Drs Passi and Handa

Quality Report

Leicester Street Medical Centre
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West Midlands
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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?	Requires improvement
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 undertook a comprehensive inspection of Drs Passi and Handa (Leicester Street Medical Centre) on 9 December 2014. The providers also have a branch surgery which is Owen Road Medical Centre but we did not inspect the branch surgery as part of our visit. We found the practice was good in providing care that was effective, caring and responsive but required improvement for effective and well-led. The overall rating for the practice is requires improvement.

Our key findings were as follows:

- The practice had some arrangements in place to ensure patients received a safe service.
- Patient care was provided by staff who had received appropriate training. The practice worked with other health and care providers to deliver co-ordinated care.
- Feedback from patients told us that they were treated with dignity and respect and that staff were friendly and helpful.
- Action had been taken to improve access to appointments. Information and feedback from patients was used to deliver service improvement
- We found the practice was organised operationally and staff understood their roles to deliver a satisfactory service.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure that robust systems and governance arrangements are put in place to protect patients from unsafe care and deliver service improvement.

The provider should:

- Implement a consistent system for ensuring appropriate clinical accountability around repeat prescribing.
- The practice should ensure staff have appropriate working knowledge of the Mental Capacity Act (2005).

Summary of findings

- The practice should ensure audits complete their full audit cycle in order to check any changes have led to improvements in patient care.
- The practice should ensure patients that are unable to produce documentation have access to a GP and staff are aware of the process to follow in that event.
- Establish clear lines of accountability so that staff are aware of whom they should approach if there any issues or concerns in the practice.
- Ensure vision and values for the practice are developed and shared with staff.

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?

Requires improvement

The practice is rated as requires improvement for safe. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. We identified inconsistencies in the way the repeat prescription medication procedures were being implemented by the GP partners and staff. We found that the practice did not have emergency medical oxygen available and there was no risk assessment in place to manage the risk. This did not ensure that the practice was equipped to deal with all emergencies.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were generally at or near the national average. There were effective arrangements to identify, review and monitor patients with long term conditions. Staff received training that was appropriate to their roles and staff skills and knowledge were kept up to date. Staff appraisals were carried out which identified their personal development needs. Health promotion and prevention was actively managed within the practice. Multidisciplinary working was evident to ensure patient needs were appropriately met.

Are services caring?

Good

The practice is rated as good for caring. We saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. Patients said they were treated with compassion, dignity and respect and we observed example of this. The practice made use of interpreters and language line to involve and explain to patients their treatment options. We found staff at the practice were also able to speak other languages spoken by the patient population.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice made use of information to understand and respond to the needs of their local population. Most feedback we received and patients we spoke with reported that access to the practice was satisfactory although some commented on the difficulty of getting an appointment. Patients said they found it easy to see the same GP which provided continuity of care, with urgent appointments available the same day. The practice was accessible to patients with mobility and other needs. The practice did not have a Patient Participation Group

Summary of findings

(PPG). The PPG is a way in which patients and GP practices can work together to improve the quality of the service. However, we saw that the practice had a comments box and had conducted a patient survey, and feedback received was being actioned. Information about how to complain was available and easy to understand.

Are services well-led?

Good

The practice is rated as good for well-led. There was a documented leadership structure and most staff felt supported by management but some lines of accountability were unclear. Staff were unsure of the vision of the practice, they were unclear who made some decisions and did not always follow appropriate paths of accountability. We saw evidence that the practice sought feedback from patients and staff and acted on it where appropriate.

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

Patients over the age of 75 years were offered health checks at dedicated clinics that took place. There were arrangements to review patients in their own home if they were unable to attend the practice. Telephone consultations were available so patients could call and speak with a GP if they did not wish to or were unable to attend the practice. Care plans were in place to monitor and review their health needs. Patients over 75 years of age had a named GP to help co-ordinate their care. Those with complex care needs and at high risk of admission had been identified so that they could be appropriately supported to live at home and avoid admission to hospital.

The practice worked with the palliative care team through quarterly meetings to provide support to patients receiving end of life care.

