

Pedmore Medical Practice

Quality Report

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

Ratings

Overall rating for this service

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. We previously inspected the service on 30 November 2016. As a result of our previous comprehensive inspection, we rated the service as requires improvement overall, with the safe, effective and well-led key questions rated as requires improvement. The practice was rated as good in the caring and responsive key questions. We found a breach of the legal requirements and as a result we issued a requirement notice in relation to:

There were gaps found in governance arrangements; care plans had not always been completed in line with patient needs, and in some areas, patient medication reviews were overdue. Systems to monitor cleaning and emergency equipment and medicines checks also needed strengthening.

You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Pedmore Medical Practice on our website at www.cqc.org.uk

We carried out an announced comprehensive inspection at Pedmore Medical Practice on 12 January 2018 to monitor that the necessary improvements had been made.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students) – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) – Good

At this inspection we found:

- The practice had systems, processes and practices in place to protect people from potential abuse. Staff were aware of how to raise a safeguarding concern and had access to internal leads and contacts for external safeguarding agencies. Staff had received up-to-date safeguarding training relevant to their role.

Summary of findings

- The practice had systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice had improved arrangements for managing infection prevention and control. An external audit had been completed since the last inspection and the practice had achieved a 96% overall score.
- There were systems in place for identifying, assessing and mitigating most risks to the health and safety of patients and staff. However, not all environmental risks to patients and staff had been formally assessed.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- The practice kept a training matrix that included planned dates for those staff who had not received essential training.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found it easy to make an appointment by telephone and told us appointments with GPs were readily available when needed.
- The practice had suitable facilities and was well equipped and maintained to treat patients and meet their needs.
- The practice were aware and monitored patient feedback and were proactively trying to reinvigorate the patient participation group.
- Governance arrangements for managing patient care had significantly improved. The practice closely monitored the management of patients with long-term conditions and performance data showed that the practice were at or above average when compared with other local practices.
- The practice had implemented effective systems of record keeping to monitor the areas identified at the previous inspection as in need of improvement.
- There was a focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider **should** make improvements are:

- Continue to improve the health and safety arrangements.
- Review the recruitment process to ensure a physical and mental health assessment on all staff employed to ensure suitability to carry out their role.
- Update safeguarding policies to include the most recent definitions.
- Complete the staff training programme to provide essential training.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

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

Pedmore Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a GP specialist advisor and a second inspector.

Background to Pedmore Medical Practice

Pedmore Medical Practice is located in the Stourbridge area of Dudley and delivers regulated activities from the Pedmore Road Practice only.

The practice is registered with the Care Quality Commission (CQC) as a partnership provider and holds a General Medical Services (GMS) contract with NHS England and provides a number of enhanced services to include minor surgery. A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract. The practice is part of the NHS Dudley Clinical Commissioning Group (CCG).

The practice treats patients of all ages and provides a range of medical services. There are currently 3,962 registered

patients at the practice. The practice local area is one of overall average deprivation when compared with the local and national averages but there are pockets of highly deprived areas. The practice has a higher percentage of patients aged 65 and over (26%) compared to the national average (17%) which could mean an increased demand for GP services. The practice has 56% of patients with a long-standing health condition compared to the CCG average of 56% and the national average of 53%.

The practice is situated in a privately owned ex-residential premises owned and maintained by a retired partner, with a formal lease agreement in place. The practice is owned and managed by a team of three GP partners who are supported by a salaried GP, a long-term locum GP, two practice nurses, a practice manager and an administration team. Opening hours are between 8am and 6.30pm Monday to Friday. The appointment system allowed patients to walk in and be seen in addition to offering pre-bookable appointments. Extended hours appointments are available on Monday and Wednesday evenings from 6.30pm to 7.15pm for patients who would otherwise find it difficult to attend the practice during the day due to work or unforeseen circumstances. These extended hours are also available to unregistered patients as part of a CCG improved access scheme.

Additional information about the practice is available on their website: www.pedmoremedicalpractice.co.uk

Are services safe?

Our findings

At our previous inspection on 30 November 2016, we rated the practice as requires improvement for providing safe services as the arrangements in respect of cleanliness and infection control were not adequate.

These arrangements had significantly improved when we undertook a follow up inspection on 12 January 2018. The practice is now rated as good for providing safe services.

We rated the practice as good for providing safe services overall and across all population groups.

Safety systems and processes

The practice had systems to keep patients safe and safeguarded from abuse.

