. Appointments were available outside of school hours and the premises were suitable for children and babies. Same day emergency appointments were available for children. There were screening and vaccination programmes in place and the child immunisation rates were higher in 16 of the 18

Good



Summary of findings

indicators when compared with the local Clinical Commissioning Group averages. The practice worked with the health visiting team to encourage attendance. New mothers were offered post-natal checks and development checks for their babies.

Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. A range of on-line services were available, including medication requests, booking appointments and access to health medical records. The practice offered all patients aged 40 to 75 years old a health check with the nursing team. The practice offered extended opening hours and a full range of health promotion and screening that reflected the needs for this age group.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. We found that the practice enabled all patients to access their GP services and assisted those with hearing and sight difficulties. A translation service available for non-English speaking patients was clearly displayed at the reception.

The practice held a register of patients with a learning disability and had developed individual care plans for each patient. Out of 32 patients on the learning disabilities register, 14 had received annual health checks for the year ending 21 March 2016. Longer appointments were offered for patients with a learning disability and carers were encouraged by GPs to be involved with care planning.

The practice had a register of vulnerable patients and displayed information about how to access various support groups and voluntary organisations. For example there were posters for a local substance misuse support service. 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.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients who

Good



Summary of findings

presented with an acute mental health crisis were offered same day appointments. People experiencing poor mental health were offered an annual physical health check. Dementia screening was offered to patients identified in the at risk groups. It carried out advance care planning for patients with dementia.

The practice had regular communication with other health professionals in the case management of patients with mental health needs. The practiced waiting room had information to signpost patients to local support services, for example, Staffordshire mental health helpline.

The practice worked closely with the health visiting team to support mothers experiencing post-natal depression. It had told patients about how to access various support groups and voluntary organisations and signposted patients to support groups where appropriate

Summary of findings

What people who use the service say

We collected 48 Care Quality Commission (CQC) comment cards. The comment cards highlighted a level of patient satisfaction comparable to both local and national averages. Comments from patients were positive about the practice staff and spoke of a friendly and caring service. A number of comments were particularly positive about access to and availability of urgent appointments. Patients said the nurses and GPs listened and responded to their needs and they provided a personal service that involved the patient in decisions about their care.

The national GP patient survey results published on 7 January 2016 suggested that the practice performance was comparable to local and national averages in general levels of patient satisfaction. For example:

- 88% of respondents said the last appointment they got was convenient compared with the Clinical Commissioning Group (CCG) average of 92% and national average of 92%.
- 73% of respondents described their experience of making an appointment as good compared with the CCG average of 73% and national average of 73%.
- 79% of respondents said they would recommend the practice to someone new in the area compared with the CCG average of 81% and national average of 78%.
- 87% of respondents said they found it easy to get through to the surgery by telephone compared to the CCG average of 69% and national average of 73%.

There were 102 responses and a response rate of 38%.

Areas for improvement

Action the service **SHOULD** take to improve

- Perform a risk assessment on the use of handwashing sinks in clinical rooms with screw top taps. Complete and maintain a risk log for the premises.

The Spires Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) Lead Inspector. The team included a GP specialist advisor, a practice manager specialist advisor and an expert by experience.

Background to The Spires Practice

The Spires Practice is situated in the city of Lichfield and has a branch surgery in the town of Burntwood. The practice was established in 1963, and after starting with a single GP, it is now a six GP partnership operating from two purpose-built properties shared with community health teams. A pharmacy is situated within the same building as the Lichfield practice but this operates independently of the practice and has no connection with the practice partners or staff. Lichfield is a cathedral city based in Staffordshire with a population of approximately 32,000. Burntwood is a Staffordshire town, four miles from Lichfield with a population of approximately 26,000. The practice has a list size of 9,700 patients of which a higher than average percentage reside in care homes. The cohort of patients living in care account for 1.1% of the total practice population compared to the national average of 0.5%. The age distribution is similar to national averages with a slightly higher percentage of patients aged 65 and over and a slightly lower percentage aged between 20 and 39 years of age. The ethnicity data for the practice shows 97.9% of patients are white British. The area is less deprived when compared to national averages sitting in the third less deprived decile. However there are pockets of deprivation in both Lichfield and Burntwood.

