Drs A E Williams, D De Rosa and A N Koodaruth

Quality Report

Drs A E Williams, D De Rosa & A N Koodaruth
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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 carried out an announced comprehensive inspection at Drs A E Williams, D De Rosa & A N Koodaruth on 23 May 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

There were areas of practice where the provider must make improvements:

Summary of findings

- Ensure that the practice protocols and procedures are reviewed so that all staff have mandatory training related to health and safety such as fire safety and infection control.

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

- Ensure national guidelines for children who do not attend for hospital events are followed.
- Review the current arrangements for checking the safety of the environment and receiving reports on the outcome of environmental risk assessments carried out at the practice to confirm that required actions are addressed.
- Review complaint handling procedures and establish a system for identifying, receiving, recording, handling and responding to verbal complaints.

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 providing safe services:

- There was an effective system in place for reporting and recording significant events.
- The practice had an effective system in place to demonstrate that ongoing monitoring of events had taken place to ensure that systems put in place were appropriate.
- When there were unintended or unexpected safety incidents, patients received reasonable support, relevant information and an apology. Patients were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems and practices in place to keep patients safe and safeguarded from the risk of abuse.
- However the practice could not confirm that all risks to patients were assessed and well managed:
  - The practice had not ensured that arrangements were in place for staff to be trained to manage environmental risks such as fire safety to ensure patients were kept safe.
  - The practice had not noted that the blinds at windows in the waiting room were unsafe. Action was taken at the time of the inspection to address this.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed that the overall achievement of 99% of the available points was higher than the locality average of 92% and the national average of 95%.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.
- Evidence of clinical audits to demonstrate direct improvements to patient care was available.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.

Summary of findings

- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs. For example, the practice was involved in the development of a service that would promote joint community based working between health and social care professionals.
- Arrangements were in place to gain patients' informed consent to their care and treatment and patients were supported to access services to support them to live healthy lives.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the National GP Patient Survey published in January 2016 showed patients rated the practice higher than others for all aspects of care.
- Feedback from patients about their care and treatment was consistently positive. The depth of positivity expressed by patients was noted in the national GP patient survey results, patient comment cards, practice surveys and speaking with patients.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. For example, the practice established links with other professionals within the health care centre where the practice was situated to support ease of access for patients to other health care services.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. Urgent appointments were available the same day and priority was given to patients under the age of five.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

- The practice had a clear vision and a written strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management.
- The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was a governance framework which supported the delivery of the strategy and good quality care.
- Risks to patients who used services were assessed; however the practice had not ensured that arrangements were in place for staff to be trained to manage environmental risks such as fire safety to ensure patients were kept safe.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on.
- There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

The practice offered proactive, personalised care to meet the needs of the older people in its population.

- The practice offered home visits and urgent appointments for those older patients with enhanced needs.
- Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people.
- The practice maintained a register of housebound older patients, older patients who required a home visit and those who could attend the surgery but needed a specific appointment to suit them and their carers.
- Older patients were offered urgent appointments for those with enhanced needs plus longer appointments which gave them more time to discuss health issues with a clinician.

People with long term conditions

Good

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

- The GPs and practice nurse had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The GP and practice nurses worked with relevant health care professionals to deliver a multidisciplinary package of care to patients with complex needs.
- The practice Quality and Outcomes Framework (QOF) for the care of patients with long-term conditions was higher overall compared to the local and national average. For example the practice performance for diabetes related clinical indicators overall was higher than the local Clinical Commissioning Group and England average (94% compared to the local average of 82% and England average of 89%).
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Summary of findings

Families, children and young people

Good

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. This included for example children who were identified as at risk of abuse and babies and children who did not attend for immunisation appointments. However the practice did not routinely follow up children who did not attend hospital appointments. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice offered patients the opportunity to register at the practice as a family.
- The records of new born babies were linked to their parents' records.
- Babies were given their first immunisations on the same day as mothers were offered their six week postnatal check.
- The practice's uptake for the cervical screening programme was 81% which was comparable to the local CCG average of 78% and England average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice held a weekly GP clinic at a local boarding school for boys and girls.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The practice had adjusted some of the services it offered to meet the needs of the working age population, those recently retired and students to provide improved accessibility and flexibility.
- The practice offered on the day pre-bookable appointments, the last pre-bookable appointment was offered at 6pm. Telephone consultations were available.
- Out of hours appointments were available from 6.30pm to 7.30pm. Three of these appointment slots were protected and allocated to patients who worked where possible.

