Duncan Street Primary Care Partnership

Quality Report

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Date of inspection visit: 1 September 2016
Date of publication: 10/02/2017

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 Duncan Street Primary Care Partnership on 1 September 2016. Overall, the practice is rated as good with requires improvement in providing a safe service.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Learning was shared with staff and reported to external agencies when required.
- Required recruitment checks had been made before staff were employed to work at the practice.
- Effective systems were in place to mitigate risks to patients who took high risk medicines.
- A training matrix and policy was in place to monitor that all staff were up to date with their training needs and received regular appraisals.
- Patients said they found it difficult to get through to the practice by telephone. The practice had put systems in place to address this. Urgent appointments were available the same day with the on call GP.
- Feedback from patients about their care was consistently positive.
- The practice engaged with the local community to support the self-management of patients with long-term conditions. For example, the practice invited patients to take part in educational and lifestyle sessions held at a local temple.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice actively managed, reviewed and responded to complaints and made improvements based on the outcome.
- The practice had a strong culture for education and learning.
- The practice had visible clinical and managerial leadership.
- Governance and audit arrangements were comprehensive and effective.

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

- Continue pro-actively identifying carers and establishing what support they need.

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

There was an effective system in place for reporting and recording significant events.

- Lessons were shared both internally and externally to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had an effective system to log, review, discuss and act on alerts received that may affect patient safety.
- The practice had processes in place to keep patients safeguarded from the risk of abuse.
- Required recruitment checks had been made before members of staff were employed to work at the practice.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were comparable to the local and national averages.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits had been completed and repeat cycles demonstrated that audit had driven improvements to patient outcomes.
- Staff worked with health care professionals to understand and meet the range and complexity of patients' needs.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and staff had personal development plans in place.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey published in July 2016 showed patients rated the practice similar to the local and national averages for several aspects of care.

Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- We saw staff treated patients with kindness and respect, and maintained patient confidentiality.
- The practice had a carers register and had systems in place to support carers. The practice had a carers champion who was proactive in their attempts to increase the carers register, which was less than 1% of the registered population.

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 (CCG) to secure improvements to services where these were identified.
- There were urgent appointments available the same day and a system to prioritise patient requests for a home visit.
- Data from the National Patient Survey published in July 2016 showed that 59% of the patients who responded said they found it easy to get through to the surgery by phone. This was significantly lower than the local CCG average of 70% and national average of 73%. The practice was reviewing the telephone system to address this.
- The outcome of the survey showed that 82% of respondents described their experience of making an appointment as good. This was similar to the local CCG average of 80% and national average of 85%.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Complaints were dealt with in a timely manner and we saw that learning outcomes were discussed with all staff.

Are services well-led?

Good

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

- The practice had a clear vision with quality and safety as its top priority. The practice had a written set of aims and objectives, which staff and patients were aware of.
- There was a clear leadership structure and staff felt supported by the management. The practice had a number of policies and procedures to govern activity and held regular team meetings.
- The practice had embedded systems and processes in place to support an overarching governance framework that improved the quality and safety of their service.

Summary of findings

- 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 shared this information with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from patients and staff, which it acted on.
- The practice had a strong culture for education and learning and was accredited to provide advanced training to GP registrars.

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 was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Older patients at higher risk of hospital admission had written advanced care plans.
- The practice had a register of frail and vulnerable older patients and these were discussed at regular multidisciplinary meetings with other health and social care professionals.

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 and were supported by the GPs in the management of patients with a chronic disease and those at risk of hospital admission were identified as a priority.
- The GPs 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) score for the care of patients with long-term conditions was similar to the local and national averages. However the practice performance for diabetes related clinical indicators overall was lower than the local Clinical Commissioning Group and England average. The practice had a proactive approach to improve the management of patients with diabetes. For example, patients who did not attend appointments were invited to take part in educational and lifestyle sessions held at a local temple to support them to manage their diabetes.

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. For example, children and young people who had a high number of A&E attendances.

Summary of findings

- The practice held regular clinical meetings where children at risk, child welfare concerns and safeguarding issues were discussed to ensure awareness and vigilance.
- The practice uptake for the immunisation of children overall was similar to the local and national averages.
- The practice's uptake for the cervical screening programme was 74% which was lower than the local Clinical Commissioning Group (CCG) average of 78% and the England average of 82%. The practice had a proactive process in place to manage this.
- Protected daily appointments were available for children of all ages. Appointments were available outside of school hours and urgent appointments were available for children.