The six GP partners work a combined total of 40 sessions per week, equal to five whole time equivalents. The partners are assisted by a clinical team consisting of two GP registrars, a nurse manager, two nurse practitioners, three practice nurses, a community practice nurse and two healthcare assistants. The administration team consists of a practice manager, an office manager, five administration staff and 12 reception staff.

The practice telephone lines open from 8am to 6.30pm, Monday to Friday. The reception opens from 8.30am to 6.30pm, Monday to Friday and from 9am to 11.30am on a Saturday (Saturday opening was part of the winter pressure scheme). Consulting times are from 8.30am to 10.30am and from 3.30pm to 5.30pm. The practice offers extended hours on a Saturday morning from 9.30am to 11.30am at both branches as part of the winter pressures scheme. In addition, the Lichfield branch offers an evening surgery from 6.30pm to 8pm on alternate Wednesdays and the Burntwood branch offers an evening surgery from 6.30pm to 8pm on alternate Thursdays. When the practice is closed patients' telephone calls are automatically diverted to the NHS 111 service. The practice has opted out of providing an out of hours service choosing instead to use a third party provider. The nearest hospitals with A&E units are situated at Good Hope Hospital, Sutton Coldfield, Queen's Hospital in Burton-Upon-Trent and Walsall Manor Hospital. There is a minor injury unit at the Samuel Johnson Community Hospital in Lichfield.

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

Detailed findings

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
- 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 other organisations and 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 inspection on 22 February 2016.

We spoke with a range of staff including the GP, nurses, practice manager and receptionist during our visit. We spoke with patients on the day and sought their views through comment cards completed in the two weeks leading up to the inspection. Information was reviewed from the NHS England GP patient survey published on 7 January 2016.

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events. There had been 22 events recorded in the preceding 12 months. A summary of the past 12 months suggested that the high number of recorded events was a positive sign that the practice was thorough and candid.

- Staff told us that a designated GP was responsible for significant events and any incidents were recorded on a form available on the practice's computer system. A summary was produced of the previous 12 months events.
- The practice carried out timely analysis of individual significant events at a weekly practice meeting and discussed learning at dedicated meetings held every six months.

We reviewed safety records, incident reports and national patient safety alerts. Lessons were shared to make sure action was taken to improve safety in the practice. For example, errors were found on new repeat prescriptions. The protocol for issuing repeat prescriptions was changed to include a requirement for a GP to authorise any repeat prescription.

When there were unintended or unexpected safety incidents the practice evidenced a robust system for recording, reviewing and learning. All clinicians were engaged with the process and information was shared informally and through a central store of electronic documents available to all staff. A culture to encourage Duty of Candour was evident through the significant event reporting process. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment. This includes informing people about the incident, providing reasonable support, providing information and an apology when things go wrong.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from the risk of abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from the risk of abuse. Contact details for local safeguarding teams 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. Clinical staff had received role appropriate training to nationally recognised standards. For example, GPs and nurses had attended level three training in safeguarding. A GP partner was the appointed safeguarding lead within the practice and demonstrated they had the oversight of patients, knowledge and experience to fulfil this role. Administration staff had completed level one in safeguarding training. Safeguarding was a standard agenda item on the weekly meeting agenda.
- Notices at the reception and in the clinical rooms advised patients that staff would act as chaperones, if required. Staff who acted as chaperones had received a disclosure and barring check (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). There was a chaperone policy and chaperone training had been given to administration staff.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice had a nominated infection control lead. There was an infection control policy in place and staff had received training infection control training, for example, training in handwashing and specimen handling.
- Handwashing sinks in treatment rooms at the Lichfield premises had screw top taps. Nationally accepted guidance is that taps should be activated by sensor or by using a person's elbows. This would help to avoid a person leaving bacterial or viral pathogens (germs) on the surface that would be touched by the next person who used the sink. The problem had been highlighted in the most recent infection control audit but the risk of infection had not been mitigated.
- Arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing,

Are services safe?

recording, handling, storing and security). There was a procedure to instruct staff what to do should the vaccination fridges temperature fall outside of the set parameters.