Summary of findings

- The practice was proactive in offering online services as well as signposted to a full range of health promotion and screening that reflects the needs for this age group.
- The practice offered returning students temporary registration with a GP.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of vulnerable patients which included patients with a learning disability. The practice offered longer appointments for patients with a learning disability.
- An easy read (pictorial) letter was sent to patients with a learning disability inviting them to attend the practice for their annual health check.
- The practice was alerted to other patients whose circumstances may make them vulnerable to ensure that they were registered with the practice if appropriate.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

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

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Summary of findings

- Staff had a good understanding of how to support patients with mental health needs and dementia.

The practice QOF data showed that:

- 84% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was the same as the national average.
- 97% of patients on the practice register who experienced poor mental health had a comprehensive agreed care plan in the preceding 12 months. This was higher than the England average of 88%. The exception reporting rate for this indicator was 3.3% in comparison to the England average of 12.6%

Summary of findings

What people who use the service say

The national GP patient survey results published in January 2016 showed the practice was performing above the local and national averages in all areas. A total of 248 surveys (6% of patient list) were sent out and 130 (52%) responses were received, which is equivalent to 3% of the patient list. The percentage of responses received was significantly higher than the England response rate of 38%. Results indicated the practice performance was higher than other practices in all aspects of care. For example:

- 93% of the patients who responded said they found it easy to get through to this surgery by phone compared to a Clinical Commissioning Group (CCG) average of 70% and a national average of 73%.
- 91% of the patients who responded said they were able to get an appointment to see or speak to someone the last time they tried (CCG average 82%, national average 85%).
- 95% of the patients who responded described the overall experience of their GP surgery as fairly good or very good (CCG average 81%, national average 85%).
- 95% of the patients who responded said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 71%, national average 78%).
- 93% of the patients who responded said they found the receptionists at this practice helpful (CCG average 85%, national average 87%)

As part of our inspection we also asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received 27 comment cards which were all positive. Patients said the practice was caring, they received an excellent service and that all staff listened, were helpful and respectful. We spoke with eight patients on the day of our inspection which included a member of the patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. They told us that they were satisfied with the care provided by the practice, that they were always treated as an individual, with respect, could always get an appointment and was given the time needed to discuss their concerns and treatment.

The practice monitored the results of the friends and family test monthly. The results for October 2015 to April 2016 showed that 48 had been completed of these 44 patients were extremely likely to recommend the practice to friends and family if they needed similar care or treatment and four patients were likely to recommend the practice. All the comments received with these responses were also positive.

Areas for improvement

Action the service MUST take to improve

- Ensure that the practice protocols and procedures are reviewed so that all staff have mandatory training related to health and safety such as fire safety and infection control.

Action the service SHOULD take to improve

- Ensure for children who do not attend for hospital events are followed.
- Review the current arrangements for checking the safety of the environment and receiving reports on the outcome of environmental risk assessments carried out at the practice to confirm that required actions are addressed.
- Review complaint handling procedures and establish a system for identifying, receiving, recording, handling and responding to verbal complaints.

Drs A E Williams, D De Rosa and A N Koodaruth

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 adviser, a second CQC inspector, a practice nurse specialist adviser, a practice manager specialist adviser and an Expert by Experience.

Background to Drs A E Williams, D De Rosa and A N Koodaruth

Drs A E Williams, D DeRosa & A N Koodaruth is registered with the Care Quality Commission (CQC) as a three GP partnership. The practice is located in Wolverhampton. The practice has good transport links for patients travelling by public transport and parking facilities are available for patients travelling by car. The practice is a located in a health centre owned by the Royal Wolverhampton Trust. The practice occupies rooms over two floors with patient access, services and facilities provided on the ground floor. There is access to the building via a ramp and all areas are accessible by patients with mobility difficulties, patients who use a wheelchair and families with pushchairs or prams.

The practice team consists of three GP partners, one female and two male. One of the GP partners had left the partnership and the practice had successfully recruited a new partner. The practice is in the process of registering the new partner with the CQC. The GP partners work a total of 21 sessions between them and are supported by a full time practice nurse and a part time healthcare assistant. Clinical staff are supported by a practice manager and eight administration / receptionist staff. In total there are 14 staff employed either full or part time hours to meet the needs of patients. The practice also use GP locums at times of absence to support the clinicians and meet the needs of patients at the practice.