Working age people (including those recently retired and students)

Good

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs of this age group.
- All patients between the age of 40 and 74 years of age were offered NHS health checks and healthy living advice.

People whose circumstances may make them vulnerable

Good

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

- The practice held a register of patients living in vulnerable circumstances.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with external health and social care professionals, to provide effective care to patients nearing the end of their lives and other 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.

Summary of findings

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).

- Eighty one per cent of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months. This was slightly below the local CCG average of 86% and national average of 84%.
- The percentage of patients with a diagnosed mental health condition who had a comprehensive, agreed care plan documented in their record, in the preceding 12 months was 80%. This was lower than the local CCG and national averages of 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- Staff 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 published in July 2016 showed the practice was performing similar to the local and national averages in several areas. A total of 341 surveys (3.5% of patient list) were sent out and 118 (35%) responses, which is equivalent to 1.2% of the patient list, were returned. Results indicated the practice performance was higher than other practices in some aspects of care. For example:

- 59% 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%.
- 82% 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 80%, national average 85%).
- 80% of the patients who responded described the overall experience of their GP surgery as fairly good or very good (CCG average 83%, national average 85%).
- 67% 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 73%, national average 78%).
- 80% of the patients who responded said they found the receptionists at this practice helpful (CCG average 84%, 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 nine comment cards which all commented positively on the standard of care received at the practice. Patients said that the service was exceptional and that staff were professional, helpful, polite and understanding. We spoke with nine patients, three of the patients were members of the practice 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. All the patients told us that they were satisfied with the care provided by the practice. Patients said that they received good treatment, were listened to and treated with respect. The PPG members said that they were encouraged by the practice staff to make suggestions to support improvement of the services provided.

Areas for improvement

Action the service SHOULD take to improve

- Continue pro-actively identifying carers and establishing what support they need.

Duncan Street Primary Care Partnership

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector**.** The team included a GP specialist advisor, a practice manager specialist advisor and an expert by experience.

Background to Duncan Street Primary Care Partnership

Duncan Street Primary Care Partnership is registered with the Care Quality Commission (CQC) as a partnership. The practice is located in an inner city area of Wolverhampton and has good transport links for patients travelling by public transport. Parking is available for patients travelling by car. The practice is a two storey building and all areas are easily accessible by patients with mobility difficulties, patients who use a wheelchair and families with pushchairs or prams.

The practice team consists of two GP partners (one male, one female) and four salaried GPs all female. The GPs are currently supported by a nurse practitioner, two practice nurses and a healthcare assistant. Clinical staff are supported by a practice manager, reception manager, three administration and six reception staff. In total there are 22 staff employed either full or part time hours to meet the needs of patients. The practice also use regular GP locums at times of absence to support the clinicians and meet the needs of patients at the practice. The practice is a training practice for GP registrars and provides advanced training for GP registrars who have not been able to complete their training in the three-year training period.

The practice is accessible by phone between 8am and 6.30pm and open from 8.30am to 6pm Monday to Friday. Appointments to see a GP are available from 9am to 11.30am and 2pm to 6pm. Patients are able to book appointments with the practice nurses between 8.30am and 12.30pm and 2pm to 6pm. 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 Vocare via the NHS 111 service.

The practice has a Primary Medical Services contract with NHS England to provide medical services to approximately 9,452 patients. It provides Directed Enhanced Services, such as childhood vaccinations and immunisations, facilitating the timely diagnosis and support for patients with dementia and the care of patients with a learning disability. The practice has a higher Asian population of 38% in comparison to other local practices. The practice is located in one of the most deprived areas of Wolverhampton. People living in more deprived areas tend to have a greater need for health services. There is a higher practice value for income deprivation affecting children and older people in comparison to the practice average across England. The level of income deprivation affecting children of 30% is higher than the national average of 20%. The level of income deprivation affecting older people is higher than the national average (32% 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 1 September 2016.

During our visit we:

- Spoke with a range of staff including the GPs, a practice nurse, a healthcare assistant, practice manager, reception staff 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 Care Quality Commission (CQC) at that time.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events. We found that some staff were not aware of significant events that had occurred but told us they would inform the practice manager or GP of any incidents that that could have an impact on the operation of the practice and the safety of patients or staff. The practice had a significant event recording form which 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 saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, relevant information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.

