Rough Hay Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Rough Hay Surgery on 25 July 2017. 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 a system in place for reporting and recording significant events.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment. Low scores in certain areas concerning patients' perception of the GP had been noted by the practice and more recent survey results had shown an improvement.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns, although only three had been recorded for the previous year.
- Patients we spoke with 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. They had begun to explore means of improving these facilities by creating new, improved premises, to better meet the needs of their patients.
- As the principal GP was supported by non-permanent clinical staff, it was felt to be important that a more formal structure be put in place for clinical matters to be discussed.
- There was no fire procedure displayed in the main reception area, which was acted upon straightaway.
- The practice should continue to identify more carers on their register.

Summary of findings

- 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 the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The areas where the provider should make improvement are:

- Adopt a more thorough approach to the recording of both written and verbal complaints, in accordance with the practice policy.
- Create a more formal structure for clinical matters to be discussed with the relevant members of the practice team.
- Continue to identify more carers from the practice register.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- From the sample of documented examples reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again and how these were treated as a learning experience.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety. On checking the emergency drugs held in the practice, we found there was no benzylpenicillin available, although this had been risk assessed. Immediately after the inspection, the practice reassessed this and supplies of the drug were now available on-site.
- At the time of our inspection, there was no fire procedure displayed in the reception area. This was to be rectified immediately.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Whilst there was evidence to show clinical matters were discussed as part of the regular general staff meetings, it was felt a more formal clinical meeting structure should be introduced.
- Staff had the skills and knowledge to deliver effective care and treatment.

Summary of findings

- There was evidence of appraisals for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients generally rated the practice higher than others for several aspects of care. We discussed a grouping of low scores taken from the January 2017 survey, relating to patient perceptions of the GP and were told by several patients and staff that these scores were more reflective of the period prior to the principal GP assuming sole responsibility for the practice in October 2016. The practice was aware of these ratings and more recent survey results had shown a marked improvement.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Frailty multi-disciplinary team meetings were to commence in late July.
- The practice's dementia champion had prepared an information pack which was being distributed.
- Information for patients about the services available was 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.

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- A community psychiatric nurse performed one session per week at the surgery.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with 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.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs. The practice had however acknowledged that more space was needed, particularly in clinical areas and discussions regarding a new, purpose-built surgery nearby, were currently underway.
- Information about how to complain was available and evidence from three examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- The practice had nominated a carers' champion who had begun to address the issue of identifying more carers on the practice register.

Are services well-led?

Good

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

- The practice had a clear vision and 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 policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour.
- The principal GP encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas and protected learning sessions.
- Care for those patients requiring palliative care had received improved support, as a key worker had been identified who

would make contact with either the patient or their families on a monthly basis. This person would also act as point of contact, should the patient need to call the surgery for advice or assistance.

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.

- There was a lower than average number of older people registered with the practice, due in part to there being only two care homes in their area. These were visited two to three times per week.
- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- Frailty multi-disciplinary team meetings were to commence in late July.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care. A key worker had been identified to act as co-ordinator for this group of patients.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible. These included vaccinations and a health check.
- There was routine liaison with other agencies such as, district nurses, community matrons, the chronic obstructive pulmonary disease (COPD) and heart failure teams and the falls team.

People with long term conditions

Good

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

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.

Summary of findings

- The practice was dealing with a high number of patients diagnosed with diabetes which related to the level of deprivation in their area. They had achieved 79% of their patients with diabetes having their last blood pressure reading (measured in the preceding 12 months), of 140/80 mmHg or less, compared to the CCG average of 79% and the national average of 78%.
- The practice followed up on patients with long-term conditions within two days of discharge from hospital and ensured that their care plans were updated to reflect any additional needs.
- The practice had produced self-management plans for patients with diabetes, asthma and COPD.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. This included a weekly session from a pharmacist, who would carry out medication reviews, as well as input from a community pharmacist as required. A monthly multi-disciplinary meeting was also held for this group of patients.
- In conjunction with the local council, approximately 600 patients from the practice had been invited onto the "Expert Patient Programme" over the past two years. The programme offered advice and support for those living with long-term conditions, and included teaching them exercise techniques and offering dietary advice.

Families, children and young people

Good

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

- There were systems 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, with, for example asthma attacks.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.

