Dr Lakshmanan Sumathy Nambisan

Quality Report

The Surgery
1 Chapel Street
Pelsall
Walsall
West Midlands
WS3 4LN
Tel: 01922 685858
Website: www.walsallgp.co.uk/chapelstreet

Date of inspection visit: 2 October 2014
Date of publication: 22/01/2015

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 undertook a comprehensive inspection of Dr Lakshmanan Sumathy Nambisan's practice on 2 October 2014. The practice is a single handed GP practice which provides primary medical services for a population of approximately 2,600 patients in Pelsall, Walsall. Our overall rating for the practice was good.

Our key findings were as follows:

- The practice was accessible to patients. Patients were able to make appointments easily and if their needs were urgent they would be seen the same day. The premises was accessible to patients with mobility difficulties. Facilities such as the hearing loop system, online appointments and extended opening hours helped ensure patients could get the care and treatment they needed.
- The practice had systems in place to ensure patients who used the service remained safe. Incidents were recorded and discussed with staff to ensure learning took place. Staff were aware of safeguarding procedures, in relation to children and vulnerable adults, so that they could take appropriate action if they were concerned someone may be at risk of harm. Medicines and vaccines held on the premises were appropriately managed to ensure they were safe to use.
- The premises were clean and tidy and records were kept to ensure standards were maintained. Some areas had recently been refurbished and provided an environment which could be easily cleaned helping to minimise the risk of cross infection.
- Patients consistently told us that they were cared for by kind and caring staff who went out of their way to help them.
- Patients were communicated with in a way they could understand so that they could make choices about their own healthcare.

However, there were areas of practice where the provider should make improvements.

- The practice should maintain robust and accurate records of imunisation status for staff, so that it is clear when boosters are required.
- Emergency equipment should be stored securely where it can be accessed without the risk of delay in administering life saving treatment.

Summary of findings

- The practice should improve systems for communicating requests between team members so that there is a clear audit to show that actions required have been completed.
- The practice should continue to develop its patient participation group by focussing on the membership and clarify the remit of the group to ensure the patient voice is heard in decisions about the service.

The practice should improve recording and minuting of meetings where action has been taken to address risks and issues relating to the practice.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated with staff to support improvement, however there was room for improvement in the recording of meetings in which safety issues were discussed. Information about safety was recorded, monitored, reviewed and addressed appropriately. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. Data available showed that the practice was performing line or better than other practices in the CCG locality. People's needs are assessed and care is planned and delivered in line with best practice. This includes assessment of capacity and the promotion of good health. Staff have received training appropriate to their roles and further training needs have been identified and planned. The practice could identify all appraisals and personal development opportunities for all staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice in line with and higher than other practices for almost all aspects of care. Feedback from patients about their care and treatment was consistently positive. We observed a patient centred culture and found robust evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how people's choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice was aware of the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) who commission health services to secure service improvements where these were identified. Patients reported good access to the practice and a named GP provided continuity of care, with urgent appointments available on the same day. The practice had good

Summary of findings

facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system and systems to share learning from them although no complaints had been recently raised.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was visible leadership and staff felt supported by management. The practice has a number of policies and procedures to govern activity and regular governance meetings took place, although recording of issues discussed could be improved . There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice was looking to strengthen its engagement with patients through the patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

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 latest nationally reported data available to us showed outcomes for conditions commonly found amongst older people were consistent with other practices. The practice offered proactive, personalised care to meet the needs of older people in its population. We saw care plans in place for older people with complex care needs. The practice participated in in the unplanned admissions enhanced service, a scheme to avoid unplanned hospital admissions to hospital by focusing and coordinating care for the most vulnerable patients. The aim is to effectively support them in their home. An enhanced service is a service that is provided above the standard general medical service contract.

The needs of carers was recognised. We received 76 comment cards, five told us that they were carers for older relatives and that they were well supported. One patient described the support they had received as exceptional. The practice participated in multi-disciplinary working to ensure patients with complex needs or nearing the end of life received the support they needed.