- Prescription pads and forms for use in computers were stored securely and there was a robust system in place to track their use (a tracking system for controlled stationary such as prescriptions is used by GP practices to minimise the risk of fraud).
- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. Patient Specific Directions (PSDs) were completed for the healthcare assistants.
- We reviewed five personnel files and found that appropriate recruitment checks had been undertaken prior to employment. For example, DBS checks and health screening had been completed for all new staff.

Monitoring risks to patients

The practice had trained staff, and had a number of policies and procedures in place, to deal with environmental factors, occurrences or events that may affect patient or staff safety.

- The practice completed a fire risk assessment and staff received fire safety training. Regular fire drills were carried out. The last fire drill had been performed on 4 December 2015. Firefighting equipment was serviced annually.
- Regular electrical checks ensured equipment was safe to use and clinical equipment was checked regularly and calibrated annually.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice had a buddy system to provide cover for holidays and absence.
- Infection prevention control audits were undertaken in line with National Institute for Health and Care Excellence (NICE) guidelines. The most recent audit had been completed in February 2016. Most actions had been completed.

- Staff had received appropriate vaccinations that protected them from exposure to health care associated infections.
- The landlord of the premises had undertaken a formal risk assessment for minimising the risk of Legionella (Legionella is a bacterium which can contaminate water systems in buildings).
- Some risk assessments had been completed but there was no risk log that included all identified risks.

Arrangements to deal with emergencies and major incidents

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

- There was a panic alarm system which alerted staff to any emergency.
- All staff had received annual update training in basic life support.
- Emergency medicines were held to treat a range of sudden illnesses that may occur within a general practice. All medicines were in date, stored securely and those to treat a sudden allergic reaction were available in every clinical room.
- The practice had emergency equipment which included an automated external defibrillator (AED), (which provides an electric shock to stabilise a life threatening heart rhythm), oxygen and pulse oximeters (to measure the level of oxygen in a patient's bloodstream).
- There was a first aid kit and accident book and staff knew where they were located.
- The practice had a written business continuity plan in place for major incidents such as power failure or building damage. A copy was kept off site by the practice manager.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed patients' 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.
- The staff we spoke with demonstrated a thorough knowledge of guidelines and care pathways relevant to the care they provided.
- NICE guidelines were a regular agenda item for the weekly meeting.

The practice was aware of the local needs of the population and engaged with the local clinical commissioning group (CCG). For example, the practice used data to identify a higher than average number of patients with chronic obstructive pulmonary disease (COPD). A GP partner had been designated the COPD lead and had attended a primary care respiratory conference and written a COPD protocol. The GP had formulated guidelines specific to the practice on how to treat COPD. These had been circulated to all clinical staff.

The practice had a register of 32 patients with learning disabilities. Annual reviews had been completed on 14 of the 32 patients for the year ending 31 March 2016.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality 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). QOF results from 2014/15 showed:

- The practice achieved 97.1% of the total number of points available in 2014/15. This was higher than both the CCG average of 92.7% and the national average of 93.5%. It was also higher than in 2013/14 when the practice achieved 85.9% of the total number of points available.

- Clinical exception reporting was 11.2%. This was slightly higher than the CCG average of 9.9% and the national average of 9.2%. Clinical exception rates allow practices not to be penalised, where, for example, patients do not attend for a review, or where a medicine cannot be prescribed due to side effects. Generally lower rates indicate more patients have received the treatment or medicine. Practice staff told us that patients were not excepted without authorisation by a GP or the nurse manager.

There had been 11 clinical audits in the last year. Four of the 11 audits were second cycles and evidenced that improvements had been made and were monitored. The audits included a review of a type of medication used to treat nausea and indigestion that followed the issue of new guidelines. Repeated cycles of this audit showed a reduction in the number of patients on this medication.

The practice followed local and national guidance for referral of patients with symptoms that may be suggestive of cancer.