The practice is open between 8am and 6.30pm Monday, Tuesday, Thursday, Friday and 8am to 1pm on Wednesday. Appointments are from 8.30am to 11.30pm every morning, 4pm to 6.30pm Monday and 3pm to 6.30pm, Tuesday, Thursday and Friday. Extended hours appointments are offered from 6.30pm to 7.30pm on Mondays. This practice does not provide an out-of-hours service to its patients but has alternative arrangements for patients to be seen when the practice is closed. Patients are directed to the out of hours service provided by Vocare via the NHS 111 service.

The practice has a General Medical Services contract with NHS England to provide medical services to approximately 4,300 patients. It provides Directed Enhanced Services, such as the childhood immunisations, minor surgery and asthma and diabetic clinics. The practice has a higher proportion of patients, mainly male patients aged 15 to 19 and a higher proportion of female patients between the ages of 45 and 85 plus when compared with the average across England. The income deprivation affecting children of 19% was similar to the national average of 20%. The level of income deprivation affecting older people was higher than the national average (21% compared to 16%).

Detailed findings

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 23 May 2016.

During our visit we:

- Spoke with a range of staff including a GP, practice nurses, and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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 were provided for specific groups of people and what good care looked like for them. The population groups are:

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

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

Requires improvement

Are services safe?

Our findings

Safe track record and learning

The practice could evidence a safe track record over time. There was an effective system in place for reporting and recording significant events. The practice had a template for recording significant events and the template had been shared with other local practices. The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts, comments and complaints received from patients. We found that the practice had a significant event policy in place and used an electronic reporting system. The reporting system was easily accessible to all staff. Staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. The practice manager was responsible for disseminating safety alerts and there were systems in place to ensure they were acted on. Safety alerts were sent to staff by email with a read receipt for staff to acknowledge that they had received, read and acted on the alert. The practice maintained a file of all alerts to show that they had been acted on.

Records we looked at showed that 14 significant events had occurred in the last year. One of the events reported concerns related to medicines prescribed for a patient to self-administer following an appointment at a hospital. The practice found that the hospital had provided the patient and practice with limited information and instructions about the treatment. The practice identified that this event had exposed the patient to the risk of a medicine error due to no written instructions. Appropriate action was taken to escalate the concerns to an external organisation that dealt with concerns about hospital practice. The practice consulted with other professionals and obtained a protocol on the management of patients diagnosed with complications during pregnancy.

We found that significant event records were maintained and systems put in place prevented further occurrence. Significant event record templates were well documented at the time they were reported and these were also used to document the outcome of the first meeting and the action agreed with a review date. It was noted that the review date reflected the level of risk associated with the significant event. Records showed that the ongoing monitoring of significant events were also recorded on the significant events record template. Information to demonstrate that learning had been shared with staff and external stakeholders and systems put in place were appropriate were also documented on the template. We found that when there were unintended or unexpected safety incidents, patients received reasonable support, relevant information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

Arrangements were in place to safeguard adults and children from the risk of abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. One of the GP partners was the lead for safeguarding. Staff we spoke with demonstrated that they understood their responsibilities and told us they had received training relevant to their role. Certificates of safeguard training at the appropriate level were seen for all staff. The practice held records for children at risk and vulnerable adults. Staff were able to share with us examples of safeguarding concerns that had been reported to the appropriate agencies. Meetings were held with health visitors when appropriate to share information about children and parents they had concerns about. However staff told us that they did not routinely follow up children who did not attend hospital appointments.

There was an infection control protocol in place. The practice nurse was the lead for infection control. There were cleaning schedules in place and cleaning records were kept, however these documents were not consistently completed to confirm that the cleaning had been carried out. Treatment and consulting rooms in use had the necessary hand washing facilities and personal protective equipment which included disposable gloves and aprons. Clinical waste disposal contracts were in place. Records Showed that clinical staff had received occupational health checks for example, hepatitis B status and appropriate action taken to protect staff from the risk of harm when meeting patients' health needs. Annual infection control audits were undertaken both internally and externally. The practice had achieved 86% in a recent general infection prevention and control audit carried out by the local Clinical Commissioning Group (CCG). We saw evidence that action was taken to address improvements identified as a

result. Training records we looked at did not show that staff had received infection control training. This was discussed with the practice manager who confirmed that staff had not received this training. The practice manager told us that arrangements would be made to address this.

A notice was displayed in the waiting room, advising patients they could access a chaperone, if required. All staff who acted as chaperones were trained for the role. Staff files showed that criminal records checks had been carried out through the Disclosure and Barring Service (DBS) for staff who carried out chaperone duties. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of the CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. The local prescribing advisor linked to the practice had carried out medicine reviews with patients who were taking four or more medicines. Some of the reviews were linked to significant events where there were concerns about older patients with memory problems taking their medicines incorrectly. Systems were put in place to help patients take medicines appropriately and prevent the risk of harm. Prescription pads and forms were securely stored and tracked.