All staff had received training in safeguarding vulnerable adults and had contact information should they suspect someone may be at risk of harm.

The practice had an older than the national average practice population and provided services that were focussed towards this population group. For example there was relevant health and support information available to older people. A hearing loop had been installed into the practice. Older patients who needed an appointment would be seen the same day and if needed longer appointments would be given. Home visits and telephone consultations were also available for those who found it difficult to attend the practice.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. The practice had a range of protocols in place which set out the processes for the management of patients with various long term conditions in line with best practice. Patients with long term conditions received regular reviews to check their health and medication needs from trained clinical staff that maintained their skills and knowledge in these areas. Patients we spoke with confirmed they underwent regular review of their health

condition. The practice had identified patients and developed care plans for those with the most complex needs as part of the unplanned admissions enhanced service and worked with relevant health care professionals to deliver a multidisciplinary package of care within the patients home. An enhanced service is a service that is provided above the standard general medical service contract.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. All staff had received training in safeguarding children so that they had the knowledge and understanding to act if they were concerned a child may be at risk of harm. There were good working relationships with the health visitor for sharing information for example information sharing about looked after children or where children were not attending immunisation appointments. Immunisation rates were high for all standard childhood immunisations and in most cases met the 100% mark.

Appointments were available outside of school hours and the premises was suitable for children and babies. Well baby clinics and child health checks were carried out at the practice.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the 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 offer continuity of care. The practice offered extended opening hours until 7pm on Mondays and telephone consultations for people who were not easily able to attend during usual working hours. Patients could make appointments and request prescriptions at their convenience. Students also registered at another practice were able to access healthcare as a temporary resident.

The practice offered health checks for the over 40 to 74 year age group and other screening services such a cervical screening to help detect early signs of disease. There was a range of health information and promotion of health screening checks which reflected the needs for this age group. Patients that needed support to live healthier lifestyles were referred to appropriate services available outside the practice.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice was able to identify patients living in vulnerable circumstances through an alert system on patient records and we saw examples of these in use. There was a register for patients with learning difficulties and these showed the majority had received an annual health check in the last 12 months. The practice was able to provide examples of how it identified and acted to ensure vulnerable patients and their carers received support they needed. Longer appointments could be made for patients and their carers that needed them. Staff told us that they did not have any patients with no fixed abode but had registered travellers as temporary residents so that they could be seen.

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 and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice maintained a register for people experiencing poor mental health. Patients on this register were offered annual physical health checks. Patients with long term conditions were screened for depression as a potential impact of their condition. There were systems in place to ensure safe prescribing of antidepressants. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia.

The practice had in place dementia protocol which they used to ensure patients with dementia received appropriate support. We spoke with one patient who had recently been diagnosed with dementia. They told us that they had every confidence in the GP to provide the support they needed.

Summary of findings

What people who use the service say

We spoke with seven patients who were registered at practice either in person or by telephone; this included a member of the practice's Patient Participation Group (PPG). The PPG is a way in which patients and practices can work together to improve the quality of the service provided. We also reviewed the 76 comment cards provided by CQC which had been completed by patients who had recently used the service.

The feedback and comments we received about the practice was overwhelmingly positive. Patients spoke very highly of the GP, clinical and reception staff. They described staff as caring and friendly and gave examples where they felt staff had gone that extra mile. Patients told us that they felt listened to and were treated with dignity and respect and they did not have any difficulties making appointments.

We also looked at feedback from patients and others about this practice. This included feedback recorded on the NHS Choices website and patient surveys carried out by the practice in 2013 and 2014 on 64 and 67 patients respectively. The feedback received indicated that patients were very satisfied with the service they received.