Ante-natal care by community midwives was provided at the practice via an appointment basis.

Effective staffing

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

- The nursing team co-ordinated the review of patients with long-term conditions and provided health promotion measures in house.
- GPs had additional training in minor surgery.
- The practice provided training for all staff. It covered such topics as safeguarding, infection prevention and control and confidentiality.
- All staff felt supported to develop and had received at least annual appraisals.
- Staff we spoke with spoke positively about the induction programme.

Coordinating patient care and information sharing

The practice had a system for receiving information about patients' care and treatment from other agencies such as hospitals, out-of-hours services and community services. Staff were aware of their own responsibilities for

Are services effective?

(for example, treatment is effective)

processing, recording and acting on any information received. We saw that the practice was up to date in the handling of information such as discharge letters and blood test results.

A number of information processes operated to ensure information about patients' care and treatment was shared appropriately:

- The GP told us that regular reviews were done for all patients who had care plans. Outcomes and follow up were coordinated informally. A receptionist was assigned to follow up non elective hospital attendances by a telephone call to patients with a care plan.
- The practice team held regular meetings with other professionals, including palliative care and community nurses, to discuss the care and treatment needs of patients approaching the end of their life and those at increased risk of unplanned admission to hospital.
- The practice participated in a service to avoid hospital admissions. The scheme required the practice to identify patients at risk of hospital admission, complete an individual care plan for each patient on the list and review the care plan annually. Additional funding secured allowed the practice to review care plans of vulnerable patients three times per year.

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, 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, where appropriate, recorded the outcome of the assessment.
- The process for seeking consent was monitored through records audits to ensure it met the practice's responsibilities within legislation and followed relevant national guidance.

- Important issues surrounding decisions on when patients decided to receive or not receive treatment were discussed and recorded to nationally accepted standards.

Health promotion and prevention

Practice staff identified patients who may be in need of extra support and provided advice when appropriate. Patients who may benefit from specialist services were referred according to their needs.

- Older patients were offered a comprehensive assessment.
- Patients aged 40 – 74 years of age were invited to attend for a NHS Health Check with the practice healthcare assistant. Any concerns were followed up in a consultation with a GP.
- Travel vaccinations and foreign travel advice was offered to patients. This included a vaccination for yellow fever.

Data from QOF in 2014/15 showed that the practice had identified 15.41% of patients with hypertension (high blood pressure). This was broadly in line with the CCG average of 14.97% and national average of 14.06%.

The practice's uptake for the cervical screening programme was 95% which was higher than the CCG average of 81.2% and the national average of 81.8%.

Data from 2014, published by Public Health England showed that the number of patients who engaged with national screening programmes was comparable with local and national averages.

- 73.5% of eligible females aged 50-70 attended screening to detect breast cancer. This was comparable with the CCG average of 73.2% and national average of 72.2%.
- 63.9% of eligible patients aged 60-69 were screened for symptoms that could be suggestive of bowel cancer. This was higher than the CCG average of 61.7% and the national average of 58.3%.

The practice provided childhood immunisations and rates were comparable with CCG and national averages.

Vaccination rates for uptake of the seasonal flu vaccination were higher than average. In the latest vaccination programme, and as of the 22 February 2016, data showed:

72% of patients aged 65 and over had received the vaccinations.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and helpful to patients attending at the reception desk and that patients were treated with dignity and respect.

We spoke with five patients during the inspection and collected 48 Care Quality Commission (CQC) comment cards. Patients were positive about the service they experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. They said the nurses and GPs listened and responded to their needs and they were involved in decisions about their care. Comments from patients highlighted that the reception staff provided a caring and personal service.

Consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in GP's consulting rooms and in nurse treatment rooms. Consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. Staff told us that patients would be advised that a confidential room was available if they wanted to discuss sensitive issues or appeared distressed but there was no notice in the waiting room.

We reviewed the most recent data available for the practice on patient satisfaction. This included comments made to us from patients and information from the national GP patient survey published in January 2016. The survey invited 265 patients to submit their views on the practice, a total of 102 forms were returned. This gave a return rate of 38%.