The practice manager and GPs received medicine and safety alerts. There was evidence that appropriate systems were in place to demonstrate they were acted on. Alerts were emailed to appropriate staff printed off and initialled before placed into a dedicated folder kept in reception. We saw evidence that alerts had been acted upon. For example, an NHS England alert issued in February 2016 highlighted risks regarding the prioritising of home visit requests. The practice updated its policy for handling home visits to ensure that GPs were able to make a prompt assessment of any that could be potentially urgent. Requests for home visits were referred immediately to the on-call GP. The practice kept a log of all visits.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. The practice had recorded nine significant events both clinical and operational that had occurred in the last 12 months. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example one of the events showed that the wrong patient was sent for a specific test. The practice procedures for checking patients were reviewed and the staff asked to be more diligent. The practice informed the patients of the error and arranged for the correct patient to receive the test. Records showed that the incident was discussed and followed up at practice meetings.

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Policies and procedures to safeguard children and vulnerable adults from abuse which reflected relevant legislation and local requirements. We saw that the 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. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and practice nurses were trained to child safeguarding level 3. The practice routinely reviewed and monitored children who did not attend appointments and also reviewed the 15 children who were included on the child protection register. All adult safeguarding concerns were recorded in patients' notes as appropriate. Suspected safeguarding concerns were shared with health visitors and midwives linked to the practice and other relevant professionals.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice had employed a cleaner and there were cleaning schedules in place and cleaning records were maintained. Treatment and consulting rooms in use had the necessary hand washing facilities and personal protective equipment which included gloves and aprons. 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. Appropriate clinical waste disposal contracts were in place. The practice nurse was the infection control clinical lead. There was an infection

control policy in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). The practice carried out regular medicines audits, with the support of a Clinical Commissioning Group (CCG) clinical pharmacist 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 in place to monitor their use. An effective system for the management of uncollected repeat prescriptions was in place. Completed prescriptions, waiting for collection were regularly checked and uncollected prescriptions destroyed after one month and patient clinical notes updated to reflect this.

  Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The health care assistant (HCA) was trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber. The practice had systems for ensuring that medicines were stored in line with manufacturers guidance and legislative requirements. This included daily checks to ensure medicines were kept within a temperature range that ensured they were effective for use.

  The practice had systems in place for the prescribing and monitoring of high risk medicines. There were shared care agreements in place with a local hospital for some patients, prescribed high risk medicines that needed to be monitored. Blood test results were accessible by the practice electronically and these were recorded and signed by the GPs to confirm that they had checked the results. The results were then added to individual patient's records. The practice provided an anticoagulation (a high risk medication used to prevent blood clotting) monitoring service to registered and non-registered patients. The HCA was trained to carry out this service.

- We reviewed five personnel files and found that there was evidence that qualification and had been completed for the practice nurses and GPs. The practice had ensured that appropriate checks had been completed We found that all recruitment checks had been undertaken prior to employment in the files we examined. The practice used GP locums to support the clinicians and meet the needs of patients at the practice. The practice obtained sufficient and appropriate information such as qualifications and confirmation of registration. This information was used to confirm that locum staff were suitable to work with patients at the practice.

Monitoring risks to patients

Risks to patients were assessed and well managed. There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had up to date public liability insurance in place. A safety folder contained details of the outcome of monthly building checks, records of repairs carried out, gas safety certificates and lift maintenance checks. There was a health and safety policy available with a poster in the reception area, which identified the health and safety representative. The practice had up to date fire risk assessments and carried out regular fire drills. The practice also had four fire marshals. A fire prevention logbook contained information about fire risk assessments completed, weekly fire prevention checks and fire drills carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. Other risk assessments were in place 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).

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. The practice used locum GPs to help meet the needs of patients at times of GP absence such as annual leave.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents, which included:

Good

Are services safe?