Areas for improvement

Action the service SHOULD take to improve

- The practice should maintain robust and accurate records of the immunisation status for staff, so that it is clear when boosters are required.
- The practice should store emergency equipment should be in a place that is secure and accessible to staff when needed without the risk of potential delays in administering life saving treatment.
- The practice should improve systems for communicating requests between team members so that there is a clear audit to show that actions required have been completed.
- The practice should continue to develop the PPG by focussing on the membership and clarify the remit of the group to ensure the patient voice is heard in decisions about the service.
- The practice should improve recording of meetings where action has been taken to address risks and issues relating to the practice. This would ensure minutes could be referred to by staff not in attendance and provide a clear description of the issues discussed.

Dr Lakshmanan Sumathy Nambisan

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and included a GP and a second CQC inspector.

Background to Dr Lakshmanan Sumathy Nambisan

Dr Lakshmanan Sumathy Nambisan is a sole provider.

The practice is based in Pelsall, Walsall with a list size of approximately 2,600. The population covered is predominantly white British and older than the practice average across England. The practice is open Monday to Friday with the exception of Wednesday afternoon.

At the time of our inspection there were two GPs working at the practice, both were female. This included Dr Nambisan and a locum GP who covered one morning each week. The practice also employed an Advanced Nurse Practitioner and practice nurse, a practice manager and four reception staff.

The practice has opted out of providing out-of-hours primary medical services to another provider.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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 are provided for specific groups of people and what good care looks 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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Detailed findings

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 2 October 2014. During our visit we spoke with a range of staff including a GP, practice manager, practice nurse, two reception staff and spoke with patients who used the service. We also looked at a range of documents that were made available to us relating to the delivery of the service.

We spoke with patients who visited the practice and observed how staff interacted with them. We reviewed comment cards where patient and members of the public shared their views and experiences of the practice. We spoke with a member of the Patient Participation Group (PPG). The PPG is a way in which patients and the practice can work together to improve the service. We also spoke with four health care professionals who work with the practice to provide care and support to patients.

Are services safe?

Our findings

Safe Track Record

Information available about this practice showed a safe track record. Feedback from patients, staff and health care professionals did not raise any concerns about safety. The practice had received no complaints in the last 12 months. Staff told us that they were encouraged to report incidents and 17 incidents were recorded in the last 12 months which demonstrated an openness to report incidents when they occurred. Many of the incidents related to the administrative errors which had occurred by services outside the practice but had been noticed by the staff. Staff advised us that performance related issues were discussed at staff meetings and other informal meetings. However these were not always well documented to show a clear picture of the practice's overall performance.

Learning and improvement from safety incidents

The Practice has a system in place for reporting, recording and monitoring significant events. Staff told us that they were encouraged to report incidents and near misses. We looked at the reports of the 17 significant events that had occurred within the last 12 months. These detailed how the incidents were investigated and acted upon, including any action which could be taken to minimise the risk and prevent further reoccurrence. Staff told us that learning identified from incidents was discussed at the staff meetings.They described action taken following one incident in which staff had not been well prepared when the fire alarm had gone off.

The practice had systems in place for responding to and acting on national patient safety alerts received. Patient safety alerts raise awareness among health care professionals of potential patient safety issues such as those relating to medicines or equipment. Safety alerts were signed by clinical staff to say they had been read and a log was kept of any action taken as a result of them. For example we saw that there was an issue with instructions for a piece of equipment. The practice sent out revised instructions to patients who had this equipment.

Reliable safety systems and processes including safeguarding

The practice had arrangements in place to protect patients from the risk of abuse. We saw evidence that staff had received training in safeguarding children and vulnerable adults and that the training was up to date. Clinical staff were trained to a level 3 (the highest level) for safeguarding children. The practice had a named lead for safeguarding and up to date safeguarding polices for children and vulnerable adults. This ensured staff had the support they needed should they suspect a patient may be at risk of harm. Contact information for the local safeguarding authority, which investigates and acts on safeguarding concerns, was displayed throughout the practice including patient areas.

We asked members of staff about patients at the practice who may be at risk of abuse and how staff were alerted to them. We saw that there were systems to alert staff if a child was on a child protection plan or adults at risk of domestic abuse enabling them to be more vigilant to any issues arising. Staff advised us that they had not made any recent referrals to the local safeguarding authority. We spoke with the health visitor who described a good working relationship and information sharing with the practice to ensure children who may be at risk were supported.

