

Halesowen Health Centre (Stourside Medical Practice)

Inspection report

Halesowen Health Centre
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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 location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

Overall summary

This practice is rated as Good overall. (In November 2017, the practice was previously rated requires improvement, with good in providing safe, effective and well-led services and requires improvement in providing caring and responsive services).

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at Halesowen Health Centre on 6 November 2017 as part of our inspection programme. Overall the practice was rated as requires improvement with requires improvement for providing caring and responsive services. The service was rated as good for providing safe, effective and well-led services. The full comprehensive report on the November 2017 inspection can be found by selecting the 'all reports' link for Halesowen Health Centre.

This inspection was an announced comprehensive inspection carried out on 22 October 2018 to confirm that the practice had carried out their plan to meet the legal requirements in relation to those legal requirements and additional findings made since our last inspection.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- The practice had a proactive approach in helping patients to live healthier lives.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients had access to care when needed but some found that the appointment system was confusing.
- Staff stated they felt respected, supported and valued and there was an open culture within the practice.
- There were clear responsibilities and roles of accountability to support good governance and management.
- There was a focus on continuous learning and improvement at all levels of the organisation.

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

- Consider further training for reception staff in the identification of serious medical conditions.
- Continue to explore how patient satisfaction rates can be improved.

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

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

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

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The team included a GP specialist adviser.

Background to Halesowen Health Centre

The GP surgery within Halesowen Health Centre is known locally as Stourside Medical Practice. The practice is based within the Halesowen area of Birmingham. Up until September 2018, there had been three surgery locations that form the practice; these consisted of the main practice at Halesowen Health Centre and branch sites at Coombswood surgery and Tenlands Road Surgery. The two branch surgeries were closed in September 2018 and the practice now operates from a single site.

The practice offers General Medical Services (GMS) through a contract with NHS England. The practice has expanded its contracted obligations to provide enhanced services to patients. Enhanced services are services, which require an enhanced level of service provision above what is required under core GMS contracts.

There are currently 6,320 patients of various ages registered and cared for across the practice. The practice has more patients aged 40 to 69 than average and less patients aged under 14 than average. The practice has fewer unemployed patients of working age than the

average. The practice has fewer than average patients with long-term conditions. The local area is within the fifth less deprived decile when compared with both local and national statistics. These indicators mean that the patients at the practice may make fewer demands on the service.

The practice website has up to date information about the practice team and the opening times.

The practice had opted out of providing out of hours care. Arrangements were in place for patients

at this practice to access a GP at weekends through a scheme for extended hours provided by

‘hub’ practices within the locality. Out of hours care is also provided by Malling Healthcare

(provided within Russells Hall hospital) and this can be accessed by dialling NHS 111. Patients

can also attend the walk-in service at Russells Hall Hospital.

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from the risk of abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from the risk of abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Learning from safeguarding incidents was available to staff. Staff who acted as chaperones were trained for their 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.)
- Staff took steps, including working with other agencies, to protect patients from the risk of abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control. The practice had responded to a recent communication and had started a review of staff immunisation for infections other than hepatitis B, such as tetanus, polio, diphtheria and measles, mumps and rubella (MMR).
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.

- Most staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. The computer system included a sepsis screening and action tool to support staff in the recognition and management of sepsis and all staff had completed an online sepsis training module. However, reception staff we spoke with were not always aware of the red flags in the identification of a patient who may require urgent medical attention. The practice sent us evidence after the inspection of a protocol and guidance document to support receptionists identify serious conditions, for example; meningitis and a stroke.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

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

- The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance. Public health data showed that the practice was below the local and national averages of prescribing antibiotics.
- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised most risks. However, we identified an alternative to the medication used in emergency situations to stop cluster seizures in patients who were taking other medication to treat epilepsy. The practice accepted that the alternative was easier to administer so ordered this medication on the day of inspection and added it to the emergency medicines list.

Are services safe?

- There was a system for receiving and acting on Medicines and Healthcare Products Regulatory Agency (MHRA) safety alerts.
- Patients' health was monitored in relation to the use of medicines and followed up appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed safety using information from a range of sources.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the evidence tables for further information.

Are services effective?

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

Effective needs assessment, care and treatment

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

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- The practice was collating a 'frailty register', a list of older patients who were frail or may be vulnerable, who received a full assessment of their physical, mental and social needs. The practice was using an appropriate tool to identify patients aged 75 and over who were living with moderate or severe frailty. Those identified as being frail would have annual clinical reviews either at the practice or at home, including a review of medication and a care plan to support their individual needs.
- The practice identified older patients at increased risk of hospital admission. These patients were pro-actively reviewed using their birth month to trigger multidisciplinary team reviews to ensure their needs were met. The multidisciplinary team meetings were held monthly and were normally attended by district nurses, a case manager, a care co-ordinator, an Integrated Plus link worker, a mental health gateway worker, a social worker and practice clinical staff (Integrated Plus is a support group that provide signposting and holistic care for patients with psychosocial needs, for example support with independent living).
- The practice followed up older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice offered memory testing and annual health checks for patients aged 75 and over.

