Norton Canes Health Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Norton Canes Health Centre on 9 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for 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 and people experiencing poor mental health (including those with dementia).

Our key findings were as follows:

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. This was evidenced in higher than average patient survey feedback and in the feedback we received about the practice.
- 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.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.

There were areas of practice where the provider should make improvements.

- Review and improve the availability of emergency medicines to ensure that the practice is able to respond appropriately to the range of medical emergencies likely to be experienced in general practice.
- Provide more detailed information to patients on appropriate ways to access out-of-hours services when the practice is closed.

Summary of findings

- Consider the development of a formal practice vision and values.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Risks to patients were discussed and when necessary changes had been made to limit the risk. We saw that risks to patients, staff and visitors from the premises or environmental events were clearly recorded. Practice staff had been trained to deal with emergency events and equipment to help in an emergency was regularly checked and suitable for use. The range of medicines stocked at the practice to help in an emergency was limited and should be improved.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

Results from the GP patient survey published in January 2015 showed;

- 92.1% said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 81.7% and national average of 86.3%.
- 93.9% said the GP gave them enough time compared to the CCG average of 81.7% and national average of 86.8%.

Summary of findings

- 97.4% said the practice nurse was good at listening to them compared to the clinical commissioning group (CCG) average of 91.6% and national average of 91%.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified.

Results from the GP patient survey published in January 2015 showed;

- 76.5% were satisfied with the practice's opening hours compared to the CCG average of 74.7% and national average of 75.7%.
- 77.7% described their experience of making an appointment as good compared to the CCG average of 72.5% and national average of 73.8%.
- 67.9% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 69.5% and national average of 65.2%.
- 60.3% felt they don't normally have to wait too long to be seen compared with the CCG average of 59.4% and national average of 57.8%.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice team planned to develop a written vision and values. Staff we spoke with described high quality patient care and to grow in both patient numbers and services provided as their vision for the practice.

There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify most risks. The practice proactively sought feedback from staff and patients. The practice had recently introduced a patient participation group (PPG) and planned to use the PPG to further develop services. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services. For example, in dementia and avoiding unplanned hospital admissions. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. All patients over the age of 75 had a named GP.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice nurse had a lead role in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Nationally reported data from 2013/14 showed that outcomes for patients with long-term conditions were good. For example, 94% of patients with chronic obstructive pulmonary disease (COPD) had been reviewed in the last year. This was higher than the CCG average of 77% and national average of 80%. Practice supplied data showed that the 2014/15 performance had increased to 96%.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There was a formal system in place to identify and follow up children living in disadvantaged circumstances and who were at risk. The GPs had extended training in women's health and provided a comprehensive range of contraceptive options in house. Immunisation rates were in line or higher than the local average for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs of this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

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

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). One-hundred per cent of patients on the practice register for dementia had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people who experienced poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

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

Summary of findings

What people who use the service say

Patients completed Care Quality Commission (CQC) comment cards, which had been left in the practice waiting area before our inspection, to tell us what they thought about the practice. We received 22 completed cards. The majority of the cards contained positive comments about the practice and staff. All contained comments that expressed care was excellent or very good. Nine individual cards used the word 'caring'. We received one comment which was less positive, although they felt the service was good overall.

We spoke with eight patients on the day of our inspection. They all told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. We heard individual accounts of when patients had been treated with respect, dignity, compassion and empathy.

We reviewed the results from the latest GP national patient survey published in January 2015. The results from interaction between GPs, nurses and patients were positive;

- 92.1% said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 81.7% and national average of 86.3%.
- 93.9% said the GP gave them enough time compared to the CCG average of 81.7% and national average of 86.8%.

The survey results in relation to access to the practice were also positive;

- 80.9% with a preferred GP said that they normally get to see that GP compared to the CCG average of 58% and national average of 60.5%.
- 82.7% found it easy to contact the practice by telephone compared to the CCG average of 75.5% and national average of 74.5%.
- 77.7% described their experience of making an appointment as good compared to the CCG average of 72.5% and national average of 73.8%.