- A comprehensive business continuity plan for managing major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and copies of the plan were kept off site.
- An instant messaging system on the computers in all the consultation and treatment rooms alerted staff to any emergency.
- All staff received annual basic life support training. 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 available,
- There was a designated emergency room used to treat patients if their condition deteriorated and a designated GP was available for patients experiencing a mental health crisis.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed patients' 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. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. The GPs could clearly outline the rationale for their approach to treatment. The practice used electronic care plan templates based on NICE guidance. Examples of these were seen and included templates for diabetes and mental health. 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 87% of the total number points available for 2014-2015 this was lower than the local Clinical Commissioning Group (CCG) average of 92% and the national average of 95%. The practice clinical exception rate of 4.9% was lower than the CCG average of 7.5% and national 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:

- The practice performance in four of five diabetes related indicators was significantly lower than the local CCG and England averages. For example, the percentage of patients on the diabetes register, in whom a specific blood was recorded was 63% compared with the CCG average of 72% and England average of 77%). The practice exception reporting rate of 3.8% showed that it was lower than the local average of 8.9% and the England average of 11.7% which meant more patients were included.
- Performance for the percentage of patients with Chronic Obstructive Pulmonary Disease (COPD) who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale (the degree of breathlessness related to five specific activities) in the preceding 12 months was 87%. This was lower than the local CCG average of 91% and England average of 90%. COPD is the name for a collection of lung diseases. The practice exception reporting rate of 0% was lower than the local average of 6.8% and national average of 11.1%.
- Performance for mental health related indicators was lower than the local CCG and national averages. For example, the percentage of patients with a mental health disorder who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 80% compared to the local CCG and England averages of 88%. The practice clinical exception rate of 3.4% for this clinical area was lower than the local CCG average of 8.7% and the England average of 12.6%.
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was comparable to the local CCG average and England averages (81% compared with the CCG average of 82% and England average of 84%). The practice clinical exception rate of 1.3% for this clinical area was lower than the local CCG average of 7.7% and the England average of 8.3%.

The practice had performed well overall with the exception of two clinical areas when compared to the local CCG and England averages. However, the clinical exception reporting rates were lower overall in 15 of the 16 identified clinical domains. For example, although the number of patients on the diabetes register, who had a specific blood test recorded was low, the overall exception reporting rates for the diabetes clinical indicators was 5.7%. This was lower than the local CCG average of 8.8% and the England average of 10.8%. The practice had identified that some of the reasons patients diagnosed with diabetes had not attended for follow up checks were related to the cultural lifestyles and attitude to food of patients from the Asian population. The practice worked with members of a local Sikh temple to educate patients on diabetes. This included

Good

Are services effective?

(for example, treatment is effective)

the importance of attending appointments for health screening and diet. The GPs attended peer review meetings with other local GP practices where clinical issues, treatments and performance were discussed.

Clinical audits were carried out to facilitate quality improvement. We saw that nine clinical audits had been carried out over the last 12 months. One of the audits looked at whether patients prescribed specific high risk medicines had appropriate management processes in place. For example ensuring that a shared care agreement with local hospital was in place with clear guidance indicating who was responsible for ensuring tests were completed. The first audit identified 58 eligible patients and nine of these patients had no shared care agreement in place. The practice introduced several changes, which included ensuring that all patients with a shared care agreement were identified on the practice information system and followed up those without an agreement. Details were also added to the prescription to make it clear whether the prescribing GP was responsible for checking blood test results. A follow up audit carried out showed improvement in patient documentation and all procedures had been followed to ensure patient safety. The results of the audit were discussed with all clinical staff and the practice planned to repeat the audit every six months.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. The practice had an induction programme for all newly appointed staff, which included GP trainees, locum GPs and non-clinical staff. The induction programme 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. The learning needs of staff were identified through a system of appraisals, meetings and reviews of their individual development needs. All staff had had an appraisal within the last 12 months, which included the salaried GPs. The practice nurses and GPs had all completed clinical specific training updates and competency assessments to support annual appraisals and revalidation.

The practice nurses had completed an assessment of competence for administering vaccinations and carrying out cervical screening. The nurses could demonstrate how they stayed up to date with changes to the immunisation programmes and had access to on line resources and discussions at local peer review meetings. Practices nurses had also received advanced training in the management of diabetes to support the practice in improving the care of patients with diabetes. There was a training matrix in place which showed training completed by staff and the date an update was due.

The practice was a training practice for GP registrars and provided advanced training for GP registrars who had found it difficult to complete the required training in the three-year training period. The practice tailored the tutorials to address the individual needs of the GP trainees.

There was sufficient staff to meet the needs of patients within the practice. The practice used locum GPs and nurses to provide cover for holiday leave and other planned absences.

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. This included care and risk assessments, care plans, medical records and investigation and test results. The practice had fully computerised links for pathology and patient discharge summaries. The practice shared relevant information with other services in a timely way, for example when referring patients to other services. We saw that referrals for care outside the practice were appropriately prioritised. The GPs followed up all patient results and contact the patients where appropriate.