People with long-term conditions:

- Patients with long-term conditions were offered a structured review at least twice a year (one to two nurse led reviews plus one pharmacist review) with the practice nurse to check their health needs were being met. Medication reviews were carried out by a GP or pharmacist. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. For example, the practice nurse had attended training and updates in the patients with asthma and patients with diabetes.
- There was a GP lead and a nurse lead for all major long-term conditions.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice used the Dudley Clinical Commissioning group (CCG) long-term condition template to provide a comprehensive nurse assessment and promoted self-management programmes, for example; the Dudley self-management programme and education about diabetes and being 'at risk' of diabetes. The performance over the last 12 months (November 2017 to October 2018) showed 74% of patients with a long-term condition have had a discussion with a clinician about the Dudley self-management programme. The Dudley CCG target threshold was 48-71%.
- Overall, the practice's performance on quality indicators for long-term conditions was in line with local CCG averages. The practice was aware of their performance year to date performance and evidenced improvement in areas identified as being below the averages for 2017-2018. For example, a review of performance over the last 12 months (November 2017 to October 2018) for providing a holistic review to all patients with a long-term condition was 72%, the Dudley CCG target threshold was 51-72%.

Are services effective?

- Patients with chronic obstructive pulmonary disorder (COPD) were issued with rescue medication prescriptions and self-management plans. Patients were educated to notify the practice when starting rescue medication.
- The practice GP lead for palliative care and cancer had guided the practice to achieve performance scores that exceeded the CCG threshold. For example, 72% of palliative care patients had held discussions around Advanced Care Planning in the last 12 months. The Dudley CCG threshold was 3-46%.

Families, children and young people:

- Childhood immunisation uptake rates were in line with the target percentage of 95% or above.
- The practice had arrangements for following up failed attendance at children's appointments following an appointment in secondary care or for immunisation. Health visitors were informed of children missing immunisation appointments.
- The practice worked collaboratively with midwives, health visitors and school nurses.
- Children and young people were treated in an age appropriate way.

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

- The practice's uptake for cervical screening was below the 80% coverage target for the national screening programme. However, the practice demonstrated a proactive approach to increasing the uptake rate through opportunistically providing education to patients on the importance of screening. For example, the practice had included an enquiry on breast screening status in the in-house template used at a hormone replacement therapy (HRT) review. A review of performance for the last 12 months (November 2017 to March 2018) highlighted that uptake rates had improved to 83%.
- The practice's uptake for breast and bowel cancer screening was comparable with the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome

of health assessments and checks where abnormalities or risk factors were identified. The practice had achieved a 129% increase in the uptake of the NHS Health Check in the last 12 months.

- A high percentage (96%) of patients who had been classified as obese had been offered a referral to a weight management service within the last 12 months.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, carers and those with a learning disability. These patients were discussed with other healthcare professionals at monthly meetings.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice offered annual health checks to patients with a learning disability and had completed 94% of patients on the learning disability register in the last 12 months.
- The practice used easy read leaflets to support patients with a learning disability to understand their care and treatment.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- When patients were assessed to be at risk of dementia the practice had arrangements in place to review them and clinicians were alerted through an alert on the clinical system.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice's performance on quality indicators for people experiencing poor mental health demonstrated that there was an effective recall system for carrying out annual reviews.

Are services effective?

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and reviewed the effectiveness and appropriateness of the care provided. The practice used the information collected for the Dudley GP Outcomes Framework (GPOF) and performance against national screening programmes to monitor outcomes for patients. Dudley is one of 29 vanguard sites in England selected to test a new model of care based on the NHS 'Five Year Forward View'. The outcome framework is different from the national Quality Outcomes Framework (QOF). GPOF and QOF are systems intended to improve the quality of general practice and reward good practice.

- The practice's overall GPOF data was comparable with other Dudley practices.
- The practice had not exception reported any patients.

The practice used information about patients' outcomes to make changes to patient care and treatment internally and externally to the practice. For example, the practice hosted a children's mental health clinic where children were assessed by a specialist outreach worker.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long-term conditions, older people and patients with poor mental health.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals and revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment. For example, palliative care and patients with multiple conditions.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long-term conditions. They shared information with, and liaised, with community services, social services and carers for housebound patients. They shared information with health visitors for children who had relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. Reception staff were trained in care navigation to assist the flow of information received after patients were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which considered the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

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

- The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through referrals to lifestyle programmes and smoking cessation services.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity, the childhood immunisation schedule and bowel cancer awareness.

Are services effective?

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.

- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the evidence tables for further information.

Are services caring?

We rated the practice as good for caring.