We spoke with the managers of two local care homes where a number of patients registered at the practice lived. One was a local care setting for children with complex needs. The manager told us that they chose this practice to register with due to the caring and empathetic nature of the GPs. They told us that the GPs, nurse and other staff were always caring and supportive. The manager of the other care setting in which a number of patients registered at the practice, including those diagnosed with dementia and many who were older lived also spoke highly of the practice.

Areas for improvement

Action the service SHOULD take to improve

- Review and improve the availability emergency medicines to ensure that the practice is able to respond appropriately to the range of medical emergencies likely to be experienced in general practice.
- Provide more detailed information to patients on appropriate ways to access out-of-hours services when the practice is closed.
- Consider the development of a formal practice vision and values

Norton Canes Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) lead inspector. The team also included a GP specialist advisor and an expert by experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service.

Background to Norton Canes Health Centre

Norton Canes Health Centre is a GP practice situated in Norton Canes, Staffordshire.

The practice is one of three practices that operate out of a shared purpose built building. Although the practices share the building, the staffing, management and patient lists are different. Other health professionals also work out of the building.

Data published in 2014 from Public Health England detailed that the practice has 58.7% of patients with health-related problems in daily life; this is higher than the national average of 48.8%. The practice also has a higher than average patient population under 18 years of age and also over twice the average number of patients who live in nursing care. These factors can, at times, greatly increase the demand on GP practices.

The practice staffing consists of two GPs (one female, one male). One female practice nurse has an active role in providing care and treatment to patients. The practice manager leads a team of three administrative and reception staff.

There are currently around 3,200 patients registered at the practice. The practice holds a General Medical Services contract with NHS England. It has extended its contractual obligations to provide a number of enhanced services which include extended hours, annual health checks for patients with learning disabilities and avoiding unplanned admissions.

The practice is open between 8am and 6:30pm Monday to Friday. Extended hours surgeries are each Tuesday 6:30pm to 7:30pm.

The practice has opted out of providing services to patients out of normal working hours. These services are provided by Staffordshire Doctors Urgent Care, patients call 111 to access this service.

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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations including NHS England and NHS Cannock Chase Clinical Commissioning Group to share what they knew. They both told us that the practice regularly engages with them.

We carried out an announced visit on 9 April 2015. During our visit we spoke with a range of staff including two GPs, a practice manager, a practice nurse and two members of administration staff. We also spoke with eight patients including two members of the patient participation group (PPG). We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We received 22 Care Quality Commission (CQC) comment cards where patients and members of the public shared their views and experiences of the service. We also contacted the managers of two local care homes. We did this to understand how care was provided to the patients who lived there.

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)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. We saw that the practice team had discussed significant events at practice meetings for at least the last two years.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred during the last year.

Significant events within the practice were raised by completion of a standard form available on computer which was completed and submitted to the practice manager. The practice had recorded nine significant events in the last year. We tracked four incidents and saw that they had been well documented and investigation, discussion and action had taken place in a comprehensive and timely manner in all of them. We saw the recording and discussion of significant events within the practice had led to changes to improve safety. For example, a letter to refer a patient to hospital was nearly misplaced as each GP placed documents in a different place for action. This incident was raised by a member of reception staff and solutions were discussed. The practice changed the process by ensuring all staff received guidance to use a drawer in a filing cabinet. Staff who worked in all roles within the practice were able to demonstrate that the practice was keen to learn improve and promote safety for patients.

Significant events, complaints, incidents and any other concerns were discussed at regular practice and clinical meetings. National patient safety alerts were shared by the GP who received them. Staff we spoke with were able to give examples of recent alerts. They also confirmed alerts were discussed within the practice to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. We looked at training records which showed all staff had received relevant role specific training on safeguarding to an appropriate level. For example, the GPs had received training to level three as suggested in guidance by the Royal College of Paediatrics and Child Health on safeguarding children and young people (March 2014).

Staff knew how to recognise signs of abuse in older patients, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. We saw that contact details for local safeguarding teams were easily accessible.

As a smaller practice there was no individual lead for safeguarding, however all clinical staff were aware of their individual and collective responsibility to raise and follow up concerns.