People with long term conditions

Good

The practice held registers of patients with long term conditions and offered structured reviews for these patients to check their health and medication needs were being met. Patients with long term conditions were reviewed by the GPs and the nurses to assess and monitor their health condition so that any changes could be made. For those with the most complex care needs, we saw the GPs worked with a range of health and care professionals to deliver a multidisciplinary package of care. We saw evidence of care plans that were in place to help manage and better co-ordinate patients care. Patients were able to see a GP in an emergency if their health was deteriorating.

Families, children and young people

Good

There was evidence of multidisciplinary working including the health visiting team. Safeguarding procedures were in place for identifying and responding to concerns about children who were at risk of harm. The childhood vaccination programme was undertaken by the practice nurse. The most recent data available to us showed immunisation rates were mostly in line with the average for the Clinical Commissioning Group area.

Working age people (including those recently retired and students)

Good

A number of clinics and services to promote good health and wellbeing were available for all patients. Emergency appointments, telephone consultations and extended hours of surgery with the nurse were available on Saturday mornings. A GP partner we spoke

with told us they were also available for if needed by the nurse. This enabled patients who worked to attend in the surgery for routine check-ups. Patients were able to order repeat prescriptions around their working day by telephone or on line if they registered for the facility. The practice carried out NHS health checks for patients between the ages of 40 and 74. The NHS Health Checks examine patients vascular or circulatory health and works out the risk of developing some of the most disabling but preventable illnesses.

People whose circumstances may make them vulnerable

Good

We were told that the practice population comprised vulnerable groups such asylum seekers. One of the GPs told us that they found that this group of patients often moved on before follow-up care could be offered. They often did not stay in the area long. We saw that staff did not discriminate in regards to race or gender. However, the practice staff we spoke with were unclear what they would do to enable patient groups such as those without a permanent address to register at the practice. The practice provided an enhanced service to avoid unplanned hospital admissions .This service focused on co-ordinated care for the most vulnerable patients and included emergency health care plans. The aim was to avoid admission to hospital by managing their health needs at home. An enhanced service is a service that is provided above the standard general medical service (GMS) contract. The practice had a translation service available and many staff at the practice were multi-lingual.

People experiencing poor mental health (including people with dementia)

Good

Patients with mental health needs were reviewed annually and the practice made available a room for Healthy Minds which could be accessed by patients on a weekly basis Healthy Minds is an NHS primary care psychological therapies service that works closely with GPs. It offers advice, information and brief psychological talking therapies. Dementia screening for all patients over 65 was available at the practice. This enabled patients to receive appropriate treatment and support if they were developing symptoms of dementia.

Summary of findings

What people who use the service say

We looked at results of the national GP patient survey 2014. Out of the 455 surveys sent, 83 were completed and returned.

The results of the national GP survey highlighted some areas where the practice was above average in comparison to other practices in the local Clinical Commissioning Group (CCG) area. 92% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern compared to 90% for the CCG average. 93% of respondents said the last nurse they saw or spoke to was good at listening to them compared to 91% local average. Also, 93% of respondents said the last nurse they saw or spoke to was good at giving them enough time compared to 91% CCG average.

There were, however, some areas where the practice fell below the CCG area average. Thirty-two percent of respondents with a preferred GP reported they were usually able to see or speak to that GP compared to 58% local CCG average. Forty-seven percent of respondents said they would recommend this surgery to someone new to the area compared to 72% local average. Fifty-One percent of respondents also described their experience of making an appointment as good compared to 73% local average.

As part of the inspection we sent the practice comment cards so that patients had the opportunity to give us feedback. We received 35 completed cards. Overall the feedback we received was positive, and patients described the quality of the service and staff as good and caring. Two comment cards also stated that patients found it difficult to get an appointment at times.

On the day of the inspection we spoke with five patients. Most of the patents we spoke with were positive about their experience but two patients commented that it was difficult at times to get through to the reception staff on the telephone. One of the patients we spoke with had joined the practice recently and had given mixed feedback regarding their experience.