The practice had a range of policies and procedures in place to help keep people safe. These were well organised and included polices relating to infection control and health and safety. The policies were accessible to staff in the office and kept up to date.

A chaperone policy was in place at the practice to support patients during a medical examination. Chaperone training had been undertaken by the nursing staff and reception staff who understood their responsibilities when acting as a chaperone. Information for patients was displayed in the waiting area to raise awareness of this service should they want to request a chaperone.

Medicines Management

The practice held some medicines on site such as emergency medicines and vaccinations. The practice nurse was responsible for monitoring and maintaining the medicine stock at the practice. We saw that medicines were stored securely and those we checked were all in date. Some medicines and vaccines needed to be stored in the fridge at specific temperatures to maintain their quality and effectiveness. We saw that daily records were kept of

the fridge temperatures which showed that the vaccines had been stored at appropriate temperatures. The practice nurse also undertook checking and replenishing the doctor bag although there were no formal records kept of this.

We spoke with the GP about how prescription pads were managed by the service. Prescription pads are controlled stationary because stolen prescriptions may be used to unlawfully obtain medicines. Staff advised us that these were locked away at night. We saw that logs were kept of prescriptions issued for home visits which had been signed and dated. This enabled the practice to account for prescriptions used and minimise the risk of unauthorised use.

The practice had systems in place for issuing repeat prescriptions. Reception staff told us that the GP identified how many repeat prescriptions could be issued before the patient needed to be seen for a medicines review. When this number was reached a note was placed with the final prescription to remind patients to attend the practice for their review. This helped to ensure the medicines they were taking remained appropriate to their health need. After three recall attempts the GP told us that they would restrict the patients repeat medicines to encourage them to attend. Patients that we spoke with during the inspection who were on long term medication confirmed that they had medication reviews.

We saw that there had been incidents reported in relation to the management of medicines. None of these were a result of errors caused by the practice but highlighted that staff were vigilant of potential problems. For example reception staff had correctly checked with the GP a prescription request received thus avoiding a potential medicine error. We spoke with the CCG Medicines Management Pharmacist who was at the practice at the time of our visit they told us that they did not have any concerns about the management of medicines at the practice.

Cleanliness & Infection Control

The practice nurse was the infection control lead for the practice. We saw from training records that they and the practice manager had received infection control training. This enabled them to provide support and training in relation to infection control for other staff at the practice and to provide input into the infection control procedures.

We saw evidence that infection control audits had been carried out by the CCG. Results from these audits showed that the practice had made improvement as a result of them. The overall score for infection control improved from 71% in 2012 to 99% in 2013.The practice manager had also undertaken an infection control audit within the last 12 months, there were no significant actions raised other than reminders to staff to keep up to date. No infection control related incidents had been reported in the last 12 months.

We found the premises clean and tidy. Some areas of the practice such as the waiting room and nurse's room had recently been refurbished. The infection control policy was kept up to date and available for staff to refer to enabling them to comply with relevant legislation. We saw that there were appropriate arrangements in place for the storage and removal of clinical waste from the premises. Although there were no arrangements for the removal of sanitary products and nappies at the practice, patients were required to take these away with them.

Records were kept of staff immunisation and their Hepatitis B status. We found the Hepatitis B status was missing for one clinical member of staff. The member of staff advised us that this had been done but could not confirm when. Confirmation was forwarded to us following our inspection. We also noticed that some non clinical members of staff had declined their Hepatitis B vaccination. However no risk assessments were in place to assess whether their duties or roles could put them or others at risk so that mitigating action could be taken. Information about staff immunity is important to the practice so that action can be taken to minimise any risks to patients and the members of staff during their work.

A legionella risk assessment had been carried out at the practice to protect patients from the risks of the legionella bacteria in the water systems. We saw that recommendations from the risk assessment had been implemented.