Chaperones were available when needed, all staff had received training, been vetted and knew their responsibilities when performing chaperone duties. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. Posters within the practice advertised the availability of chaperones for patients.

All of the staff at the practice had received appropriate checks with the Disclosure and Barring Service (DBS). DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found that they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept within the required temperatures which described the action to take in the event of a potential failure. We saw records to confirm staff members undertook daily checks of the medicines.

Good

Are services safe?

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice nurse administered vaccines using patient group directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these directions and evidence that they had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were kept securely at all times and were handled in accordance with national guidance.

Cleanliness and infection control

The practice was one of three practices housed within the building. The clinical areas were different although the waiting room was shared.

The practice was visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

All cleaning was performed by the NHS building landlord, although the practice staff we spoke with knew their individual responsibility for promoting infection control practice in their own clinical and work areas.

We checked and saw that clinical and domestic waste was stored appropriately and in line with legislative requirements.

The building landlord had completed a risk assessment for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). They managed the necessary tests required under the risk assessment, for example, regular water temperature testing.

Equipment

Staff we spoke with told us they had suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this.

All portable electrical equipment was routinely tested and displayed stickers indicating the date of the last test. We saw that equipment used in the assessment of a patient's condition had been checked and calibrated where necessary to ensure it gave accurate readings. For example, a blood pressure measuring device.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to a staff member commencing employment. For example proof of identification, references, qualifications, professional registrations with the appropriate body and criminal records checks through the Disclosure and Barring Service (DBS) where required..

The practice manager told us about arrangements for planning and monitoring the number and skill mix of staff needed to meet patients' needs. This was based on experience of increasing the number of staff on duty when the practice was busy. The practice had not received any complaints or raised any significant events concerning issues with shortages of staff.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

A GP told us that they were working within the locality to establish a cross cover network. This was an added level of safety for GP practices, many of which were smaller, to ensure that GP cover could be sourced in the event of a GP not being able to attend work. They told us other practices were keen to get involved as sourcing a locum GP at short notice could be challenging.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. We spoke with staff who knew and explained their individual responsibility to raise issues of risk appropriately

All monthly maintenance checks were carried out by the buildings landlord and we saw examples of risks that may affect patient safety had been identified and mitigated. All of the buildings fire drills and fire safety arrangements were managed by the buildings landlord. Practice staff had also received fire safety training and knew the practice emergency fire procedures.

Good

Are services safe?

Staff had been trained and knew what to do in an emergency. We spoke with two patients who both told us that practice staff had dealt with them in a swift professional manner when they had experienced deterioration in their health which had required emergency admission to hospital.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support.

Emergency equipment was available at a secure central point. Equipment included a nebuliser (a device to help to deliver medicine into the lungs to assist someone with difficulty in breathing), a pulse oximeter (to measure the level of oxygen in a patient's bloodstream) and an automated external defibrillator (which provides an electric shock to stabilise a life threatening heart rhythm).

We checked the emergency medicines available within a secure central area of the practice. Although some emergency medicines were available, for example to treat anaphylaxis (allergic reaction, the medicines were not comprehensive enough to treat the range of emergencies that may be faced at the practice. One example was that there was no medicine available to treat bradycardia (a very low pulse). The practice provided intra-uterine contraceptive methods (a hormone implant device to prevent unwanted pregnancy) on site. A recognised complication of performing this procedure is to experience a prolonged episode of fainting, which may require medicine to improve the situation. Guidance issued by the Royal College of Obstetricians and Gynaecologists (January 2013) recommends that Atropine is available to treat symptomatic bradycardia (a very low pulse, which causes adverse symptoms such as loss of consciousness and low blood pressure). Following our discussion during the inspection a GP took immediate action by sourcing Atropine to be made available within the practice. The practice planned to review the stock of emergency drugs available and planned to update their emergency medicines and procedures.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Guidelines were discussed within protected learning time, in peer discussion and at practice meetings when appropriate.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with high cholesterol who were prescribed medicine to help lower their cholesterol levels had received care, advice and treatment in line with national guidance.