We reviewed the personnel files for three recently recruited staff and one member of staff who had been employed at the practice for a number of years. Three of the files were thorough and contained appropriate recruitment checks which had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. We found that there was one record where a DBS check had not been completed for the member of staff (non-clinical) who had worked at the practice for a long period and a risk assessment had not been carried out to demonstrate why a DBS check was not necessary. The practice manager took action to address this. We found that the same GP locums were used occasionally in the absence of the GP partners. Information was available to confirm that systems were in place to continuously monitor the suitability of GP locums to work with patients.

Monitoring risks to patients

The practice had processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. A health and safety policy was available and a poster was displayed in the reception area. Two of the GP partners were the named health and safety representatives on the poster. A monthly health and safety check was carried out. The checklist covered areas such as electrical safety, slips, trips and falls and fire safety. These checks also included ensuring that information governance arrangements were followed by staff to ensure patient confidentiality and data protection procedures such as prescriptions locked away and smart cards which gives access to patient information was not left in personal computers. The records included mitigating action to manage any risks identified.

We noted however that a blind hung at windows in the waiting room had a loose cord which was easily accessible to children. The department of health had published an alert on looped cords and chains on window blinds in 2010 due to the identified risk of harm from strangulation to children and vulnerable adults. The alert recommended that risk assessments should be carried out on looped blind cords, primarily in healthcare environments where children and vulnerable adults are commonly present. The practice had not taken action to address the recommendations made by the alert and a risk assessment had not been carried out. The practice secured the loose cord at the time of the inspection, completed a risk assessment and forwarded an email to the property services team responsible for the premises to find out what action they would take to address this. A copy of this email correspondence had been forwarded to us.

The practice had had fire drills carried out by the property services team that managed the health centre where the practice was situated. A copy of a report detailing the outcome of a fire drill carried at the practice on 12 May 2016 by the property services team was seen. Areas for improvement by practice staff and other staff working at the practice were noted and action had been taken to address these. The practice manager told us that environmental risk assessments such as fire risk

assessments and a legionella assessment had been completed by the property services team. (Legionella is the term for a particular bacterium that can contaminate water systems in buildings). The practice manager had requested the reports from the property services team but had not received them. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked and maintained annually to make sure it was working properly. Records showed that the equipment had been checked on 3 February 2016.

We noted that training records did not demonstrate that staff had received health and safety related training. Examples of this included infection prevention and control, control of substances hazardous to health (COSHH), moving and handling, and fire safety training. When asked reception staff were not aware of which extinguisher they should use if there was an electrical fire. The practice manager confirmed that staff had not received health and safety training. We were assured by the management team that these training needs would be addressed.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff and staff with appropriate skills were on duty. There was information to confirm that locum staff were offered a formal induction.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff had received recent annual update training in basic life support. The practice had a defibrillator (this provides an electric shock to stabilise a life threatening heart rhythm) available on the premises and oxygen with adult and children's masks. Systems were in place to ensure emergency equipment and medicines were regularly checked. Reception staff had access to guidance on the immediate action they should take to manage medical emergencies, this included referral to a GP at the practice.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. Emergency medicines were available to treat a range of medical emergencies. Examples were medicines for the treatment of cardiac arrest, anaphylaxis (allergic reaction) and hypoglycaemia (low blood sugar level). The practice had a range of emergency medicines suitable and safe to be used for children of different ages. All the medicines we checked were in date. The practice nurse was responsible for checking the medicines in the doctor's bag which they used when visiting patients in their home and at the clinic carried out at the local boarding school. We saw that all these medicines were in in date.

A business continuity plan was in place for responding to a range of emergencies that may impact on the daily operation of the practice. Examples of risks recorded included the loss of premises, unplanned staff absence and loss of access to medical records. When we spoke with staff they were aware of the actions they should take in the event of an emergency. The plan included emergency contact numbers for staff. Risks identified in the business plan detailed mitigating actions to be taken to reduce and manage the risk. The practice had an emergency alert button which was linked to the local police station.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. For example evidence of best practice guidelines were seen to be included in the plan of care for patients diagnosed with asthma. The GP and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and systems were in place to keep all clinical staff up to date. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and reviewed their performance against the national screening programmes to monitor outcomes for patients. The practice achieved 99% of the total number points available for 2014-2015 which was above the local Clinical Commissioning Group (CCG) average of 92% and England average of 95%. The practice had an overall clinical exception rate of 6.3% compared to the local CCG average of 7.5% and England average of 9.2%. (Clinical exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Further practice QOF data from 2014-2015 showed:

- Performance for diabetes assessment and care was higher than the local Clinical Commissioning Group and England average (94% compared to the local average of 82% and England average of 89%). The practice clinical exception rate was 6.4% for this clinical indicator. This was lower than the local CCG average of 8.8% and the England average of 10.8%.
- The percentage of patients with hypertension for whom the last blood pressure reading in the last 12 months was at or below a given measurement was higher than the local CCG and England averages (88% compared to the local average of 80% and England average of 84%). The practice clinical exception rate of 2.1% for this clinical area was lower than the local CCG average of 3.1% and England average of 3.8%.
- Performance for mental health assessment and care was higher than the local CCG and England average (97% compared to the local and England average of 88%). The practice clinical exception rate of 3.3% for this clinical area was significantly lower than the local CCG average of 8.7% and England average of 12.6%.
- The dementia diagnosis rate was similar to or the same as the local and England average (84% compared to the local average of 82% and England average of 84%). The practice clinical exception rate of 8.6% for this clinical area was higher than the local CCG average of 7.7% and England average of 8.3%.

The practice had performed well overall when compared to the local CCG and England averages. There were no QOF clinical indicators that required further enquiry. We saw that the CCG benchmarked the practice against other practices in the locality. Practice performance information was provided and discussed as part of its Practice Support Visit (PSV) carried out by the CCG. At the last PSV meeting there had been no areas identified for improvement. The practice worked closely with a local diabetic consultant. The consultant attended the practice every three months to review the practices' management of patients diagnosed with diabetes. The outcome of this intervention demonstrated a 1% reduction in the levels of glucose (sugar) present in the blood of high risk patients and had improved diabetic care at the practice generally.

We saw records for four clinical audits that had been carried out at various times over the past four years, three of which were two cycle audits. All demonstrated direct benefits to patients. One of the two cycle audits looked at whether patients commenced on a medicine to treat diabetes had received appropriate counselling and education about the risk of hypoglycaemia (low blood sugar) at the time the medicine was started. The first audit cycle identified that of the 16 patients identified 12 (75%) were not offered counselling about the possibility of hypoglycaemia occurring. The practice ensured that action was taken to address this. The second audit cycle looked at four new patients who had been started on the medicine in the past six months. The findings showed that three of the four new patients had received appropriate counselling. As

Good

Are services effective?

(for example, treatment is effective)

a result of the audit the practice had written a protocol. The practice demonstrated a change in behaviour to ensure that all patients managed by the practice received appropriate and timely counselling at the time of starting the medicine. Other audits carried out included minor surgery and antibiotic prescribing.

Effective staffing

The practice had appointed a number of new staff who told us that they had an initial induction. The practice used a mentor system to support the induction and competency of new staff.

The learning needs of the staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs. Staff had the skills, knowledge and experience to deliver effective care and treatment. All staff had annual appraisals that identified their learning needs and from which personal development plans were identified. All staff had had an appraisal within the last 12 months. Records we looked at showed that staff had received training that included safeguarding, basic life support, chaperone training, duty of candour, confidentiality and information governance awareness.

The GP partners and practice nurse had completed clinical specific training updates to support annual appraisals and revalidation. The GP partners and practice nurse had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. One of the GP partners had recently completed an accredited course in diabetic care. The practice nurse received training and attended regular updates for the care of patients with long-term conditions and administering vaccinations.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient electronic record system and their shared computer drive. This included risk assessments, care plans, medical records and investigation and test results. The practice shared relevant information with other services in a timely way, for example when referring patients to secondary care such as hospital or to the out of hours service. Information such as NHS patient information leaflets were also available. We found that staff were manually recording hospital recommendations for changes to patients' treatments, such as medication variations firstly into a book, and not directly into patients' electronic records. This was discussed with the management team who were not aware that this was the practice and reassured us that this would be addressed to ensure that staff were adhering to information governance arrangements.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. The practice worked within a health centre and this supported ease of access to other professionals which included a practice based physiotherapist and a midwife who carried out weekly antenatal clinic at the practice. Further examples included carrying out a clinic at a local boarding school. The practice felt that access to other professionals within the extended primary care team such as health visitors and district nurse was increasingly difficult. The practice felt that this would change with the implementation of local initiatives.