Equipment

We saw that the practice had a service level agreement in place for the maintenance of equipment used at the practice. We saw records to show that equipment had been calibrated and undergone electrical safety testing within the last 12 months. The practice manager advised us that they kept manufacturer's instruction manuals for equipment so that staff could refer to them if needed.

Are services safe?

Staffing & Recruitment

The practice had a low turnover of staff. We were advised that the most recent member of staff had been employed in 2011. We looked at the staff recruitment records for this member of staff and found that there were some gaps in the checks to ascertain whether the new member of staff was suitable for their position. For example there was no evidence of proof of identity being obtained. We saw that the recruitment policy had been revised since this person's employment but the practice had not yet had to implement it as no further staff had been recruited. This detailed a more robust recruitment process if used.

We saw that all of the staff at the practice had undergone disclosure and barring service (DBS) checks to ensure staff were suitable to work with vulnerable people. For relevant staff, checks were also undertaken to ensure that they were registered with their appropriate professional bodies and had professional indemnity.

The practice had arrangements in place for managing expected and unexpected staff absences. We saw from the business continuity plan that there were some restrictions on too many staff taking leave at the same time, this was also included in a job contract we reviewed. The practice manager advised us that unexpected staff absences were covered by existing staff many of who were part time. A locum agency would be used for GP cover if needed and there was a locum information pack available to support them.

Monitoring Safety & Responding to Risk

The practice had arrangements in place to enable staff to respond to a medical emergency. We saw from a sample of records that staff had received training in basic life support so that they would know what to do if a medical emergency arose. Emergency equipment including oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency) and emergency medicines were available and checked regularly to ensure they were present, in date and in good working order. The emergency equipment and medicines were stored in the practice nurse's room. Staff that we spoke with knew where the emergency equipment was kept and were able to access the room to collect it. However, storage of emergency equipment in the practice nurse's room could cause difficulties if the nurse was undertaking a patient consultation, examination or procedure when the emergency equipment was required.

Arrangements to deal with emergencies and major incidents

The practice had in place arrangements to manage situations which could disrupt the smooth running of the service, such as power failure or staffing absences. A business continuity policy was available which provided staff with guidance in the event of an emergency. This included contact telephone numbers for services which may need to be contacted. The members of staff we spoke with were aware of the policy. Staff told us that there had been no recent incidents in which they have had to implement the business continuity plan. However, they told us there had been repeated power failures in the past which they had responded to by ensuring they had a print out of patient appointments the night before to minimise the risk of disruption.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinical staff we interviewed confirmed that they had access to best practice guidance such as those from the National Institute for Health and Care Excellence (NICE). We saw minutes from meetings where new guidance was discussed with clinical staff.

We saw evidence that clinical staff maintained their skills and knowledge through continuing professional development. We saw training records which showed staff had received training in the last 12 months enabling them to keep their skills and knowledge up to date. The GP told us that they were the lead GP for palliative care and that they were a representative on the Local Medical Committee (LMC) which gave them an opportunity to share knowledge and experiences with colleagues at other practices.

We spoke with patients who had been referred to secondary care health services. They told us of their confidence in the GP to make referrals as needed. One patient described a situation in which the GP had saved their life by their prompt action to their health concerns.

Management, monitoring and improving outcomes for people

The practice routinely collects information about patient's care and outcomes. It participates in Quality Outcomes Framework (QOF), an incentive scheme for GP practice We reviewed some of the QOF data and found that the practice's performance was in line with other practices nationally.

The practice showed us four clinical audits that had undertaken in the last 5 years all were completed audits where the practice was able to demonstrate changes resulting since the initial audit. One of the audits related to the appropriateness of referrals for suspected cancer. A re audit showed greater correlation between suspected and confirmed cancer diagnosis from referrals made. This demonstrated a more appropriate use of the two week wait referrals to secondary care. Another audit shown to us related to the treatment of hypertension and showed improvements in prescribing in relation to NICE guidance.