Patients with dementia were included in a practice register. Care and treatment was coordinated and reviewed at regular intervals. We saw that 100% of patients with a recorded diagnosis of dementia had received an annual health assessment in the last 12 months. Patients who displayed signs or symptoms that may be due to dementia, were identified and assessed by GPs. Patients, who the GPs suspected as having previously undiagnosed dementia, were referred for diagnosis. Data from the clinical commissioning group (CCG) showed that the practice had exceeded the identification of expected numbers of patients with dementia.

The practice offered 14 directed and local enhanced services. Enhanced services are the provision of services beyond the contractual requirement of the practice. Examples of enhanced services included;

- Contraceptive implants
- Extended hours opening
- Learning disability health check

We looked at the latest available data from NHS Business Authority (NHSBA) published in December 2014 on the practice levels for prescribing antibiotic and hypnotic medicines. We saw that the practice levels of prescribing of both medicines were in the similar to expected range when compare to the national average

Patients who experienced both short and long-term poor mental health were supported at the practice. Patients with depression were screened using nationally accepted assessment methods. Eighty- seven per cent of patients with long-term poor mental health had a comprehensive care plan in place, which was reviewed at least annually. This was higher than the national average of 86%.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patients' age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about patients' care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us 11 audits that had been undertaken in the last two years. Some of the audits were on a rolling cycle that required regular re-audit, whilst some had been in response to understand particular issues or risk. For example, following an alert received about the interaction between two medicines, the practice audited and identified patients that may be affected. The prescribed medicines were changed to reflect national guidance. Other audits included on side effects from contraceptive implants, reasons for accident and emergency attendances and flu vaccination rates.

We saw that staff discussed the practice performance in the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The practice had achieved 84.3% of the overall QOF points available in

Good

Are services effective?

(for example, treatment is effective)

2013/14. This result was lower than the national average of 94.2%. The practice had reviewed processes and monitoring of QOF and had achieved a higher performance in 2014/15, although that data had not been formally published. Examples of practice performance in the 2013/14 QOF for reviewing the care needs of patients included;

- 73% of patients with Asthma had a review of their condition within the last 12 months. The national average was 75.5%. Practice supplied held data showed that the 2014/15 performance had increased to 91%.
- 94% of patients with chronic obstructive pulmonary disease (COPD) had been reviewed in the last year. This was higher than the CCG average of 77% and national average of 80%. Practice supplied data showed that the 2014/15 performance had increased to 96%.
- 78% of patients with hypertension (high blood pressure) had a recent recorded blood pressure reading lower than the highest acceptable limit. The national average was 84%. Practice supplied data showed that the 2014/15 performance had increased to 91%.

The practice performance for reviewing patients who experienced depression had been below local average. The 2013/14 QOF data showed that 16.7% of patients who presented with a new diagnosis of depression had been reviewed between two to four weeks after their first appointment. This was lower than the CCG average of 50.5% and national average of 57.4%. The practice had revised procedures for recalling patients and recording the care and treatment given. The practice performance in the area had improved markedly and in 2014/15 the practice had achieved a depression review rate of 90%.

There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

GPs told us they used nationally recognised methods of the fast track referral to hospital specialists for patients who had symptoms that could be suggestive of cancer. We reviewed data from Public Health England from 2014 which showed the rates for using nationally accepted standards for patients with symptoms that could be suggestive of cancer were in line with both the local and national average.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support. The GPs were both female and male which allowed patient choice wherever possible. We noted that the GPs had a good skill mix. For example, both had additional training in women's health. We also saw the GPs held addition training and qualification including sexual and reproductive health and emergency medicine

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The practice employed one experienced practice nurse. They had undertaken further training in providing diabetic, asthma and chronic obstructive pulmonary disease (COPD) care to patients. COPD is a term for a number of diseases which affect the function of a person's breathing. They had also been trained to perform annual health assessments for patients with a learning disability. When the nurse was unavailable the GPs supported each other with tasks as required.