The practice had eight patients on its palliative care register. Formal multidisciplinary case review meetings where all the patients on the palliative care register were discussed were held every three months. The minutes for these minutes lacked detail to clearly demonstrate decisions made and changes in the care to be delivered. We saw evidence that the plan of care for these patients was available and followed a recognised framework. We found that these were not always updated to demonstrate changes to the plan of care. The wider multidisciplinary team were involved in the planning and delivery of patients care and treatment. Patients were referred for specialist care when needed, patients wishes on their place of death where observed and decisions related to resuscitation should their health deteriorate was documented.

Consent to care and treatment

We found that staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. The practice had a comprehensive policy on obtaining consent which included the process for patients to withdraw their consent and the process for obtaining patients consent to having a student present during consultation and treatment. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was

Good

Are services effective?

(for example, treatment is effective)

unclear the GP or nurse assessed the patient's capacity and where appropriate, recorded the outcome of the assessment. We saw that patients' consent had been recorded clearly using nationally recognised standards. For example, when consenting to certain tests and treatments, minor operations and vaccinations.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. This included patients with conditions that may progress and worsen without the additional support to monitor and maintain their wellbeing. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet and smoking. Patients were signposted to local community services for smoking cessation and dietary advice. We saw that information was displayed in the waiting area and also made available and accessible to patients on the practice website. The practice had sought the support of the local learning disability team to complete health assessments for patients with a learning disability. Patients had access to appropriate health assessments and checks.

National cancer screening data published by Public Health England in March 2015 showed that the number of patients who engaged with the national cancer screening programmes was higher in most areas compared to the local CCG and England averages:

- 65% of eligible females aged 50-70 years had been screened for breast cancer in the last 36 months. This was comparable to the local average of 68% and England average of 72%.
- 80% of eligible females aged 50-70 years were screened for breast cancer within 6 months of invitation. This was higher than the local average of 66% and England average of 73%
- 62% of eligible patients aged 60-69 had been screened for bowel cancer in the last 30 months. This was higher than the local average of 52% and England average of 58%
- 61% of eligible patients aged 60-69 were screened for bowel cancer within 6 months of invitation. This was higher than the local average of 51% and England average of 55%.

We saw that the uptake for cervical screening for women between the ages of 25 and 64 years for the 2014-2015 QOF year was 81% which was slightly higher than the local CCG average of 78% and comparable to the England average of 82%. (Exception reporting for cervical screening was 1.8% which was much lower than the local CCG and England average of 6.3%). The practice was proactive in following these patients up by telephone and sent reminder letters and encouraged patients to attend national screening programmes.

The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. Data collected by NHS England for 2014 -2015 showed that the performance for all childhood immunisations was comparable to the local CCG average. For example, childhood immunisation rates for the vaccination of children under two years of age ranged from 71% to 100%, children aged two to five 86% to 100% and five year olds from 90% to 100%. Information available showed that parents that missed appointments were written to about the importance of attending and the health visitor was also informed. The practice nurse shared with us a recent experience related to a child not attending for childhood immunisations despite reminders. The concern was escalated to the safeguarding team. This was appropriately resolved following escalation. The practice nurse also wrote a protocol for staff to follow.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard. We saw that reception staff knew when patients wanted to discuss sensitive issues or appeared distressed and patients were offered a private area where they could not be overheard to discuss their needs.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 27 completed cards. The comments received were over-whelmingly positive about the practice and staff. Patients commented that the service was excellent, they received a high standard of service and all staff were respectful, caring, and supportive and felt their concerns were listened to. We also spoke with eight patients on the day of our inspection which included a member of the patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. Patients told us that they were treated with respect and dignity and that the GP and staff treated them as individuals, listened to their concerns and were very kind, caring and friendly.

Results from the national GP patient survey results published in January 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was above average in all satisfaction scores on consultations with GPs and nurses. For example:

- 100% of the patients who responded said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 83% and national average of 89%.
- 99% of the patients who responded said the GP gave them enough time (CCG average 83%, national average 87%).
- 100% of the patients who responded said they had confidence and trust in the last GP they saw (CCG average 93%, national average 95%).
- 99% of the patients who responded said the last GP they spoke to was good at treating them with care and concern (CCG average 80%, national average 85%).
- 95% of the patients who responded said the last nurse they saw or spoke to was good at listening to them (CCG average 90%, national average 91%).
- 95% of the patients who responded said the last nurse they saw or spoke to was good at giving them enough time (CCG average 91%, national average 92%)
- 99% of the patients who responded said they had confidence and trust in the last nurse they saw (CCG average 96%, national average 97%).
- 95% of the patients who responded said the last nurse they spoke to was good at treating them with care and concern (CCG average 89%, national average 91%).