- The practice had systems to safeguard children and vulnerable adults from abuse. Policies were reviewed and were accessible to all staff. Staff knew how to identify and report safeguarding concerns and had access to internal leads and contacts for external safeguarding agencies. Staff shared examples of reporting safeguarding concerns and worked with other agencies to support patients and protect them from neglect and abuse. However the adult safeguarding policy did not include all the new definitions of abuse such as modern day slavery.
- The practice had a range of safety policies in place which were communicated to staff and regularly reviewed. There were systems in place for identifying, assessing and mitigating most risks to the health and safety of patients and staff. There were records of safety checks undertaken. However, we found not all environmental risks to patients and staff had been formally assessed.
- We saw the practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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). However no mental or physical health assessment had been carried out on staff to check suitability to carry out their role.

- Clinical and administration staff acted as chaperones. They were trained for the role and had received a DBS check. Notices were displayed in consultation and clinical rooms advising patients that chaperones were available if required. Patients were advised on the practice website.
- Staff had received up-to-date safety training or safeguarding training appropriate to their role.
- There was an effective system to manage infection prevention and control (IPC). There was a designated infection prevention and control clinical lead in place. An IPC audit was carried out every three years by external auditors and each year by the practice IPC lead. The most recent external audit had been carried out in July 2016 and the practice achieved a 96% overall score. An action plan had been developed to address the improvements identified, for example a windowsill had been repaired and the toilet brush holders changed. A hand hygiene audit had also been carried out to assess staff compliance with the hand hygiene policy and observations and any concerns identified were documented and actioned.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. Rotas were produced for GPs, nurses and reception staff.
- There was an effective induction system for temporary staff tailored to their role. For example, we saw checklists in place for locum staff that included checks made against their registration status, qualifications and training records. An induction pack was available and included fire procedures, external agency numbers, the appointment system, internal procedures, workflow information, staff team members and roles.

Are services safe?

- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety. For example, a GP going on maternity leave.
- The practice had a business continuity plan with up to date contact numbers. Copies were kept off site.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- We reviewed two routine referral letters and an urgent referral letter and saw these included all of the necessary information.
- The practice used a directory of local guidelines to facilitate referrals along accepted pathways. This provided comprehensive, evidenced based local guidance and clinical decision support at the point of care and is effective in reducing referrals. GPs carried out peer reviews on each other's referrals.

Safe and appropriate use of medicines

The practice had systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. Emergency medicines were held at the practice and anticipatory medicines were taken on home visits. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing.

- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. For example, changes in medicines following test results, hospital discharges and clinics held for long term conditions.
- Patients on high risk medicines were managed appropriately. We checked 21 patients on a high risk medicine used to treat rheumatoid arthritis and all had up to date blood test monitoring.

Track record on safety

The practice had a good safety record.

- There were risk assessments in relation to safety issues in place and records of routine safety checks undertaken. However, there was no risk log and no hard wire test had been done.
- There was a health and safety lead who had received training specific to their role and was supported by named first aiders and fire marshals.
- There was a visitor's book but no attendance log for staff.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system and procedure for recording and acting on significant events and incidents. There was a standard recording form available on the practice's computer system. Staff we spoke with told us they were encouraged to raise concerns and report incidents and near misses and demonstrated an understanding of the procedure. Most staff were able to share an example of a recent significant event, the action taken and learning shared. Staff told us they were supported by managers when raising significant events.
- There were adequate systems for reviewing and investigating when things went wrong. The practice had recorded six significant events in the last 12 months. Events were recorded, investigated and shared practice wide during monthly meetings held and action taken to improve safety in the practice. For example, following a follow up letter being sent to a patient to follow up a scan, it was found that the scan had not been done. As a result, a log sheet was created to track follow up treatment had been received. A follow up recall system was introduced in July 2017 and had achieved 100% attendance since implementation.

Are services safe?

- There was an effective system in place led by the practice pharmacist to log, review, discuss and act on external alerts, such as the Medicines and Healthcare products Regulatory Agency (MHRA) alerts that may

affect patient safety. Following an alert being received, the practice checked to ensure that patients were not affected by the medicines or equipment involved and took appropriate on going action where required.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 30 November 2016, we rated the practice as requires improvement for providing effective services as the arrangements in respect of alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA), clinical audits and staff appraisal needed improving.

These arrangements had significantly improved when we undertook a follow up inspection on 12 January 2018. The practice is now rated as good for providing effective services.