Summary of findings

- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics. A weekly midwifery clinic was held and there was regular communication with the health visitors to discuss children at risk and safeguarding issues.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

Working age people (including those recently retired and students)

Good

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

- The needs of these populations 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 on Monday evenings was offered, as well as early nurse and health care assistant appointments throughout the week.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice offered telephone consultations whenever appropriate.
- Booking appointments online and ordering of repeat medications was available.

People whose circumstances may make them vulnerable

Good

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

- The practice held a register of patients with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable and a palliative care key worker was in place.
- The practice offered longer appointments for patients with a learning disability and this could be at the end of a surgery to offer a more calming environment. Dedicated health checks were also offered.

Summary of findings

- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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 carried out advance care planning for patients living with dementia.
- 76% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the CCG average of 84% and the national average of 82%.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia and a community psychiatric nurse session was held weekly. The patient record system carried alerts on patients with risk of self-harm or overdose. Risk assessments were carried out.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- 91% of patients with schizophrenia, bipolar affective disorder and other psychoses had had a comprehensive, agreed care plan documented in the record, in the preceding 12 months, compared to a CCG average of 92% and a national average of 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment, before being referred to the appropriate specialist service.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.

Summary of findings

- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health. These included patients who had overdosed, or had experienced a psychosis.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2017. The results showed the practice was mostly performing in line with local and national averages. 335 survey forms were distributed and 102 were returned. This represented 3% of the practice's patient list.

- 77% of patients described the overall experience of this GP practice as good compared with the CCG average of 81% and the national average of 85%.
- 81% of patients described their experience of making an appointment as good compared with the CCG average of 80% and the national average of 84%.
- 68% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 72% and the national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection.

We received 45 comment cards which were generally positive about the standard of care received. Patients told us they found all staff were caring and understanding and the doctors were attentive and sympathetic. Only a small number commented about being unable to get an appointment.

We spoke with five patients during the inspection. All said they were satisfied with the care they received and thought staff were approachable, committed and caring. They were particularly complimentary about the principal GP, the nursing team and receptionists. The practice invited patients to complete the NHS friends and Family test (FFT). The FFT gives each patient the opportunity to provide feedback on the quality of care they received. We looked at the results for 2016. These indicated that 94% of patients would recommend this practice to their friends and family.

Areas for improvement

Action the service SHOULD take to improve

- Adopt a more thorough approach to the recording of both written and verbal complaints, in accordance with the practice policy.
- Create a more formal structure for clinical matters to be discussed with the relevant members of the practice team.
- Continue to identify more carers from their register.

Rough Hay Surgery

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.

Background to Rough Hay Surgery

Rough Hay Surgery is located in Darlaston, near Walsall in the West Midlands. The surgery operates on a single floor, with some restrictions in the space available, particularly in clinical areas. The practice is looking at ways of addressing this, by planning new, purpose built premises close by. Disabled facilities are provided. Limited parking is available on-site, although street parking is available. The surgery is on a regular bus route and there is a pharmacy nearby.

There are four GPs working at the practice, all of whom are female. There is a principal GP working seven sessions per week, a Registrar working four sessions per week and two locums, both working one session per week. There is a part-time Nurse Practitioner, who works mornings only and is also a nurse prescriber, a Practice Nurse and Health Care Assistant (HCA), both of whom are part-time. There is a full-time practice manager, three part-time receptionists and two part-time administrators. Since October 2016, the principal GP has been without the support of a partner following retirement. A recruitment process to introduce a second partner has begun, although we were told this is in its early stages.

The practice is a GP training practice, which means GP trainees and second and third year doctors are able to undertake part of their training there.

The practice is open from 8.30am to 6pm on Tuesday, Wednesday and Friday. On Monday the practice opens at 8.30am until 7.30pm and on Thursday, opens at 8.30, closing at 1pm.

GP appointments are from: Monday 9am to 11am and 4.30pm to 7.30pm. Tuesday 9.30am to 11.30am and 3pm to 5.40pm. Wednesday 9.10am to 11.10am and 2pm to 5pm. Thursday 9.10am to 11.10am and the practice is closed in the afternoon. Friday 9am to 11.30am and 3pm to 5.40pm.Patients requiring medical assistance when the practice is closed are asked to contact Waldoc, the out of hours provider.