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 after they were discharged from hospital. The practice identified patients approaching the end of their life and had 14 patients on its palliative care list. We saw evidence that formal multidisciplinary meetings were held with the practice clinical team, community matron and local hospice palliative care nurses. Each of these patients had a named GP and there were processes in place to monitor and appropriately discuss the care of patients with end of life care needs. The practice held a frail and vulnerable register of patients and these were also discussed at multi-disciplinary meetings with other health and social

Good

Are services effective?

(for example, treatment is effective)

care professionals. The frailest 2% of practice patients had an admission avoidance care plan in place, which included patients with long-term conditions. The practice had systems in place to "flag" patients with chronic or life limiting conditions to the out-of-hours service and provide information to enable continuity of care.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. There was no evidence to confirm that staff had had access to training on consent and MCA 2005. However, staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 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. Staff were aware of the importance of involving patients and those close to them in important decisions about when and when not to receive treatment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. 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 held a stop smoking clinic for its patients. Patients had access to appropriate health assessments and checks and were signposted to relevant services where appropriate.

The uptake for cervical screening for women between the ages of 25 and 64 years for the 2014/15 QOF year was 74% which was lower than the local CCG average of 78% and the England average of 82%. The practice was proactive in following these patients up by telephone and sent reminder letters. Public Health England national data showed that patient response for other cancer screening examinations was lower than the local CCG and England averages. For example the number of female patients screened for breast cancer in the last 36 months was 64% which was lower than the local CCG average of 68% and England average 72%. The data for other breast and bowel cancer screening showed that they were significantly lower than the local and England averages. For example, the number of patients aged 60 to 69 years who had been screened for bowel cancer in the last 30 months was 43% compared to the local CCG average of 52% and England average of 58%. The practice was aware of this and took the time to educate patients on the importance of attending health screening programmes.

Travel vaccinations and foreign travel advice was offered to patients. Childhood immunisations and influenza vaccinations were available in line with current national guidance. Data collected by NHS England for 2014/15 showed that the performance for childhood immunisations was mostly similar to the local CCG averages for example, immunisation rates for children:

- under two years of age ranged from 74% to 94%, (CCG average 74% to 96%),
- children aged two to five 76% to 97%, (CCG average 84% to 96%)
- children aged five year olds from 66% to 94%, (CCG average 77% to 95%)

The practice was proactive in following up children who required immunisation. If there were three missed appointments, the practice worked closely with the health visitors and local centre for children to follow up these children.

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. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. Signs in the waiting area made patients aware that a quiet room was available.

All of the nine 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 three members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards 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 was mostly similar to the local clinical commissioning group (CCG) average for its satisfaction scores on consultations with GPs and nurses. For example:

- 79% of patients said the GP was good at listening to them compared to the CCG average of 85% and the national average of 89%.
- 80% of patients said the GP gave them enough time compared to the local CCG average of 83% and the national average of 87%.
- 89% of patients said they had confidence and trust in the last GP they saw compared to the local CCG average of 93% and the national average of 95%
- 78% of patients said the last GP they spoke to was good at treating them with care and concern compared to the local CCG average of 81% and the national average of 85%.
- 90% of patients said the nurse was good at listening to them compared to the local CCG average of 91% and the national average of 91%.
- 90% of patients said the nurse gave them enough time compared to the CCG average of 91% and the national average of 92%.
- 92% of patients said they had confidence and trust in the last nurse they saw compared to the local CCG average of 96% and the national average of 97%.
- 88% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the local CCG average of 88% national average of 91%).

The patient responses for satisfaction with the receptionists at the practice were lower than the local and national averages. The results showed that:

- 80% of the patients who responded said they found the receptionists at the practice helpful (CCG average 85%, national average 87%).

Care planning and involvement in decisions about care and treatment

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

- 78% 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%.
- 75% 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%).
- 89% of the patients who responded said the last nurse they saw or spoke to was at explaining tests and treatments (CCG average 89%, national average 90%)
- 85% of the patients who responded said the last nurse they saw was good at involving them in decisions about their care (CCG average 83%, national average 85%).

Patients told us they were encouraged to be 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.

Good

Are services caring?