We rated the practice as good for providing effective services overall and across all population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The practice prescribed less antibiotics when compared to the Clinical Commissioning Group (CCG) and national averages. The number of items the practice prescribed was 0.7 items compared to the CCG and national averages of 0.9.
- The percentage of high risk antibiotics prescribed (Co-amoxiclav, Cephalosporins or Quinolones) was 5.6%, compared to the CCG of 3.2% the national average of 4.7%.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or vulnerable were identified and received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

- Patients over the age of 75 years had a named GP.

People with long-term conditions:

- The practice offered a number of clinics for patients with long-term conditions. Patients had a structured annual review to check their health and medicines needs were being met. Patients were provided with a management plan developed in partnership with them and agreed targets set for the next review. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- Data for the year starting April 2017 showed that 93% of patients with atrial fibrillation had a structured assessment of the risk of a stroke.
- Data for the year starting April 2017 showed that 89% of patients on the asthma register had received a lung function assessment. The CCG target was between 45% and 80%.

Families, children and young people:

- Child immunisations were offered by the practice and carried out in line with the national childhood vaccination programme. Patients who missed any of their immunisations were reported to the health visitor, monitored and recalled. Uptake rates for the vaccines given to under two year olds were above the target percentage of 90%. The uptake rates for vaccines given to children aged up to two years of age ranged from 92% to 97%.
- Antenatal clinics were held by appointment on a Thursday afternoon with the visiting community midwife. The practice provided health surveillance clinics where the mother and baby were reviewed.
- In order to prioritise treatment, a triage system using red flag indicators was used under-fives who have used the walk in service. These included temperature, breathing, eating and drinking patterns and urine output.
- Full contraception services were offered including implants and free condoms.
- Chlamydia screening packs were available to patients and signposted in reception to promote discretion.

Working age people (including those recently retired and students):

Are services effective?

(for example, treatment is effective)

- The practice's uptake for cervical screening within the target period was 69%, which was comparable with the Clinical Commissioning Group average of 72% and the national average of 73%.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. Information about this vaccine was readily accessible and displayed in the waiting area and recall letters were sent to patients.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. Data provided by the practice showed they had invited 162 patients since 1st April 2017 and completed 114 of these health checks for the same period. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice hosted the palliative care meetings with a range of professionals to ensure those who were approaching end of life have a more cohesive plan of care across all agencies.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice had 23 registered patients with a learning disability cared for in local care homes and in their own homes. Sixteen of these patients had received an annual review.
- The practice had identified 59 (1.5%) of the patient list as carers and signposted them to local services offering support and guidance.

People experiencing poor mental health (including people with dementia):

- The practice was supported by a Community Mental Health Nurse (CMHN) who attended the monthly multidisciplinary meetings.
- All patients experiencing poor mental health were offered a mental health review annually. There was a patient recall system in place to support attendance.

- All patients diagnosed with dementia were recalled for a dementia review annually. A total of 82% of patients diagnosed with dementia had been reviewed in the preceding 12 months.
- There was a patient call in system to provide a GP appointment to any patient known to have deliberately self-harmed or attempted suicide.
- The practice had a named dementia lead and provided in house screening and diagnosis.

Monitoring care and treatment

The practice had a structured programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. The practice had carried out audits to include a full cycle audit on patients diagnosed with hypertension. The first audit in 2016 identified 76% of patients with hypertension were within blood pressure targets set by The National Institute for Health and Care Excellence (NICE) guidelines. This had risen to 82% in the second cycle carried out in 2017. A second audit looked at the target blood pressure for patients with hypertension and diabetes. The first cycle completed in 2016 showed 55% achieved target. This improved to 81% in a second cycle carried out in 2017.

The practice used the information collected for the Dudley CCG Outcomes for Health Framework and performance against national screening programmes to monitor outcomes for patients. (Dudley CCG are one of four vanguards in England to implement a system intended to improve the quality of general practice and reward good practice). Data we reviewed for the year starting April 2017 showed that the practice performance was generally in line or above the CCG targets. For example:

- 54% of patients with a long-term condition had received a comprehensive, holistic assessment that included a medication review since April 2017. The CCG target for a full 12 months was between 50% and 80%.
- 63% of patients with a long-term condition had received a care plan co-developed with the patient to include details of individualised personal goals. The CCG target for a full 12 months was between 50% and 80%.
- 56% of patients with a diagnosis of diabetes had a recorded HbA1c level within target. The CCG target was between 35% and 75%.