All staff had annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

A GP told us that staff sickness levels at the practice during the previous year had been zero. Staffing levels were stable, the practice manager had worked at the practice for a high number of years and was able to provide support on reception or to staff the telephone lines in times of increased activity.

Good

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

The practice had an established system in place for handling and taking action on the information received from local hospitals, out-of-hours providers and the 111 service. The information received was both in an electronic and paper format. Communications included blood test results, hospital discharge summaries and letters from other health partners about the care and treatment of patients. We spoke with staff who were able to describe and demonstrate the system in place for managing communications. The system involved tasking of actions to individual members of staff and where appropriate patients were contacted with an appointment date to discuss results with a GP. The staff we spoke with felt the system worked well. We checked and saw that the management of communications was up to date. There had been no recorded incidents during the previous year where any communication item had not been followed up.

The practice was aware of, and benchmarked, its own performance within the CCG locality. Members of the practice team met with other practices within the CCG area on a regular basis.

The practice held multi-disciplinary team meetings to discuss patients' identified at high risk of unplanned admission to hospital on a monthly basis. MDT meetings to discuss the care and treatment needs of patients who were approaching the end of their life on a three monthly basis.

Information sharing

Patients who were included in the enhanced service for avoiding unplanned admission to hospital had documented care plans at home and also scanned onto their computerised medical records. The practice manager told us this would help to provide other health professionals with information should they become involved in the patients' care at a time when the practice was closed.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Important information concerning patients who were receiving end of life care was shared with the out-of-hours services and community nurses by a secure process.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We saw care records that showed staff had applied the principles of the Mental Capacity Act 2005 when involving patients in decisions about the care they received.

Patients we spoke with confirmed that they had treatment options explained and had been supported to make informed decisions about their care. We saw examples of when consent had been obtained and documented. A manager of a local care home that GPs provided care with respect for a patients' capacity and documented all decisions, discussing these with relatives where appropriate.

A GP told us that patients and those close to them were supported through decisions when their capacity may be impaired. For example, patients approaching the end of their life received guidance on recording their treatment wishes in the event of their health deteriorating. This information was recorded in patient notes and templates to nationally recognised standards.

Health promotion and prevention

The practice offered a range of in house health promotion services in conjunction with the CCG. These included smoking cessation, weight management and childhood immunisations.

We saw that the most recent published data from QOF showed that vaccination rates for standard childhood immunisations were mostly higher than the local average. For example, 98% of children aged one had received the pneumococcal vaccine (PCV) to help reduce the risk of acquiring the bacteria that can cause pneumonia, blood poisoning and meningitis. This was higher than the CCG average of 97%.

The practice offered NHS Health Checks to patients in the age group of 45 – 74 years of age. The practice had provided 116 health checks in between April 2014 to December 2014 and was on target to exceed their expected levels of providing health checks. Since the introduction of

Good

Are services effective?

(for example, treatment is effective)

NHS Health Checks at the practice two patients had been found to be diabetic and 10 had been diagnosed with high cholesterol and had been placed on medicines in an attempt to improve the situation.

The practice nurse took a lead role in providing regular health assessments for patients with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD). They had also been trained to perform annual health assessments for patients with a learning disability.

Flu vaccination rates for patients aged 65 and over were 72%, this was slightly lower than the national average of 74%. We saw that 50% of patients under the age of 65 and in the 'at risk' groups had received a flu vaccination; this was slightly lower than the national average of 52%.

It was policy to offer all new patients a health check with the practice nurse when joining the practice. The practice waiting room contained posters and leaflets on health promotion subjects and provided patients with contacts for other organisations that may have been able to support with living a healthier lifestyle.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP patient survey published in January 2015.