Areas for improvement

Action the service MUST take to improve

- Ensure that robust systems and governance arrangements are put in place to protect patients from unsafe care and deliver service improvement.

Action the service SHOULD take to improve

- Implement a consistent system for ensuring appropriate clinical accountability around repeat prescribing.
- The practice should ensure staff have appropriate working knowledge of the Mental Capacity Act (2005).
- The practice should ensure audits complete their full audit cycle in order to check any changes have led to improvements in patient care.
- The practice should ensure patients that are unable to produce documentation have access to a GP and staff are aware of the process to follow in that event.
- Establish clear lines of accountability so that staff are aware of whom they should approach if there any issues or concerns in the practice.

Ensure vision and values for the practice are developed and shared with staff.

Drs Passi and Handa

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a second CQC inspector. The team also included a specialist advisor GP and a specialist advisor practice manager with experience of primary care services.

Background to Drs Passi and Handa

Drs Passi & Handa is a registered provider of primary medical services with the Care Quality Commission (CQC) and has one registered location (practice).This is Leicester Street Medical Centre, Whitmore Reans, Wolverhampton, WV6 0PS. The practice also has a branch surgery which is Owen Road Medical Centre, 130 Owen Rd, WolverhamptonWV3 0AJ. This inspection focused on the main surgery Leicester Street Medical Centre. However, the data we reviewed before the inspection visit represented both surgeries.

The registered patient list size is approximately 6700 patients. The practice is open Monday to Friday 8am to 6:30pm. The consulting hours were from 8:30am to 10:30am and 3:30pm to 5:30pm. The practice provided extended hours on Saturdays from 9am to 12.30pm. The practice has opted out of providing out-of-hours services to their own patients. This service is provided by an external out of hours service contracted by the CCG. CCGs are groups of GP practices that commission most of the hospital and community NHS services in the local area for which they are responsible.

There are two GPs (one male and one female) and a salaried GP who works six sessions a week. All the GPs worked at both the main and branch surgery sites. The practice employs one nurse practitioner (a nurse who is qualified to treat certain medical conditions without the direct supervision of a doctor), a practice nurse and three health care assistants one of whom was a trainee. There is also a team of six administrative staff and a deputy practice manager who was acting in the role of the practice manager.

The practice has a General Medical Service contract (GMS) with NHS England. A GMS contract ensures practices provide essential services for people who are sick as well as for example, chronic disease management and end of life care. The practice also provides some enhanced services such as minor surgery. An enhanced service is a service that is provided above the standard GMS contract.

We reviewed the most recent data available to us which showed that the practice is located in a deprived area in Wolverhampton. The patient population comprised a large group of Asian people as well as recent immigrants and asylum seekers. The practice has a lower than average patient population who are aged 45 years and over and a higher than average patient population aged between 20 and 34 years in comparison to the practice average across England.

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. This provider had not been inspected before and that was why we included them.

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.

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, we reviewed a range of information we held about the service. We also asked other organisations and health care professionals to share what they knew about the service. We sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received 35 completed cards where patients shared their views and experiences of the service. We carried out an announced inspection on 9 December 2014. During our inspection we spoke with a range of staff including the practice manager, clinical and non-clinical staff. We spoke with patients who used the service. We observed the way the service was delivered but did not observe any aspects of patient care or treatment.

Requires improvement

Are services safe?

Our findings

Safe track record

We spoke with five patients about their experience at the practice. None of the patients we spoke with reported any safety concerns to us.

We saw that there was a significant events policy. The policy outlined how significant events should be recorded, analysed and discussed at staff meetings to share lessons learnt. We saw evidence that this was being done and discussions with staff demonstrated that they were aware of the process for incident reporting. We saw an incidents folder with incidents recorded over a number of years demonstrating a safe track record over a longer period.

The practice staff were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we saw staff recorded three verbal complaints and concerns from patients as incidents so that learning could be implemented and shared amongst staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. A significant event is any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice. For example, we saw an incident that documented a fridge used to store vaccines had reached a temperature of 20 degrees Celsius which was above the recommended temperature for keeping medicines and vaccines. This was because the fridge had been switched off in error. We saw evidence that this was discussed at a team meeting and learning implemented by putting labels on the plug so that power to the fridge was not turned off. We saw documented evidence that the affected medicines were discarded appropriately.