Effective staffing

Are services effective?

(for example, treatment is effective)

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training opportunities for personal development. Newly appointed staff received an induction to their work. Records of staff skills, qualifications and training were maintained. However, we identified not all staff had received up-to-date essential training to enable them to carry out their duties safely. The provider acknowledged that not all staff were up to date with their training requirements and could evidence that a programme of training had been planned.
- Staff were encouraged and given opportunities to develop. For example a receptionist had been upskilled to allow them to carry out the role of a healthcare assistant.
- The practice provided staff with ongoing support. This included an induction process, appraisals, tutorials, clinical supervision and support for revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- All locum GP referrals were reviewed by one of the GP partners.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.

- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. Meetings were held with external healthcare partners to discuss patients with complex needs.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. For example, patients with long term conditions.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health and supported and signposted patients that required support.
- The practice had effective systems in place to monitor the uptake of flu immunisations. Data for 2017/18 showed that 67% of patients aged over 65 had received a flu immunisation.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- Clinicians were able to share examples of how and what procedures they obtained consent for. For example, written consent was obtained for immunisations and minor surgery.

Are services caring?

Our findings

At our previous inspection on 30 November 2016 we rated the practice as good for providing caring services. Following this inspection we have continued to rate the practice, and all of the population groups, as good for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private area to discuss their needs. There was a sign in the waiting area to inform patients.
- Twenty seven of the 30 patient Care Quality Commission comment cards we received were very positive about the service experienced. Two patients gave mixed feedback, negative comments were made about the building but these were combined with positive statements about the service provided. One comment mentioned about the poor service by a GP during consultation.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Two hundred and fifty nine surveys were sent out and 114 were returned. Patient satisfaction scores for consultations with GPs and nurses were generally above the CCG and national averages. For example:

- 90% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) and the national averages of 89%.
- 89% of patients who responded said the GP gave them enough time; compared with the clinical commissioning group (CCG) average of 87% and the national average of 86%.

- 99% of patients who responded said they had confidence and trust in the last GP they saw; compared with the clinical commissioning group (CCG) average of 96% and the national average of 95%.
- 86% of patients who responded said the last GP they spoke to was good at treating them with care and concern; compared with the clinical commissioning group (CCG) average of 85% and the national average of 86%.
- 96% of patients who responded said the nurse was good at listening to them; compared with the clinical commissioning group (CCG) average of 93% and the national average of 91%.
- 97% of patients who responded said the nurse gave them enough time; compared with the clinical commissioning group (CCG) average of 93% and the national average of 92%.
- 100% of patients who responded said they had confidence and trust in the last nurse they saw; compared with the clinical commissioning group (CCG) average of 98% and the national average of 97%.
- 95% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; compared with the clinical commissioning group (CCG) average of 92% and the national average of 91%.
- 92% of patients who responded said they found the receptionists at the practice helpful; compared with the clinical commissioning group (CCG) of 86% and the national average of 87%.

The practice had reviewed the results and considered their practice generally performed well in terms of patient experience.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care. Interpretation services were available for patients who did not have English as a first language. Although notices were not displayed in the reception areas advising patients of this service, the staff we spoke with were able to tell us how they would support a patient with accessing this external service in addition to obtaining information in a variety of formats, for example, large print.

- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.

Are services caring?

- Staff helped patients and their carers find further information and access community and advocacy services.

The practice proactively identified patients who were carers. The practice's computer system alerted GPs and staff if a patient was also a carer and referred them to a local voluntary carers association. The practice had identified 59 patients as carers (1.5% of the practice list). There was a carers' pack available in the patient waiting area that included useful contact numbers and information on local support services.

Staff told us that if families had experienced bereavement, they passed on their condolences and signposted them to a counselling service hosted by a voluntary organisation who visited the practice on a regular basis.

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

- 90% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 87% and the national average of 86%.
- 89% of patients who responded said the last GP they saw was good at involving them in decisions about their care; compared with the clinical commissioning group (CCG) and the national averages of 82%.