The evidence from the GP national patient survey showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated higher than others for patients who rated the practice as good or very good. The practice was also higher than others for its satisfaction scores on consultations with GPs and nurses. For example:

- 92.1% said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 81.7% and national average of 86.3%.
- 93.9% said the GP gave them enough time compared to the CCG average of 81.7% and national average of 86.8%.
- 95% said they had confidence and trust in the last GP they saw compared to the CCG average of 92.9% and national average of 95.3%.
- 97.4% said the practice nurse was good at listening to them compared to the clinical commissioning group (CCG) average of 91.6% and national average of 91%.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 22 completed cards. The majority of the cards contained positive comments about the practice and staff. All contained comments that expressed care was excellent or very good. Nine individual cards used the word 'caring'. We received one comment which was less positive. The person who completed the card felt they had been rushed at an appointment, although they described the practice as friendly. We also spoke with eight patients on the day of our inspection. They all told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. We heard individual accounts of when patients had been treated with respect, dignity, compassion and empathy.

We spoke with the managers of two local care homes where a number of patients registered at the practice lived. One was a local care setting for children with complex needs. The manager told us that they chose this practice to register with due to the caring and empathetic nature of the GPs. They told us that the GPs, nurse and other staff were always caring and supportive. The manager of the other care setting in which a number of patients registered at the practice lived, including those diagnosed with dementia and many who were older. The manager in this care setting also spoke highly of the practice.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Modesty curtains and blankets were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk and seating was sited away from the main desk which helped keep patient information private. A system operated to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. Additionally, 90.5% said they found the receptionists at the practice helpful compared to the CCG of 86.8% and national average of 86.9%.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice mainly above others in these areas. For example:

- 85.9% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81.1% and national average of 86.3%.
- 81.6% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 75.3% and national average of 81.5%.

Good

Are services caring?

All of the eight patients we spoke with felt involved in decisions relating to their care and treatment. Patient feedback on the comment cards we received was also highly positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients responded positively to questions about involvement in planning and making decisions about their care and treatment and rated the practice in line with others in these areas. For example:

- 80.9% with a preferred GP usually get to see or speak to that GP compared to the CCG average of 58% and national average of 60.5%.
- 93.7% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 89.8% and national average of 90.4%.
- 89.5% described their experience at the practice as good compared with the CCG average of 81.6% and national average of 85.2%.

We received numerous positive comments from patients we spoke with and within comment cards about the emotional support provided by staff at the practice. We heard examples of occasions of when patients felt that they had received high levels of support at difficult times.

Staff told us that if families had experienced a bereavement, their usual GP contacted them. 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

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice offered home visits to those who were housebound or not well enough to attend the practice in person. Double appointments could be booked for those with complex health needs.

The NHS England Area Team and clinical commissioning group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

We spoke with managers from two local care homes where some patients who were registered at the practice lived. One care home specialised in caring for children with complex health and emotional needs the other provided nursing and residential care from patients who were mainly older and many also had complex health needs. Staff from both care homes told us that the practice responded to requests for advice or visits promptly. One manager told us that the GPs were very accessible and often they would often instigate contact to follow up on information they had received about a patient.

The practice had recently set up a patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. We spoke with two members of the newly formed PPG. Both had been approached by staff at the practice to become involved in shaping future changes within the practice. The PPG planned to conduct surveys and promote important health topics such as flu immunisation and cancer screening.

Tackling inequity and promoting equality

All facilities at the practice were situated on a single level and all main areas were accessed via automatic opening doors. Doorways and corridors were wide enough to allow prams and wheelchairs to turn and access all rooms. We saw patients with walking aids mobilising through the practice without hindrance.

For patients whose spoken English was not strong, a telephone interpreter could be provided.

The practice was not aware of any patients that had circumstances that could present challenges to meeting the requirements of registering for GP services. For example, a person who was homeless. The practice manager told us that they aimed to be a fully inclusive practice and would assist anyone who required their services.

All of the staff at the practice had completed equality and diversity training. The practice staff we spoke with were all able to demonstrate they recognised the importance of treating all patients, carers and visitors with equality and respect for diversity.

Access to the service

The practice was open from 8am to 6:30pm on Monday to Friday. During these times the reception desk and telephone lines were always staffed. Early evening appointments were offered each Tuesday from 6:30pm to 7:30pm.Appointment times varied during different times throughout the day and had reflected the availability of the GPs. Patients could book appointments in person, by telephone and by using an online system for those had registered to access appointments in this way. A member of reception staff told us that appointments were a mixture of book on the day (for urgent health concerns) and pre-bookable (for routine concerns). We saw that there were urgent appointments available on the day of our inspection and also pre-bookable appointments within three working days.