Reliable safety systems and processes including safeguarding

Safeguarding information was readily available for staff. We saw comprehensive guidelines for reporting safeguarding concerns in the policies available to staff on the shared drive of the practice computer system. Staff we spoke with knew where they were kept.

Training records demonstrated that clinical staff had received safeguarding training appropriate for their role and other staff had also received training. Staff we spoke with were aware of their roles and responsibilities with regards to protecting people from abuse or the risk of abuse. They were able to tell us how to recognise the signs of abuse and demonstrated how they would respond to safeguarding concerns.

We saw that a chaperone policy was in place and chaperone duties were usually undertaken by nursing staff. Other staff undertook this duty if a nurse was not available. We saw staff had received online training. A chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure and is a witness to continuing consent of the procedure. Chaperones were available during examinations if patients wanted one. Staff had received chaperone training from an external training provider so that they were aware of the role and responsibilities of a chaperone. We saw chaperone notices were displayed in different areas of the surgery. Most patients we spoke with were aware that they could have chaperone if needed. Records we looked at showed that all staff had undergone Disclosure and Barring Service (DBS) checks. DBS checks helps to 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 they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to be taken in the event of a potential failure understood.

Staff, as part of stock control, routinely checked and recorded the expiry dates of medicines held in the practice. We noted that a template used to monitor expiry dates of medicines was not updated. We saw that a medicine was listed as having expired in February 2014 but when we checked we saw it had been replaced but had not been updated on the monitoring sheet. The nurse we spoke with informed us that this was probably an oversight and would be updating this.

A system was in place for repeat and acute prescribing so that patients were reviewed appropriately and any repeat

medications were relevant to their health needs. However, we were concerned about the robustness the system for monitoring repeat prescribing. Non clinical staff told us that they routinely re-authorised and issued repeat prescriptions. These were then taken to GPs for signature. Furthermore, a GP partner told us there were QOF alerts on the clinical system which highlighted if patients needed a review for their repeat prescription. Staff then alerted the GPs in turn. This was not sufficiently robust as not all repeat prescribing is linked to QOF conditions and so there was a risk that some patient reviews would be missed. The second GP we spoke with told us that non clinical staff were unable to re-authorise medication without permission. This suggested there was an inconsistency in what the GPs thought was happening with the prescribing system. We also noted that secondary care correspondence (for example from outpatient appointments or discharges from hospital stays and may include medication changes) were being reviewed by non-clinical staff. Although staff were not triaging or making decisions from these correspondence it was unclear how clinically safe this would be. A GP partner we spoke with told us that staff always took directions from the GPs.

Cleanliness and infection control

We observed all areas of the practice to be visibly clean, tidy and well maintained. The practice had an infection prevention and control policy (IPC) with a responsible lead. We saw evidence that staff had training in IPC to ensure they were up to date in all relevant areas. Aprons, gloves and other protective equipment were available in all treatment areas as was hand sanitizer and safe hand washing guidance.

The IPC lead for the practice was one of the GP partners; however we saw that the practice nurse carried out infection control audits such as hand washing audits.

Environmental cleaning of the whole building was undertaken by an external contractor and monitored by the acting practice manager. We saw that cleaning schedules for all areas of the practice were in place.

We found that suitable arrangements were in place for the storage and the disposal of clinical waste and sharps. Sharps boxes were dated and signed with the date of use to enable staff to monitor how long they had been in place. A contract was in place to ensure the safe disposable of clinical waste.

A legionella risk assessment had been completed by an external agency giving details as to how to reduce the risk of the legionella bacterium spreading through water and other systems in the work place. Legionella is a bacterium that can grow in contaminated water and can be fatal.

Equipment

Patients were protected from the use of unsafe equipment in a medical emergency. There was an equipment matrix which listed all equipment needing servicing and checks. We saw all equipment was checked regularly to ensure it was in working condition and drugs were within expiry dates. The checks also included the annual testing of fire protection equipment such as fire extinguishers. This ensured that all equipment was maintained in good working order.