- 95% of patients who responded said the last nurse they saw was good at explaining tests and treatments; compared with the clinical commissioning group (CCG) average of 91% and the national average of 90%.
- 93% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; compared with the clinical commissioning group (CCG) average of 88% and the national average of 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- The reception area included a screen to promote confidentiality when on the telephone. Seating areas were set back away from the reception desk.
- The practice had a bell and separate entrance for those patients with mobility problems or those with prams or pushchairs. Treatment rooms were available on the ground floor and used when required to remove the need to access the second floor. Appointments were coordinated whenever possible to be on days when a ground floor treatment room was free.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 30 November 2016 we rated the practice as good for providing responsive services. Following this inspection we have continued to the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example extended opening hours, online services such as repeat prescription requests and walk in on the day appointments.
- The practice had reviewed and increased its workforce and employed additional clinicians to help meet the health and social needs of patients and the demand for access to appointments.
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered. The practice had addressed the difficulties presented by being on two floors. Stair lifts had been considered but a fire safety officer had advised against due to restrictions that may delay evacuation of the building.
- The practice made reasonable adjustments when patients found it hard to access services. For example, telephone consultations were available with a duty GP and home visits were provided for patients who were housebound or had enhanced needs.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients over 75 years had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.

- Quarterly reviews were carried out on all nursing home patients. A rapid access telephone number was provided to nursing home staff to access support and advice over the telephone.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. Same day access was offered to patients aged over 75 to ensure that assessment was made within six hours of initial contact.

People with long-term conditions:

- Care plans and a named care co-ordinator were provided to each patient with a long-term condition.
- The practice provided a number of long term condition clinics in order to support patients to manage these conditions, monitor their wellbeing and develop management plans in conjunction with them.
- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met.
- The practice held regular meetings with external health professionals to discuss and manage the needs of patients with complex medical issues.
- A diabetes specialist nurse attended the practice to provide monthly clinics. All patients identified at risk of diabetes were invited for an annual review.
- Referrals to self-management programmes included a Lifestyle team, Action Heart and specific programmes such as pulmonary rehabilitation, and Diabetes Education Programme.

Families, children and young people:

- The practice had systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- A triage service was provided to all patients less than five years of age who presented at the walk in clinic.
- Monthly meetings were held with the health visitor and the school nurse.
- Antenatal clinics were held by appointment on a Thursday afternoon with the visiting community midwife. The practice provided health surveillance clinics where the mother and baby were reviewed.
- Full contraception services were offered including implants and intrauterine contraceptive devices (coils).

Are services responsive to people's needs?

(for example, to feedback?)

- Appointments were available outside of school hours.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours appointments were offered on Monday and Wednesday evenings to offer the greatest flexibility for patients.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- NHS Health Checks were provided for patients aged 40 to 74 and patients were given lifestyle advice on exercise and diet.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice was proactive in supporting the local authority with any patients with safeguarding issues and had met with social workers and attended multi-disciplinary team meetings to support other clinicians in the care of these patients.
- The practice hosted the palliative care meetings with a range of professionals to ensure those who were approaching end of life have a more cohesive plan of care across all agencies.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Patients could be referred into nurse led clinics with the Community Mental Health Nurse (CMHN). The practice had a designated nurse dementia lead.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had access to initial assessment, test results, diagnosis and treatment.
- Patients found it easy to make an appointment at the practice and we saw that pre-bookable appointments

were available within one week with a GP and within three days with the nurse. Same day appointments were available each day as part of the walk in appointment system

- Patients with the most urgent needs had their care and treatment prioritised.

Results from the national GP patient survey published in July 2017 showed that patients' satisfaction with how they could access care and treatment was consistently higher than the local and national averages. For example:

- 82% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 78% and the national average of 76%.
- 89% of patients who responded said they could get through easily to the practice by phone; compared with the clinical commissioning group (CCG) average of 67% and the national average of 71%.
- 86% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; compared with the clinical commissioning group (CCG) average of 82% and the national average of 84%.
- 85% of patients who responded said their last appointment was convenient; compared with the clinical commissioning group (CCG) of 80% and the national average of 81%.
- 77% of patients who responded described their experience of making an appointment as good; compared with the clinical commissioning group (CCG) average of 71% and the national average of 73%.
- 65% of patients who responded said they don't normally have to wait too long to be seen; compared with the clinical commissioning group (CCG) average of 61% and the national average of 58%.

This was supported by observations and discussions held with staff on the day of inspection and completed comment cards from patients.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to continually improve the quality of care.

- Information about how to make a complaint or raise concerns was readily accessible in the practice and information on the practice website signposted patients

Are services responsive to people's needs?