The results from the GP national patient survey showed patients were satisfied with how they were treated by the GPs and nurses. The practice had satisfaction rates comparable with both local and national averages. For example:

- 87% said the last GP they saw or spoke to was good at giving them enough time compared to the Clinical Commissioning Group (CCG) average of 88% and national average of 87%.

- 87% said the last nurse they saw or spoke to was good at listening to them compared to the CCG average of 92% and national average of 91%.

The patient feedback on the receptionists was higher than both local and national averages:

- 96% said they found the receptionists at the surgery helpful compared to the CCG average of 89% and national average of 87%.

Care planning and involvement in decisions about care and treatment

The GP patient survey information we reviewed showed patient satisfaction was comparable to both CCG and national averages when asked questions about their involvement in planning and making decisions about their care and treatment with GPs. The GP patient survey published in January 2016 showed:

- 81% said the last GP they saw was good at involving them about decisions about their care compared to the CCG average of 82% and national average of 82%.
- 81% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%.
- 84% said the last nurse they saw was good at involving them about decisions about their care compared to the CCG average of 86% and national average of 85%.
- 87% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 90% and national average of 90%.

Comments we received from patients on the day of inspection were positive about their own involvement in their care and treatment.

Patient/carer support to cope emotionally with care and treatment

The practice had a carer's policy that promoted the care of patients who are carers. The policy included the offer of annual flu immunisation and annual health checks to all carers. There was a carer's register that numbered 119 patients. There was a dedicated notice board for carers situated in the practice waiting room with information on support and services provided both at the practice and in the local community.

Are services caring?

Patients gave positive accounts of when they had received support to cope with care and treatment. We heard a number of positive experiences about the GPs taking time to provide support and compassion.

The practice recorded information about carers and subject to a patient's agreement a carer could receive information and discuss issues with staff.

If a patient experienced bereavement, practice staff told us that they were signposted to services and were supported by a GP when appropriate. A bereavement card was sent to the family upon notification of a patient's death.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice provided online services for patients to book appointments, order repeat prescriptions and access a summary of their medical records.
- There were longer appointments available for people with a learning disability.
- Home visits were available for older patients / patients who would benefit from these.
- Same day appointments were available for children and those with serious medical conditions.
- There were disabled facilities and all treatment rooms were located on the ground floor of the building.
- Translation services were available for patients.
- There was a hearing loop at the reception desk.
- Baby changing facilities were available and well signposted.

The practice regularly communicated with multi-disciplinary teams in the case management of patients with mental health needs. This included support and services for patients with substance misuse and screening for alcohol misuse with onward referral to the local alcohol service if required. The practice also worked closely with the health visiting team to support mothers experiencing post-natal depression. Regular multidisciplinary team meetings were held. For example, a monthly meeting was held with the district nurses and community matron to discuss avoidable hospital admissions and patients on palliative care.

The GPs performed regular visits to patients residing in care homes. There was a designated, named GP partner for each home to provide continuity of care. The practice employed a community nurse who provided approximately 12 visits per week to housebound patients and those living in care homes. The service provided by the community nurse included chronic disease management, blood tests and new patient checks.

Access to the service

The practice telephone lines opened from 8am to 6.30pm, Monday to Friday. The reception opened from 8.30am to

6.30pm, Monday to Friday and from 9am to 11.30am on a Saturday (Saturday opening was part of the winter pressure scheme). Consulting times were from 8.30am to 10.30am and from 3.30pm to 5.30pm. As part of the winter pressures scheme the practice offered extended hours on a Saturday morning from 9.30am to 11.30am at both branches. In addition the Lichfield branch offered an evening surgery from 6.30pm to 8pm on alternate Wednesdays and the Burntwood branch offered an evening surgery from 6.30pm to 8pm on alternate Thursdays. When the practice was closed patients' telephone calls were automatically diverted to the NHS 111 service. The practice had opted out of providing an out of hours service choosing instead to use a third party provider.