We saw all equipment had been tested and that the provider had contracts in place for annual Portable appliance testing (PAT). PAT is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use. There were arrangements in place for routine servicing and calibration of equipment such as blood pressure cuffs, weighing scales, and blood pressure monitoring equipment.

Staffing and recruitment

The registered patient list size was approximately 6700 patients. There were two permanent GPs and a salaried GP. The acting practice manager confirmed that most of the staff had worked at the practice for a number of years which provided stability within the staff team and ensured patients received continuity in their care. The practiced employed two practice nurses, three health care assistants (HCA) one of whom was a trainee. There was also an administrative team which included secretaries and reception staff and an acting practice manager.

We looked at three staff files, including the file of the most recent member of staff employed at the practice. There was evidence that most of the appropriate pre-employment checks were completed prior to staff commencing their post. This included photographic identity, references and a DBS check at an appropriate level for the role and responsibilities.

The acting practice manager told us that they rarely used locum GPs however, in the event this was required

appropriate documentation was sought prior to them working at the practice. We saw contact details of three locum agencies and appropriate contract in place for providing locum staff.

Monitoring safety and responding to risk

Risk assessments were in place which included areas of health and safety associated with the general environment. Records showed that essential risk assessments had been completed, and where risks were highlighted measures had been put in place to minimise the risks.

Arrangements to deal with emergencies and major incidents

The practice had an up to date business continuity plan in place. This covered a range of areas of potential risks relating to foreseeable emergencies that could impact on the delivery of the service. All staff spoken with were aware of the plan and showed us a 'disaster box' in the reception area which had equipment such as a torch, blanket and first aid equipment that would be needed in the event of an emergency and major incident. The 'disaster box' also contained an up to date business continuity plan.

There were some arrangements to deal with foreseeable emergencies. We saw that the staff at the practice had received training in medical emergencies such as cardiopulmonary resuscitation (CPR). The practice had an Automated External Defibrillator (AED) which is a piece of life saving equipment that can be used in the event of a medical emergency. All of the staff we asked knew the location of the emergency medicines and equipment.

Medical oxygen is widely used in emergency medicine, both in hospital and by emergency medical services or those giving advanced first aid. Having immediate access to functioning emergency oxygen cylinder kit helps people survive medical emergencies such as a heart attack. However, the practice did not have emergency medical oxygen available. There was also no risk assessment in place to determine how a patient would be dealt with if they required medical oxygen. One of the GP partners we spoke with told us that they had previously had medical oxygen available at the practice. But they were advised by the then Primary Care Trust (PCT, now replaced by the Clinical Commissioning Group, CCG) not to stock medical oxygen. The practice informed us after the inspection that they had made an order to purchase medical oxygen.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with were able to describe how they accessed and implemented guidelines based on best practice such as the National Institute for Health and Care Excellence (NICE) and doctors.net modules. NICE provides national guidance and advice to improve health and social care. The GPs told us that they had bi-monthly practice education sessions so that they could discuss latest guidance. To keep up to date with guidance the GPs told us that they attended meetings and read around subjects as well as attending appropriate courses.

The practice was undertaking an enhanced service to reduce unnecessary emergency admissions to secondary care. GP practices can opt to provide additional services known as enhanced services that are not part of the normal GP contract. By providing these services, GPs can help to reduce the impact on secondary care and expand the range of services to meet local need and improve convenience and choice for patients. The focus of this enhanced service was to optimise coordinated care for the most vulnerable patients to best manage them at home. The acting practice manager informed the practice nurse of any patients who had an unplanned admission to accident and emergency (A&E), in order they could review the patient. This allowed the practice to proactively assess the needs of at risk patients with the aim of helping them develop better management strategies. We saw evidence that care plans were in place to better support patients.

Patients who were receiving end of life care had a named GP and there were arrangements to share information with out of hours services for when the practice was closed. Meetings were held with the palliative care teams to ensure coordinated care that respected patients' needs and wishes.