The GP national patient survey information we reviewed showed a positive response from patients to questions about access to appointments and mostly rated the practice in line with others in these areas. For example:

- 76.5% were satisfied with the practice's opening hours compared to the CCG average of 74.7% and national average of 75.7%.
- 77.7% described their experience of making an appointment as good compared to the CCG average of 72.5% and national average of 73.8%.
- 67.9% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 69.5% and national average of 65.2%.
- 60.3% felt they don't normally have to wait too long to be seen compared with the CCG average of 59.4% and national average of 57.8%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The majority of patients we spoke with found the appointments system easy to use and they felt the appointments met their needs.

We spoke with patients about how to access out-of-hours care and treatment when the practice was closed. Four out of the eight patients we spoke with said they would dial 999 for an ambulance. Whilst this may have been appropriate in an emergency situation, it would not be appropriate for any condition that was not an emergency or life threatening. We noted that the practice booklet did not contain the information on how to access out-of-hours care and there was a notice in the practice waiting room, this was based on the NHS choose well campaign. We spoke with a GP and the practice manager about our finding; they told us that they planned to provide more detailed information on the out-of-hours system for patients.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. The practice displayed clear information on how to raise a complaint in the waiting room and in the practice booklet. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

The practice had received two written complaints in the previous year. We tracked both complaints and saw they had been responded to in an appropriate timescale. One of the complaints was ongoing and still under investigation. Those who complained were made aware that they could raise their concerns with the Parliamentary and Health Service Ombudsman (PHSO) if they remained dissatisfied following the practice findings after a complaint.

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 formal written vision and strategy. We spoke with a number of staff and asked them their vision for the practice and how this would be achieved. All of the staff told us it involved doing the best for patients. The practice manager and GP had a vision to attract more patients and increase the number of services provided.

The GP partnership had been recently changed following the retirement of a longstanding GP. The practice manager told us that they planned to work on a business plan and were also considering setting a practice vision and values in corroboration with staff.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to each member of staff. We looked at three of these policies and procedures and saw that they had been reviewed annually and were up to date. All of the staff we spoke with knew of the existence of policies and procedures and where to access them.

The GPs, nurses and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards.

As a smaller practice the team did not meet on a formal basis. Information was shared on a continuous basis. All of the staff we spoke with were aware of relevant issues that may affect governance such as significant events, complaints and alerts. We saw examples of when risk had been discussed with individual team members. For example, following a significant event.

Leadership, openness and transparency

The GPs were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. Some of the members of staff we spoke with described the practice team like a family.

Staffing levels were stable and most staff members had been employed at the practice for a number of years. Staff told us that there was an open culture within the practice and that they felt respected, valued and supported.

All of the staff we spoke with knew the leadership structure and the scheme of responsibility for individual duties and tasks.

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

The practice was aware of patients' opinions and had sought these in a number of ways:

- The practice had commissioned its own internal patient survey in late 2014. The results of the survey showed that 87% of patients' ratings about the practice were good, very good or excellent.
- The practice had invited feedback since December 2014 using the NHS Friends and Family Test. The feedback was positive, 88% of patients would recommend the practice.
- A newly formed patient participation group (PPG) had been recently formed.
- Patients told us they felt able to make suggestions and they commented that the practice manager and GPs were accessible to them.

In response to the internal patient survey carried out late 2014, the practice had acted on some areas that had received lower feedback than expected. For example, being able to contact a GP by telephone. The practice increased the number of telephone appointments.

Staff told us that they felt able to make suggestions to the way the practice worked and were encouraged to do so. Regular appraisals were held, although they told us they could raise an issue at any time.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place which included a personal development plan.

Are services well-led?

Good

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

Significant event and complaint learning outcomes were shared with staff. The practice manager told us this was to promote an open culture in which everyone could contribute to improving the care, treatment and experience of patients.