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to, supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey published in January 2016 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. The results for the practice were all higher than the local and national averages. For example:

- 99% of the patients who responded said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and national average of 86%.
- 98% of the patients who responded said the last GP they saw was good at involving them in decisions about their care (CCG average 76%, national average 82%).
- 95% of the patients who responded said the last nurse they saw or spoke to were good at explaining tests and treatments compared to the CCG average of 89% and national average of 90%.

Good

Are services caring?

- 96% of the patients who responded said the last nurse they saw or spoke to were good at involving them in decisions about their care (CCG average 83%, national average 85%).

Patient and carer support to cope emotionally with care and treatment

The practice had a carers policy in place. This provided a definition of a carer for staff, details of the local carer support schemes available and a referral form for the practice to formally refer patients to the scheme. Further written information was available for carers to ensure they understood the various avenues of support available to them. This included notices in the patient waiting room which told patients how to access a number of support groups and organisations. There were 54 carers on the practice carers register, which represented 1.3% of the practice population. The practice's computer system alerted the GP and nurse if a patient was also a carer.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location, which could be a visit to the family home if appropriate and the family were happy with this. The practice shared with us recent examples of the support given to carers and family members following the death of patients. Two patients spoken with also confirmed the support they received during a bereavement. Patients were signposted to support services. This was confirmed by one of the patients we spoke with. There was a lack of leaflets and other written information on bereavement in the waiting area. Information was available for patients on the practice website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local clinical commissioning group (CCG) to plan services and to improve outcomes for patients in the area. Services were planned and delivered to take into account the needs of different patient groups, flexibility, choice and continuity of care. For example:

- The families of patients at the terminal phase of their life were given the mobile numbers of their named GP to call out of hours.
- Patients who experienced memory problems and lived alone were contacted on the day of their appointment as a reminder. Advance care planning had been completed for patients with dementia.
- Patients who experienced poor mental health were referred to appropriate community based services and signposted to various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- The practice held a weekly GP clinic at a local boarding school for boys and girls.
- Access was provided to translation and interpretation services to ensure patients were involved in decisions about their care.
- Facilities for patients with mobility difficulties included access via automatic doors, a ramp for patients who used a wheelchair and adapted toilets for patients with a physical disability.
- The practice offered varied appointments which could be booked up to three months in advance, on the day and urgent appointments. More book on the day appointments were made available following a bank holiday.
- There were longer appointments available for patients with a learning disability, older people, carers and patients with long-term conditions.
- Home visits were available for older patients and patients who would benefit from these.
- The practice made visits to patients in care homes with the support of other health and social care professionals where needed.
- Urgent access appointments were available for children and those with serious medical conditions.
- Telephone consultations were available every day after morning clinics.
- Extended opening hours were available one evening per week for patients. Three of these appointment slots were protected to ensure that they were accessible to patients who worked.

Access to the service

The practice was open between 8am and 6.30pm Monday, Tuesday, Thursday, Friday and 8am to 1pm on Wednesday. Appointments were from 8.30am to 11.30pm every morning, 4pm to 6.30pm Monday and 3pm to 6.30pm, Tuesday, Thursday and Friday. Extended hours appointments were offered from 6.30pm to 7.30pm on Mondays. The practice did not provide an out-of-hours service to its patients but had alternative arrangements for patients to be seen when the practice was closed. Patients were directed to the out of hours service provided by Vocare via the NHS 111 service.

Results from the national GP patient survey published in January 2016 showed that patients' satisfaction with how they could access care and treatment was significantly higher than the local and national averages.

- 88% of patients said they were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 75%.
- 93% patients said they could get through easily to the surgery by phone (CCG average 70%, national average 73%).
- 98% of patients said the last appointment they got was convenient (CCG average 91%, national average 92%).
- 89% of patients said the last appointment they got was convenient (CCG average 69%, national average 73%).
- 82% usually wait 15 minutes or less after their appointment time to be seen (CCG average 69%, national average 65%).
- 83% of patients said the last appointment they got was convenient (CCG average 56%, national average 58%).

Patients told us on the day of the inspection that they were able to get appointments when they needed them and had no concerns about appointments at the practice. The practice had a system in place to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. The patient or carer was contacted by telephone to gather further information to allow for an informed decision to be made. The GP made a decision on

Good

Are services responsive to people's needs?