Dementia screening for all patients over 65 was available at the practice. This enabled those patients who chose to be screened to receive appropriate treatment and support if they were developing symptoms of dementia.

Management, monitoring and improving outcomes for people

The practice had an audit folder containing details of various audits conducted. We saw that the audits were searches for disease conditions some of which were linked to the Quality Outcomes Framework (QOF) and the practice was able to review patients using the searches. 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 e.g. diabetes and implementing preventative measures. The results are published annually. However, it was difficult to determine any impact as there were no updates available. Also, one of the GP we spoke with told us about a vitamin D audit they had completed. What we saw was a search rather than a clinical audit; this allowed the practice to understand the prevalence of vitamin D deficiency in the patient population, but did not in itself function as a quality improvement activity. We saw one completed audit the practice had forwarded before the inspection. This was a diabetes audit which looked at blood glucose at different levels. Results looked at showed that the practice had made some improvements as there was a small reduction in the blood glucose level of patients at the higher level.

There were arrangements in place to ensure women received cervical smear tests by one of the GP partners and the practice nurse. Samples were sent to a local NHS hospital to be analysed and reported on in line with national guidance and recall systems. The latest data showed that the practice had performed better than the local and national average. The GP we spoke with described an annual audit carried out so that action could be taken for inadequate smears. We saw where a repeat test was required letters were sent out so that appointments could be booked. We saw that some had been booked while alerts had been put on the computer system for others who had not booked.

Performance information on patient outcomes was available to staff and the public, which included monitoring reports on QOF. The practice assigned different areas of QOF to different staff members depending on clinical lead roles. For example, the practice nurses reviewed patients with long term conditions such as diabetes. QOF targets were reviewed regularly and we saw evidence of satisfactory QOF achievement.

Effective staffing

We saw that there was a recruitment policy in place and staff files we looked at showed that it had been followed.

Good

Are services effective?

(for example, treatment is effective)

Staff received appropriate training and support to undertake their role. Records demonstrated that most of the staff had completed essential training to support safe and effective practice such as basic life support and safeguarding. The practice nurse we spoke with told us they had opportunities for continuing professional development to enhance their role. We saw evidence that one of the nurses had attended a conference in nursing in practice which helped them to stay up to date with current guidance.

The practice had systems in place for the induction of new staff as well as annual appraisals for all staff. We saw evidence of induction in staff files we looked at and staff we spoke with confirmed that appraisals took place.

There were systems in place to monitor and review staffing levels to ensure any shortages were addressed and did not impact on the delivery of the service. Staff, including nursing and administrative staff were able cover each other's annual leave as well and resources from the branch surgery could be utilised when necessary. Some of the reception staff we spoke with felt that the surgery could get very busy at times and it was very difficult to meet the demand during those periods. We fed this back to the providers during the inspection who agreed to investigate further so that appropriate action could be taken.

Clinical staff at the practice ensured they developed their knowledge and skills through continuous professional development (CPD). For GPs this included revalidation which happened every five years. Revalidation is a process by which the GPs demonstrate that they are meeting the standards set by the General Medical Council. Both GP partners informed us that they had been through the revalidation process. Practice nurses completed a similar process set by the Nursing and Midwifery Council (NMC) and renewed their registration to practice annually.

Working with colleagues and other services

Discussions with staff and records showed that the practice worked in partnership with other health and social care providers such as social services, end of life care teams and district nursing services to meet patients' needs.

There were systems in place to ensure that the results of tests and investigations from out of hours services and hospitals were reviewed and actioned. We noted that although non clinical staff were not triaging or making decisions from correspondence, pathology or radiology reports. They were coding and making medication changes from correspondence. One GP we spoke with told us that this was supervised by them.

The practice had opted out of providing out of hours (OOH) services. This had been contracted by the CCG to an external service provider. The practice faxed appropriate information of patients that were on end of life care so that the OOH service would be aware of any management needs while the practice was closed. The practice also received an electronic summary for patients who had accessed the OOH service. These patients were reviewed and followed up where necessary by the GPs at the practice.