There are 3,574 patients registered with the practice. The practice is in the second most deprived decile in the country, and 3.4% of their patients are of mixed race, 15% Asian and 3% black. There is a lower than average elderly population due to there being only two care homes in the area.

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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the Walsall Clinical Commissioning Group (CCG), to share what they knew. We carried out an announced visit on 25 July 2017. During our visit we:

- Spoke with a range of staff including GPs, the nurse practitioner, the nurse and HCA, the practice manager, as well as two receptionists and an administrator. We also spoke with patients who used the service.
- Observed how patients were being cared for in the reception area 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.
- Looked at information the practice used to deliver care and treatment plans.

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 living 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.

Good

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We were told the practice was considering the benefits of introducing a male clinician into the team.
- There was no fire procedure displayed in the reception area. This was rectified straightaway.
- From the sample of 11 documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, were given a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, the practice manager had corresponded with the manufacturer of equipment used in the taking of bloods, to ascertain whether a defect discovered was a known fault with that particular batch. In another example, following the taking of bloods, the details had been recorded in the wrong patient's record. Subsequently, staff had been reminded to thoroughly check the patient's details whilst carrying out a consultation and specifically before processing any samples for testing.
- The practice also monitored trends in significant events and evaluated any action taken, always treating these as a learning experience.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. 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. The principal GP was the lead member of staff for safeguarding. We were told of an incident which occurred whilst the principal GP was away from the practice. This involved a locum GP who had dealt competently with a safeguarding incident, by following agreed procedures and reporting the incident to the appropriate agencies. The principal GP was then informed immediately upon their return.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs and the nurse practitioner were trained to child protection level three, the nurse and HCA to level two and the remainder of staff to level one.
- We were unable to locate a notice in the waiting room advising patients that chaperones were available if required and this was rectified immediately. There were however adequate notices displayed in all other clinical areas. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a

result. Audits had taken place in November 2016 and July 2017. The first had produced a score of 92% and although the outcome of the most recent audit was awaited, the practice was confident this score would be improved upon.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal). On checking the emergency drugs held in the practice, we found there was no benzylpenicillin available, although this had been risk assessed. This was used for the treatment of bacterial meningitis in infants and young children. The practice was very responsive and agreed to introduce supplies of this drug straightaway.
- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. The nurse practitioner had qualified as an Independent Prescriber and could therefore prescribe medicines for some clinical conditions within their expertise. They received mentorship and support from the principal GP for this extended role. Patient Group Directions had been adopted by the practice to allow the nurse to administer medicines in line with legislation. The HCA was trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

We reviewed two personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises. We were however unable to find a fire procedure notice in the main waiting area and the practice manager agreed to address this straightaway.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to 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 received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

- Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.
- The practice had systems to keep all clinical staff up to date. There was evidence to show clinical issues were being discussed regularly in general staff meetings. However, it was felt the practice would benefit from creating a forum in which the lead GP could initiate discussions with their clinical colleagues, such as the non-permanent locum GPs, the registrar, nurse practitioner and the nurse, when clinical matters could to be discussed in detail. It was however recognised that the principal GP tried to spend time with their GP colleagues, either before or at the end of a surgery.
- Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- 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 used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 98% of the total number of points available compared with the clinical commissioning group (CCG) average of 97% and national average of 95%.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2016/17 showed:

- Performance for diabetes related indicators was similar to the CCG and national averages. For example, 79% of patients in whom the last BP reading, (measured in the preceding 12 months), was 140/80mmHg or less, compared to a CCG average of 79% and a national average of 78%.
- Performance for mental health related indicators was similar to the CCG and national averages. For example 91% of patients with schizophrenia, bipolar affective disorder and other psychoses, had had a comprehensive, agreed care plan documented in the record, in the preceding 12 months, compared to a CCG average of 92% and a national average of 89%.

There was evidence of quality improvement including clinical audit:

- There had been three clinical audits commenced in the last two years, all of these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, recent action taken following an atrial fibrillation audit had resulted in all patients on this register receiving a medication review using the CCG's anticoagulation pathway. This had resulted in six additional patients being referred for warfarin treatment and a practice protocol being developed.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff, including locum and trainee doctors. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, staff caring for those patients with long-term conditions had been trained to carry out spirometry tests and wound care, as well as the management of diabetes.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals and informal discussions as training issues arose. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support,

clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months, with the exception of one member of staff who had recently returned from maternity leave, although plans were in place to carry this out at an appropriate time in the near future.

- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

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 record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a regular basis when care plans were routinely reviewed and updated for patients with complex needs.

- 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. A palliative care key worker had been identified who kept in regular contact with patients and their relatives, offering guidance and support when needed.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

The practice's uptake for the cervical screening programme was 66%, in April 2017. The current uptake for breast screening in the practice was 66%, which was just short of the national minimum uptake target of 70%. The practice was working actively to reach this target within the agreed timescale. The practice's figures for bowel screening showed the total number of patients adequately screened to be 129 from a total number invited of 240 (54%). As this information was provided by the practice, it was unverified and also meant that comparative averages for the CCG and England were not available.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG/national averages. For example, rates for the vaccines given to under two year olds ranged from 88% to 100% and five year olds from 83% to 94%.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and

Good

Are services effective?

(for example, treatment is effective)

NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that 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.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All clinical staff were female and this did not make it possible for patients to be treated by a clinician of the same sex. However, we were not aware of this being an issue, either by speaking to staff, patients, or looking at surveys and the CQC comment cards. The principal GP told us this would be a consideration during the recruitment of a second GP partner, the process for which had recently commenced.

All of the 45 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with five patients including members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice had received mixed results for its satisfaction scores on consultations with GPs, whilst the results for nursing care were consistently high. For example:

- 74% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 85% and the national average of 89%.
- 71% of patients said the GP gave them enough time compared to the CCG average of 83% and the national average of 86%.
- 85% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%
- 65% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 82% and the national average of 86%.
- 95% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 91%.
- 97% of patients said the nurse gave them enough time compared with the CCG average of 91% and the national average of 92%.
- 99% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 97% and the national average of 97%.
- 92% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and the national average of 91%.
- 93% of patients said they found the receptionists at the practice helpful compared with the CCG average of 85% and the national average of 87%.

We received no negative comments from Walsall CCG regarding the practice's overall performance.

Regular visits were made to two local care homes and we had received no negative feedback regarding the service provided by the practice.

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 and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals. All children under the age of 12 years old needing an emergency appointment were triaged and seen on the same day by a GP. Baby clinics and immunisation

appointments were available during any clinical session, in order to offer mothers greater flexibility and to improve attendance rates. Children under the age of two years old were also offered open access for review throughout the week.

Results from the national GP patient survey showed a mixed response from patients in relation to questions about their involvement in planning and making decisions about their care and treatment. Nursing scores were higher than local and national averages. For example:

- 70% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 84% and the national average of 86%.
- 66% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and the national average of 82%.
- 95% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 91% and the national average of 90%.
- 91% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%.

We spoke to the principal GP, the practice manager, other staff and members of the PPG regarding a group of comparatively low scores relating to the patients' perception of the GP taken from the latest National Patient survey in January 2017. There was a general consensus of opinion that these ratings were more reflective of the period prior to the principal GP assuming sole responsibility for the practice in October 2016 and that this perception had improved markedly since then. This was borne out from the results taken from a recent General Practice Assessment Questionnaire (GPAQ) survey, where previously low scores had been recorded in areas such as patient's overall experience of the surgery now increased to 99% from 77% and 80% now being likely to recommend the practice to family or friends from a previous score of 68%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.
- We were informed that the principal GP and practice manager had been asked to consider providing additional support for the secretarial team due to increased workload, following an increase in the number of patients registering with the practice and this was being considered.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 35 patients as carers (1% of the practice list). We discussed this relatively low number with the practice, who informed us a carers' champion had been introduced to help ensure that the various services supporting carers were co-ordinated and effective. This included the production of a new information pack to direct carers to the various avenues of support available to them. Staff throughout the practice were also being encouraged to identify new carers.

Staff told us that if families had experienced bereavement, the GP contacted them and sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on a Monday evening until 7.30pm for working patients who could not attend during normal opening hours.
- Plans were being discussed for surgeries to be held on a Thursday afternoon, when the practice was currently closed. This would either be from a series of hub facilities in the local area, or by the practice, following the introduction of a second GP partner. Weekend opening was also under consideration, depending on demand.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments.
- Patients were able to receive travel vaccines available on the NHS. Those only available privately were referred to other clinics for vaccines available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- A pregnancy testing service was available and pregnant women were always offered same day appointments, and a regular midwifery clinic. Advice on contraception and testing for sexually transmitted infections were also available.
- A frailty multi-disciplinary team meeting was to be introduced in late July.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.