The practice provided facilities to help patients be involved in decisions about their care. The practice had a higher number of Asian patients (38%) on its register. Staff told us that translation services were available for patients who did not have English as a first language. Interpreters were available onsite. We saw notices in the reception areas informing patients this service was available. Information leaflets and notices were available in easy read format and in different languages. The GPs were multilingual which also provided support for patients during their consultations

Patient and carer support to cope emotionally with care and treatment

The practice had 87 patients over the age of 18 years on its practice carers register. This represented 0.9% of the practice population. This was just under the expected minimum of 1%. The practice was actively reviewing its patient registers to identify patients who may have a carer supporting their care needs. This included a review of its vulnerable patient registers for example patients with dementia, poor mental health and those with a learning disability to ensure that all possible carers were identified. The practice was also looking at its Asian community. The practice was aware that based on the cultural lifestyle of this group of patients extended families often lived in the same house and members of the family could be involved in looking after the older generation or other vulnerable family members. The practice was aware that these reviews could increase the carers register to at least 3%.

There were notices and leaflets displayed in the waiting room and a carers pack that provided patients with appropriate information on the support and services provided both at the practice and in the local community. One of the practice nurses was the lead for a virtual carers group of about 40 patients set up by the practice. The group also formed part of the patient participation group and the practice maintained communication with the group through telephone contact and emails. The practice offered carers longer appointments, health checks and the flu vaccination.

The practice maintained a register of patients that had died. Patients told us that they felt supported at difficult times and felt positive about the care and support they received to cope with their bereavement. Staff told us that if families had suffered bereavement, they were contacted, sent a condolence card and offered an appointment with the duty GP or their usual GP if preferred and at a time to suit them. Patient information leaflets and notices were available in the patient waiting area, which told patients how to access a number of bereavement, and counselling support groups and organisations. Information about support groups was also available 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 practice maintained a register of 113 patients who experienced poor mental health. The patients were invited for an annual review by the lead GP who contacted them personally by telephone offered them a convenient appointment to suit them. The practice monitored patients who did not attend for appointments and carried out opportunistic reviews where possible. Patients that failed to attend were referred to secondary care services.
- The practice had a transient and diverse population and was aware of vulnerable patients who were from Eastern Europe and asylum seekers. The practice supported patients to register with them whether permanently or as temporary patients'. The practice sign posted patients to appropriate support organisations and alerts were added to the medical records of all identified vulnerable patients'.
- The practice had a register of 39 patients with a learning disability. In the first six months of the 2016/17 Quality and Outcomes Framework performance (QOF) year the practice had reviewed 17 patients and updated their care plans and was on target to complete the remaining reviews for this group of patients.
- The practice had identified 58 patients with dementia and had referred a further two patients to the memory clinic for a formal diagnosis.
- Patients were able to receive travel vaccinations available on the NHS and were referred to other clinics for vaccines available privately.
- The practice offered online access for making appointments and ordering repeat prescriptions.
- Patients were sent telephone texts to remind them about their appointment and to send test results.
- The practice had a disabled access assessment completed to confirm the suitability of the building. Facilities for patients with mobility difficulties included level access to the practice, adapted toilets and a hearing loop. The practice was easily accessible to patients who used wheelchairs and families with pushchairs or prams.
- There were longer appointments available for patients with a learning disability, older people and patients with long-term conditions.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Urgent access appointments were available for children and those with serious medical conditions.

Access to the service

The practice was accessible by phone between 8am and 6.30pm and open from 8.30am to 6pm Monday to Friday. Appointments to see a GP were available from 9am to 11.30am and 2pm to 6pm. Patients were able to book appointments with the practice nurses between 8.30am and 12.30pm and 2pm to 6pm. This practice did not provide an out-of-hours service to its patients but had alternative arrangements for patients to be seen when the practice is closed. Patients are directed to the out of hours service Vocare via the NHS 111 service. This information was available on the practice answerphone, practice leaflet and website. The practice had a designated on call GP daily. The GP on call had no booked appointments and followed up patients who visited the practice on the day. Patients accessing this clinic included children under one year old and patients over the age of 75 years, telephone appointments, requests for sick notes and managed the review and allocation of home visit requests.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was varied compared to the local and national averages.

- 80% of patients who responded were satisfied with the practice's opening hours compared to the local average of 77% and England average of 76%.
- 59% of patients who responded said they could get through easily to the surgery by phone (local average 70%, England average 73%).

The practice was aware through the outcome of surveys of the comments related to the difficulty in getting through to the practice by phone. The practice discussed these issues at practice meetings, with the patient participation group

Good

Are services responsive to people's needs?

(for example, to feedback?)