(for example, to feedback?)

the urgency of the patients need for care and treatment and the most suitable place for this to be received. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system included a poster which was displayed.

We found that the practice complaint leaflet was not easily accessible to patients as it was kept behind the reception desk. Patients we spoke with were aware of the process to follow if they wished to make a complaint. The practice told us that they received verbal which they responded to at the time. These were not recorded to show the action taken to address and resolve the complaint.

We saw records for one complaint received in the last 12 months and found that this had been responded to, satisfactorily handled and dealt with in a timely way. Lessons were learnt from any concerns and complaints received and action was taken to improve the quality of care.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to provide accessible, high quality, evidence based care in cooperation with its patients in a caring and friendly environment. The practice had a written strategy to cover the period 2016/18. The strategy clearly identified the direction the practice wanted to move in as related to its future development. The strategy was driven firstly by its patients and secondly the governments' vision for the future of the NHS, which includes the introduction of new models of care to meet patient's needs. Staff and patients felt that they were involved in the future plans for the practice for example, the practice sought the views of patients and input of the patient participation group (PPG) on how services at the practice could be improved.

Governance arrangements

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

- There was a clear staffing structure and all staff were clear about their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- The practice held formal monthly meetings at which governance issues were discussed. There was a structured agenda and an action plan, however the points of action were not clearly defined and records did not show that any action identified was always followed up.
- The practice carried out internal audits, which demonstrated direct benefits to patients.
- Arrangements for identifying, recording and managing risks and implementing mitigating actions were in place but did not cover all areas to ensure that patients and staff were protected from the risk of harm at all times.

Leadership and culture

The GP partners had the experience, capacity and capability to run the practice and ensure high quality care. The management team was visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.

The provider was aware of and complied with the requirements of the Duty of Candour. The GP encouraged a culture of openness and honesty. The practice manager told us that an open door policy was operated for all staff. There was a clear leadership structure in place and staff felt supported by the management team. Staff we spoke with were positive about working at the practice and felt that they worked in a caring and compassionate environment. Staff told us they felt comfortable enough to raise any concerns when required and were confident these would be dealt with appropriately. Staff described the culture at the practice as open, transparent and very much a team approach.

Clinical meetings were held weekly and practice meetings monthly. Informal meeting were also held by staff teams but were not always documented. We saw minutes for formal meetings were structured but had limited detail to confirm discussions that had taken place. There was a practice whistle blowing policy available to all staff to access on the practice's computer system. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. The practice had consistently received positive feedback from patients. The outcome of a survey carried out by the practice this year showed that 96% of patients were very satisfied with the practice and 4% fairly satisfied. Comments made by patients were mostly complimentary and patients commented that there was nothing they wanted to change. The National GP Patient Survey results published in January 2016 identified that 92% of patients were extremely likely to recommend the practice to family and friends and 8% likely to recommend the practice. These figures were aligned with the results of other surveys including, the practice survey and the friends and family test. The practice had noted that the patient participation group (PPG) had lapsed and it was difficult to get patients

Are services well-led?

Good

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

interested. One of the GP partners had actively started to rebuild the group and six patients had been recruited. Guidance had also been sought from the local CCG on how to build and retain an active PPG.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and the management team. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

The practice had completed reviews of significant events and other incidents. We saw records to confirm this. We found that the outcome of these were followed through to evidence that patients received appropriate support where a risk of potential harm was identified.

The practice was involved in local pilot initiatives which supported improvement in patient care across Wolverhampton. One of the GP partners was the chair of Wolverhampton CCG and a further partner attended the locality meetings. The practice was a member of the local GP federation and was looking at developing a sub-federation locally. The practice was involved in the pilot of a model of care to promote joint working across primary, community and secondary care to provide a multidisciplinary approach to care and improvements to the care of patients who lived in care homes. The GP partners were working closely with other local GP practices on how to introduce access to GPs over the seven day week. The GP partners could demonstrate involvement in clinical meetings with their peers to enable them to discuss clinical issues they had come across, new guidance and improvements for patients.

The practice was looking at the future development of the practice and how it could best meet the increasing needs of patients and government initiatives. Some of the areas the practice had discussed included extending the existing premises, a move to larger premises or the possibility of building new premises to meet the needs of the increasing numbers of patients, recruitment and skill mix of staff. The practice had plans in place to be accredited for the training of GP registrars.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not ensure that the risks to the health and safety of service users were assessed by doing all that is reasonably practicable to mitigate any such risks.**