Pre-bookable appointments could be booked up to six weeks in advance and same day urgent appointments were offered each day. Patients could book appointments in person, by telephone or online for those who had registered for this service. The practice offered telephone consultations each day. We saw that there were bookable appointments available with GPs within one week and with nurses the next working day. We saw that urgent appointments were available on the day of inspection. A protocol for reception staff when booking appointments included; patients should never be asked to call back for an appointment and patients asking for an urgent appointment should be seen on the same day. The appointment system was regularly audited to review capacity and was a standing agenda item for the weekly practice meeting.

Results from the national GP patient survey published in January 2016 showed comparable rates of satisfaction for indicators that related to access when compared to local and national averages.

- 72% of patients were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 75%.
- 88% of patients said the last appointment they made was convenient compared to the CCG average of 92% and national average 92%.
- 87% of patients said they found it easy to get through to the surgery by telephone compared to the CCG average of 69% and national average of 73%.
- 81% of patients were able to secure an appointment the last time they tried compared to the CCG average of 85% and national average of 85%.

Are services responsive to people's needs?

(for example, to feedback?)

This was supported by patients' comment on the day of inspection. A number of patients stated that there could be a long wait after their appointment time to be seen but said they felt reassured that clinicians took the time to provide treatment and advice.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a

designated responsible person who handled all complaints in the practice. Information was available to help patients understand the complaints system and the complaints process was detailed in the practice booklet.

The practice had received 15 complaints in the last 12 months. All complaints were either ongoing, or had been investigated and responded to in line with the practice complaints policy. Complaints were discussed individually with staff and at practice meetings. The practice provided apologies to patients both verbally and in writing. There was no trend in the nature of complaints and when appropriate the complaint had resulted in a significant event being recorded and reviewed. A meeting was held annually to review complaints for the past 12 months.

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 did not have a formalised business plan, although the partners and management told us of plans for the future that had been discussed and agreed between GP partners and the practice management team. These included a longstanding project to relocate to new premises and plans to appoint a GP to lead on each chronic disease

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A programme of continuous clinical and internal audit which was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- A comprehensive understanding of the performance of the practice was maintained.
- Each of the six GP partners had a specific area in which they led. For example, women's health.
- The practice held regular and scheduled clinical meetings and had a set of standard agenda items that included safeguarding, palliative care patients and significant event reviews.

Leadership, openness and transparency

The leadership team within the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The GP partners, nurse manager and practice manager were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.

The provider was aware of and complied with the requirements of the Duty of Candour. The GP encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents.

When there were unexpected or unintended safety incidents:

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

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

- 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 in doing so and felt supported if they did.
- Staff said they felt respected, valued and supported. All staff were involved in discussions about how to run and develop the practice.

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

The practice was aware of patient feedback through completed forms that could be posted in a suggestions, comments and compliments box situated in the patient waiting room. Practice staff were aware of the results of the GP Patient Survey published in January 2016. There was a virtual Patient Participation Group (PPG) that used email correspondence and communicated with patients to keep them informed. The virtual group had existed for two years but it had been decided that a face to face group would be more effective and establishment work was underway.

Staff told us that their opinions were sought and valued by both the GP and the practice manager.

Continuous improvement

The staff we spoke with told us they felt supported to develop professionally and all had received recent appraisals and half a day per month was set aside for protected learning time. The practice provided training for

Are services well-led?

Good 

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

trainee GPs. Simulated Sunday surgeries using friends and family were arranged for the GPs in training. The GP partner who led on education and training was a professor of values based in Medical Education.

The practice was aware of data that benchmarked them with other local GP practices. For example, the practice identified that, when compared to other local practices, the number of mental health patients with a reviewed care plan was low. An action plan that included an improved recall system for this cohort of patients had been formulated.

Innovation

The practice was involved with a number of innovative projects. Examples included work with the local network of GP surgeries to provide cross-cover of staff to reduce the reliance on using locum agencies. The practice was proactive in the formation of a network that existed between six GP practices in the Lichfield and Burntwood area. Monthly meetings were held and collaborative work included a scheme to create a specialist team from within the network to provide acute and chronic medical care for residents of care homes in the area.