At our November 2017 inspection we rated the practice as requires improvement for providing caring services. This was because the patient feedback scores in relation to their involvement in planning and making decisions about their care and treatment were below local and national averages. At this inspection we found that improvements had been made.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients about the way staff treated people had improved since the last inspection but some scores continued to be below both local and national averages.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice's GP patient survey results were in line with local and national averages for questions relating to kindness, respect and compassion.
- A Christmas Party was being organised for December 2018 for patients aged 70 years and over to offer support for those who may be experiencing social isolation or would benefit from some peer support. The practice planned to expand this to include carers, dementia, young persons (a board was being collated to support those patients about to turn 16).

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids with pictorial guidance and easy read materials were available for patients with a learning disability.
- Staff helped patients and their carers find further information and access community and advocacy services, for example the carer's hub. There was a dedicated noticeboard in the patient waiting area.
- The practice proactively identified carers at new patient registration health assessments, NHS checks and long-term condition health reviews.
- The practice's GP patient survey results were in line with the local and national averages for questions relating to involvement in decisions about care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues or appeared distressed, reception staff offered them a private room to discuss their needs. A confidentiality room was available when required and the reception layout helped maintain a patient's confidentiality.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the evidence tables for further information.

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as good for providing responsive services.

At our November 2017 inspection, we rated the practice as requires improvement for providing responsive services. This was because the patient feedback scores in relation to access to care and treatment were below local and national averages. At this inspection we found that improvements had been made.

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered. All rooms were on the ground floor and a ramp was provided at the main entrance for those unable to use the steps.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice. For example, information was available on support groups for eating disorders, alcohol and substance misuse and talking therapies.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services. Minutes of meetings we reviewed supported this.

Older people:

- All patients had a named GP.
- The practice had regular meetings with local support workers and care co-ordinators to review packages of care for elderly patients. For example, following a discharge from hospital.
- Patients aged 75 and over were normally offered same day appointments, or referred to the duty doctor if no appointment was available. Longer appointments and home visits were made available to housebound patients and those too ill to attend the practice.

People with long-term conditions:

- Patients with a long-term condition received an annual health review with the practice nurse to check their health needs were being appropriately met. Patients received annual medication reviews with GPs either at the request of the practice nurse, opportunistically or in response to blood monitoring.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- New patients were offered a new patient health check. Patients identified as having a long-term condition were followed up appropriately.

Families, children and young people:

- We found 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.
- There was a system in place to follow up children that failed to attend for immunisations.
- All parents or guardians calling with concerns about a child under the age of five were offered a same day appointment or referred to the duty doctor.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, telephone consultations and online facilities to book appointments and request repeat prescriptions.
- The uptake rate for cervical screening had improved following a practice wide focus on educating and encouraging patients to increase the uptake of cervical screening.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including housebound, children and vulnerable adults safeguarding and those with a learning disability.
- A major alert was placed on the clinical system to highlight vulnerable patients to all staff.

Are services responsive to people's needs?

- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice held a register of patients with dementia or patients experiencing poor mental health.
- The practice signposted patients experiencing poor mental health to support services such as MIND.

Timely access to care and treatment

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients feedback from the GP patient survey highlighted that telephone access to appointments was above local

and national averages. However, the results were below local and national averages for questions relating to access to appointments. Following the inspection, the practice submitted evidence of a leaflet that had been produced to explain the appointment system to patients.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available in the reception area and on the practice's website. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns, complaints and also from analysis of trends. It acted as a result to improve the quality of care.

Please refer to the evidence tables for further information.

Are services well-led?

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They had effectively navigated the practice through a period of change.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. For example, the GPs and nurses were allocated a 'study budget' and given protected study time to attend local education sessions held every six weeks.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social care priorities across the region. The practice planned its services to meet the diverse needs of the practice population.

Culture

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

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.

- Staff we spoke with told us they were able to raise concerns and were encouraged to do so either directly with the management, through appraisal or at staff meetings. They had confidence that these would be addressed.
- All staff had received annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- The practice actively promoted equality and diversity. All staff had received equality and diversity training and used this training to support patients from different countries and cultures. Staff felt they were treated equally.
- There were positive relationships between the staff and the management team.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management joint working arrangements promoted coordinated person-centred care.
- Staff were clear on their roles and accountabilities including safeguarding and infection prevention and control.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear processes for managing risks, issues and performance.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints. Learning from these was shared with staff at staff meetings.
- Clinical audits on the quality of care and outcomes for patients had been completed and seen to drive quality improvement.
- The practice had plans in place and had trained staff for major incidents.

Are services well-led?

- The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients. Patient views were captured through the friends and family test where each patient with a known mobile phone number was sent a text message after each consultation to request feedback.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses. For example, uptake of cervical screening had increased in the last 12 months following a practice wide focus to encourage and educate eligible patients.
- The practice used information technology systems to monitor and improve the quality of care.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Leaflets were available at the reception desk informing patients how their data was used.

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients' staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was an active patient participation group (PPG).
- The practice worked closely with the locality and Dudley Clinical Commissioning Group (CCG).
- The service was transparent, collaborative and open with stakeholders about performance.
- The practice reviewed the results from the friend and family test and from the patient satisfaction survey and acted on issues identified.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the evidence tables for further information.