Access to the service

The practice was open from 8.30am to 6pm on Tuesday, Wednesday and Friday. On Monday the practice opened at 8.30am and offered an extended surgery until 7.30pm. On Thursday the practice opened at 8.30, closing at 1pm.

GP appointments were from: Monday 9am to 11am and 4.30pm to 7.30pm. Tuesday 9.30am to 11.30am and 3pm to 5.40pm. Wednesday 9.10am to 11.10am and 2pm to 5pm. Thursday 9.10am to 11.10am and the practice closed in the afternoon. Friday 9am to 11.30am and 3pm to 5.40pm. Patients requiring medical assistance when the practice was closed were asked to contact Waldoc, the out of hours provider.

In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them.

We checked the next available urgent and routine appointments. For the GP, these were available on the same day. The nurse practitioner had appointments available three days later, as they were not scheduled to work again until then. The nurse had appointments on the following day and the HCA had appointments available on the same day.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable or higher than local and national averages.

- 80% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 74% and the national average of 76%.
- 89% of patients said they could get through easily to the practice by phone compared to the CCG average of 71% national average of 71%.
- 81% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 80% and the national average of 84%.
- 78% of patients said their last appointment was convenient compared with the CCG average of 78% and the national average of 81%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 76% of patients described their experience of making an appointment as good compared with the CCG average of 71% and the national average of 73%.
- 57% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 57% and the national average of 58%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

Reception staff would record a telephone request for a home visit on a form and this would be passed to the GP for assessment. The GP would then call each patient or carer and would conduct a telephone consultation to gather information to allow for an informed decision to be made on prioritisation according to clinical need. If appropriate, arrangements would be made for the patient to be visited at home. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. 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 a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. This was contained in a leaflet held in a display stand in reception. The practice manager agreed to display a notice making this clearer for patients.

We looked at three complaint received in the last 12 months and found these had been satisfactorily handled, dealt with in a timely way, with openness and transparency and to the complainant's satisfaction. The practice manager told us that despite only being received occasionally, what were described as "minor issues" would be more consistently recorded in future, in accordance with the practice's policy.

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 deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement and staff knew and understood the values.
- The practice had a clear strategy which reflected the vision and values and were regularly monitored.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. The principal GP had overall strategic responsibility for the direction of the practice, as well as being the lead for prescribing and safeguarding. The practice nurse had responsibility for infection prevention control.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice. As there was evidence of clinical issues being discussed in this meeting, we suggested these should perhaps be specifically discussed in a meeting involving members of the clinical team only.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints. Other issues discussed were infection control, safeguarding and health and safety.

Leadership and culture

On the day of inspection the principal GP demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the principal GP was approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The principal GP encouraged a culture of openness and honesty. From the examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice manager told us they would be more thorough in recording verbal complaints, as well as written correspondence in future.

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

- The practice held and minuted a range of multi-disciplinary meetings including with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported. All staff were involved in discussions about how to run and develop the practice, and the principal GP encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

Are services well-led?

Good

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

- Patients, through the patient participation group (PPG) and through surveys and complaints and suggestions received. The PPG met regularly and submitted proposals for improvements to the practice management team. For example, changes to the car parking arrangements had been implemented, as these were limited on-site. Issues discussed in their meetings included: extended hours, patient survey results and the Care Quality Commission.
- The NHS Friends and Family test, complaints and compliments received.
- Staff, through their monthly meetings, appraisals and general discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and the practice was a member of the Walsall Alliance GP Federation, which was formed by a group of 31 GP practices in Walsall working on a range of issues including: improving the provision and delivery of patient services, improving the quality and safety of services and strengthening the clinical governance framework. Formal peer review meetings facilitated by the CCG were to start soon, as were locality meetings, where a group of practices would meet regularly to discuss issues such as best practice, improving the quality of care and producing better outcomes for their patients, as well as other common areas of concern. We were also made aware of the important roles that the principal GP held outside the practice, both as Local Medical Committee (LMC) secretary and especially the "Black Country" representative on the General Practitioner Committee of the British Medical Association.