(for example, to feedback?)

to the practice manager. Reception staff had access to the complaints process and told us leaflets explaining the process were shared with new patients registering at the practice in addition to other leaflets including patient information. We saw that the complaint leaflet and letters of response to complainants included details of how to complain to the NHS Ombudsman should a patient not be satisfied with the outcome of their complaint.

- The practice manager was the designated lead for managing complaints. The complaint policy and procedures were in line with recognised guidance. We

saw three complaints had been recorded this year. We reviewed the complaints and found that they were satisfactorily handled in a timely way. An analysis of trends identified the bedside manner of a new GP as a cause for complaint on more than one occasion. This GP had been supported on how to improve patient satisfaction during consultations. Complaints were discussed with colleagues at practice meetings and multidisciplinary team meetings as appropriate. Minutes were provided to those staff members unable to attend.

Are services well-led?

Good 

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

Our findings

At our previous inspection on 30 November 2016, we rated the practice as requires improvement for providing well-led services as there was no overarching governance structure.

We issued a requirement notice in respect of these issues and found arrangements had significantly improved when we undertook a follow up inspection of the service on 12 January 2018. The practice is now rated as good for being well-led.

We rated the practice as good for providing a well-led service overall and across all population groups.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. For example, the practice wanted to reduce the demand on GP appointments and to provide an alternative complimentary source of primary healthcare alongside services traditionally provided by its GPs but was confined by space.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. Staff had lead roles and were aware of their roles and responsibilities.
- The practice had effective processes to develop leadership capacity and skills by delegating to the wider practice team. For example, the GP was looking to empower the nurses to play a more managerial role in the long-term condition management.

Vision and strategy

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

- The practice had an informal strategy that was discussed between partners and the practice manager.

- The practice planned its services to meet the needs of the practice population. For example, the practice worked closely with the 'integrated plus' service, a social prescribing and support service. The practice referred into the service and staff from the service attended multidisciplinary team meetings.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed and had access to a policy in the event of needing to raise concerns in relation to staff practice in the workplace.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. Staff had received an annual appraisal in the last year and were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for attending various meetings held in addition to professional development and evaluation of their clinical work.
- The practice actively promoted equality and diversity. However, most staff had not yet received training in this area. Staff felt they were treated equally and reported there were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out,

Are services well-led?

Good 

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

understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. Delegation had taken place to extend responsibilities among the practice team, for example; the nurse was taking the IPC responsibilities from a GP.
- Practice leaders had established policies and procedures however, we saw a number of these required more detail, for example the DBS policy had been discussed but was not documented.
- Policies were accessible to staff but there was no audit trail or document control. The practice told us that they planned to use an electronic system to sort this out.
- Monthly meetings were held and attended by all staff except the GPs. Standing agenda items included complaints, significant events, health and safety, safeguarding and minutes of the multidisciplinary team meetings. The GPs had monthly clinical meetings in conjunction with the multidisciplinary team meetings. Significant events were shared with the wider healthcare team and we saw that standing agenda items included complaints and reviews of unplanned hospital admissions.

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

- There was a process to identify, understand, monitor and address current and future risks including risks to patient safety. Some environmental health and safety risk assessments had been completed to identify hazards and mitigate potential risks, however there was no risk log and we found some gaps.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through checks and discussions of their consultations, prescribing and referral decisions. Practice leaders had oversight of incidents, and complaints in addition to external alerts, such as the Medicines and Healthcare products Regulatory Agency (MHRA) alerts that may affect patient safety.

- Clinical audit had a positive impact on quality of care and outcomes for patients.
- The practice had plans in place for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- The practice had established a patient participation group (PPG) although meetings had ceased due to lack of patients willing to be members. The future aspirations of the practice included reinvigorating the group to encourage greater patient engagement.
- The service was transparent, collaborative and open with stakeholders about performance.
- Results from the friends and family test for the 12 months from August 2016 to July 2017 showed that 93% of patients would recommend the practice to friends and family.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

Are services well-led?

Good 

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

- There was a focus on continuous learning and improvement at all levels within the practice. The practice had a strong audit programme that extended outside the local and national requirements.
- The practice was working with other practices to develop their locality and for sharing best practice. The GPs and practice managers met regularly to take the work forward and to strengthen and support each other and ensure future sustainability.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- We saw evidence of where the practice had initiated monitoring outside of the Dudley Quality Outcomes for Health Framework and the Dudley Long-term Condition (LTC) Programme. For example, the practice kept a register and had a recall system for patients discharged from urology clinics that required follow up to test for prostate cancer and for coeliac patients who required annual blood tests.