Midwifes attended the practice weekly and the practice made available a room for Healthy Minds and Wolverhampton Healthy Lifestyle services. Healthy Minds is an NHS primary care psychological therapies service that works closely with GPs. It offers advice, information and brief psychological talking therapies for people aged 16 and over, who are often feeling anxious, low in mood or depressed. Healthy lifestyles services offers advice and support for the population of Wolverhampton about their individual cardio vascular risks and how these can be reduced. The service can be accessed at many sites including GP practices.

Information sharing

We saw evidence that the practice held multi-disciplinary meetings to discuss the needs of patients with complex needs. For example, those with end of life care needs to ensure important information was shared. We saw joint working arrangements were also in place with the palliative care team quarterly.

There was a system in place to ensure the out of hours service had access to up-to-date treatment plans of patients who were receiving specialist support or palliative care.

Consent to care and treatment

The GPs we spoke with told us that they had not received any formal training on the Mental Capacity Act (2005). Our conversations with the GP partners revealed that they did not have a working knowledge of the act. The GP partners we spoke with told us about the principles involved in contraception particularly around young people. This was

Good

Are services effective?

(for example, treatment is effective)

in regards to Gillick competency and Fraser Guidance. Gillick competency is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. Fraser Competency is a term used to describe a child under 16 who is considered to be of sufficient age and understanding to be competent to receive contraceptive advice without parental knowledge or consent.

We spoke with five patients. None of them raised any issues around consent and all told us that they had been involved in decisions about their care and treatment.

Health promotion and prevention

The practice had a procedure in place for new patients registering with the practice, this included a health check with the nurse and those patients on regular medication were also reviewed by a GP. Patients between 40 and 74 years of age were invited for annual health checks. The NHS Health Check programme was designed to identify patients at risk of developing diseases including heart and kidney disease, stroke and diabetes over the next 10 years.

Information leaflets and posters were available in the patient waiting area on health promotion and prevention. A practice leaflet was available for patients in the waiting area but this did not detail the types of service available. The acting practice manager told us that they were working with the CCG to develop a practice website.

Clinical staff we spoke with confirmed that health promotion information was available for all patients. They told us that they discussed health issues such as smoking, drinking and diet with patients when they carried out routine checks with patients. Staff confirmed that patients were given information to access other services as was needed.

Mental health patients and patients with learning disability were offered regular health checks. Similar mechanisms were in place to identify patients at risk such as those who were likely to be admitted to hospital and or patients receiving end of life care. These patient groups were offered further support in line with their needs. Records we looked at showed that patients with long term illness such as diabetes were regularly reviewed.

The childhood vaccination programme was undertaken by the practice nurse. The most recent data available to us showed immunisation rates were mostly in line with the average for the CCG area.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We looked at results of the national GP patient survey 2014. Out of the 455 surveys sent 83 were completed and returned. We saw that 92% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern compared to 90% for the CCG average. 93% of respondents said the last nurse they saw or spoke to was good at listening to them compared to 91% local average. Also, 93% of respondents said the last nurse they saw or spoke to was good at giving them enough time compared to 91% CCG average.

We saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. Reception staff told us that a consultation room was always available if a patient requested for private discussions. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room and 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 easily overheard.

We spoke with five patients on the day of our inspection. We also sent the practice comment cards prior to our inspection so that patients had the opportunity to give us feedback. We received 35 completed cards where patients shared their views and experiences of the service. Overall these completed cards contained positive feedback. Our discussions with patients on the day and feedback from comment cards told us patients felt that staff were caring and their privacy and dignity was respected. The main area for improvement was the appointment system; some patients described difficulty accessing appointments in a timely manner.

Care planning and involvement in decisions about care and treatment

The practice partners told us that they had a large population of asylum seekers and recent immigrants registered with them. The practice made use of interpreters and language line to involve and explain to patients their treatment options. Staff at the practice were also able to speak other languages such as Punjabi and Urdu. We saw reception staff talking to patients in other languages as needed.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. The GP national survey showed that 83% of respondents stated that the last nurse they saw or spoke to was good at involving them in decisions about their care. This was above the local (CCG) average of 68%.