(PPG), and made changes to improve the patients' experience. For example, the practice had ensured that all reception and administration staff were aware that they were all responsible for answering the phones in a timely manner at busy times.

The practice had a system in place to assess whether a home visit was clinically necessary and reviewed the urgency of the need for medical attention. 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. Requests for home visits were referred to the on-call duty GP. The GP on duty for the day allocated the home visits to the GP registrars and was available for advice if needed. The practice kept a log of all visits requested and carried out.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager and one of the GPs were both responsible for managing complaints at the practice. We saw that information was available to help patients understand the complaints system including leaflets available in the reception area. This information was also available in different languages to meet the needs of patients registered at the practice. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

Records we examined showed that the practice responded formally to both verbal and written complaints. We saw records for 17 complaints received over the past 18 months and found that all had been responded to in a timely manner and satisfactorily handled in keeping with the practice policy. The records identified that lessons were learnt from individual concerns and complaints and action was taken to as a result 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 deliver high quality care and promote good outcomes for patients. The practice mission statement was displayed and accessible to patients and staff . The staff and patients (through the PPG) knew and understood the values. Records showed that the practice reviewed the practice performance and discussed future plans. For example the practice had completed a major review of its financial position and as a result had had to review its skill mix and reduce the number of staff employed. The changes required were discussed with staff at planned meetings and staff were kept informed of how the changes would affect them and the operation of the practice. Patients were also made aware of the changes to be made and care was taken to ensure that these would not have negative impact on patient care. Both staff and patients felt they were supported through this change.

Governance arrangements

The practice had embedded systems and processes in place to support an overarching governance framework.

- There was a clear staffing structure and all staff were clear about their own roles and responsibilities. Allocated roles included a lead for governance, managing patients with long-term conditions and safeguarding.
- All staff were supported to address their professional development needs.
- We found that the management and leadership team had an understanding of the performance of the practice.
- Practice specific policies were in place and available to all staff.
- The practice held formal monthly meetings at which governance issues were discussed and we saw that there was a structured agenda and an action plan.
- The practice carried out internal audits, which were used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks and implementing mitigating actions were in place.

Leadership and culture

On the day of inspection the GPs in the practice 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 GPs were approachable and always took the time to listen to all members of staff. GPs we spoke with told us that they felt valued and professionally fulfilled. The GP registrars also told us that they felt supported by the practice team.

The provider was aware of and had systems in place 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 partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment, affected people received reasonable support, relevant information and a verbal and written apology. The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by the management. Staff told us the practice held regular team meetings. These included coffee mornings with the GPs, individual practice team meetings, clinical educational meetings for GP trainees and whole practice meetings. Topics on meeting agendas included significant events, audit and unplanned admissions. 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. We noted team away days had been held. Staff said they felt respected, valued and supported. All staff were involved in discussions about how to run and develop the practice, and the partners 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, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

Are services well-led?

Good

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

- The practice had an active Patient Participation Group (PPG) and other methods in place to gather feedback from patients who used the service. These included comment boxes and surveys. The practice carried out surveys with the support of the PPG. Eight PPG group members attended regular meetings at the practice. The group also included a virtual group of approximately 40 patients. One of the practice nurses ensured that the group was kept up to date through emails or telephone contact. The practice monitored and acted on feedback from patients. For example, an advanced appointment booking system was introduced offering patients to book an appointment with their preferred GP if possible.
- 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. The practice staff worked effectively as a team and their feedback was valued.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice was involved in a number of local pilot initiatives which supported improvement in patient care across Wolverhampton. The practice was involved in a partnership initiative with the local Clinical Commissioning Group (CCG) and Public Health Department. This involved carrying out tests to check the TB, HIV and Hepatitis status of identified patient groups. One of the GPs was the CCG joint GP advisor for the information technology team. One of the partners had completed a clinical leadership course and three other senior staff had been successful in gaining place on the course.

The practice was a training practice for GP trainees and an advanced training practice for GPs who needed to repeat their training. The teaching programme for GP trainees included tutorials from patients on the management of their condition. The practice took part in a number of university linked research projects. The practice had achieved 'Research Ready' accreditation issued by the Royal College of General Practice (RCGP). RCGP Research Ready is an online quality assurance framework, designed for use by any general practice in the UK actively or potentially engaged in research, on any scale. The accreditation enabled the practice to demonstrate their legal, ethical, professional, governance and patient safety responsibilities at all stages of the research process.