Patient/carer support to cope emotionally with care and treatment

The practice policy was to send a card to families after bereavement with details of other support services. Staff told us that they may also attend funerals.

The practice also started counselling sessions for patients once a week. This was a new service was by appointment only and only after a referral had been made either self-referral or through the GP. The practice also used the emergency access team at Penn Hospital for further advice, support or referral in regards to patients with mental health needs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Respect, dignity, compassion and empathy

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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 clear vision and strategy to develop the practice. We saw that there were quality priorities displayed in the reception area which were developed by Wolverhampton CCG. However, staff we spoke with were not able to explain what they were and told us that the previous practice manager had put them up.

We saw that the practice had developed a set of aims and objectives as part of their registration with the Care Quality Commission (CQC). These were submitted to us before the inspection. However, none of the staff we spoke with were aware of these objectives and how the practice was going to deliver them.

We spoke with the acting practice manager who told us that they had plans to develop a website for the practice and were working in partnership with Wolverhampton CCG. They also told us that they were working on developing a vision and values for the practice.

Governance arrangements

There were administrative supervisors in place and nurses and GPs had lead clinical roles and responsibilities that partly supported the governance framework at the practice. The practice manager was acting in the role and it was unclear if they would be made working in the role permanently. From our discussion with staff, we were told that there had been a high turnover of practice managers. As a result some of the staff went to the GP partners if there were any issues without following appropriate paths of accountability. This was because staff were unsure who made some of the decisions. This did not ensure that there was a clear line of roles, responsibility and accountabilities. Where there were clear roles and accountabilities it was unclear if the appropriate person was undertaking this role. For example, the practice nurse carried out many infection control duties including conducting infection control audits. However, the infection control audit lead in the policy was one of the GP partners.

We noted a lack of clinical oversight with regard to repeat prescribing and management of patient correspondence which exposed patients to unnecessary risks. The GP providers we spoke with at times gave us conflicting information. For example, there were inconsistencies in the way repeat prescribing was authorised with both GPs telling us different methods that were used. This did not ensure consistent approach to care delivery.

Leadership, openness and transparency

We saw evidence of staff appraisals that were regularly undertaken. Staff members we spoke with told us that they aimed to provide a caring service but were not aware of any visions and values of the practice.

Staff members we spoke with felt supported in their roles and were able to speak with the acting practice manager if they had any concerns. They told us that opportunities for progression were discussed and actioned where appropriate.

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

The acting practice manager told us that they had given out a staff questionnaire so that the feedback could be used to develop service further. However, at the time of our inspection we saw that only one questionnaire was returned completed. The acting practice manager planned to remind staff to complete the questionnaire so that they were able to review the response and take appropriate actions.

The practice did not have a patient participation group (PPG) to gather patient opinion regarding the service offered. The PPG is a way in which patients and GP practices can work together to improve the quality of the service. However, we saw that the practice had a comments box and feedback received was being actioned. We saw that the practice informed patients on the actions being taken through notices in the waiting area. We saw that patients had commented on the reception chairs being scruffy and the practice informed patients that they were in the process of getting a quote for new chairs. Other patients commented that they had trouble getting appointments. The practice informed patients that they had trialled a new system at the branch surgery which was a success and were going to implement this new system at the main surgery so more appointments would be available for patients.

Management lead through learning and improvement

The practice held regular meetings that ensured continued learning and improvements for all staff. All staff we spoke

Are services well-led?

Good

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

with confirmed that meetings had taken place. This included significant events, complaints and palliative care for patients, with discussions on actions to be completed where appropriate.

Staff files we looked at showed that regular appraisals had taken place which included a personal development plan. Staff told us that the practice was very supportive of training.

GPs held regular meetings to discuss each patient who had been admitted to hospital to monitor their progress and to determine if there were any lessons to be learnt.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Governance arrangements were not sufficient to protect patients and others from inappropriate or unsafe care. Risks relating to unforeseen events were not adequately managed. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.