Effective staffing

We saw evidence to confirm that the GP had undertaken annual appraisals and a date had been set for revalidation. This is the mechanism by which doctors demonstrate their fitness to practice. The GP showed us a certificate to show that they had in the past participated in a more in-depth appraisal through a local university.

All other clinical and administrative staff had received appraisals within the last year to discuss their performance and learning needs. Nurses were appraised by the GP who told us that they also aimed to undertake formal supervision sessions every two to three months. Non clinical staff also received annual appraisals from the practice manager.

Staff were encouraged and supported to develop their skills and knowledge. Staff confirmed that they received training opportunities if they wanted them. We saw evidence of training sessions held in-house where staff had discussed policies and procedures, for example, the disposal of confidential waste, safeguarding and whistleblowing. We saw training records which showed that the nurse kept up to date and undertook training in areas that were relevant to their role and duties for example immunisations and cervical screening.

New staff working at the practice were given induction training. We saw evidence from the most recent employee that they were given a five week induction period in which job based competencies had been signed off by the practice manager. We also saw a locum pack available which provided practical information for a locum GP working at the practice at short notice. Information in the pack included contact numbers and information about the IT systems and processes used at the practice.

Working with colleagues and other services

We found the practice worked with other services to meet people's needs and manage complex cases. Patient information such as hospital discharge information and medical test results were received electronically or by post. The GP advised us that they reviewed this information and would inform reception staff as to what action, if any, was needed. However, this was usually done on pieces of paper and did not provide an audit trail to ensure all actions requested by the GP had been completed. We discussed this with the GP at the time of the inspection as there may be a risk that actions may get missed.

Are services effective?

(for example, treatment is effective)

Results from medical tests were reviewed on a daily basis by the practice nurse. Any abnormal results were discussed with the GP with the outcomes of this discussion documented on the patient record. Patients were advised to call in for their results but were contacted if the was a clinical need to do so.

The practice held multi disciplinary team meetings every three months to discuss the needs of complex patients and those with end of life care needs. The meetings were attended by palliative care nurses, community matron, district nurses and others. We saw minutes from the last two meetings which detailed who was discussed and any actions required.

Information Sharing

We spoke with three health care professionals who worked with the practice to deliver shared care to patients. The health professionals we spoke with described good working relationships with the practice. They described how information was shared and told us that they could discuss anything with the GP when needed.

The practice communicated with the out of hours provider to share information about patients who may need to use the service. We saw an example where information had been shared in this way.

Consent to care and treatment

The practice did not undertake any minor surgical procedures at the practice for which formal consent to treatment may be required.

We found that the GP was aware of the Mental Capacity Act 2005 and had information available in their room relating to this. The GP described a situation within the last 12 months in which they undertook a visit in conjunction with a psychiatrist to assess a person's capacity. We spoke with one patient who told us that they had recently been diagnosed with dementia and that their experience so far had been good. They told us that they had confidence in the GP to act in their best interest. We found that other staff at the practice were less aware of this legislation and told us that if there were any concerns about a person's capacity they would refer this to the GP who had received training.

Although we did not see any specific examples, staff demonstrated an understanding of the Gillick competencies for assessing whether children under 16 were mature enough to make decisions without parental consent.

Health Promotion & Prevention

The practice offered all new patients registering with the practice a health check with the practice nurse. The practice also offered NHS Health checks to patients aged 40 to 75 years. Information about this was displayed in the practice. The practice nurse advised us that if they had any concerns about a patient they would refer this to the GP.

Services offered by the practice in relation to disease prevention included cervical screening, flu and travel vaccinations. Information available to us on childhood immunisations showed the practice compared well in comparison to other practices in the CCG area. Uptake of childhood vaccines for eligible children was 100% for all but one vaccine. We also saw that the practice performance for uptake of cervical smears in the last five years was exceeding the 80%target.

The practice supported national screening programmes. The practice was able to demonstrate that 78% of their eligible patients had attended for breast screening, exceeding minimal national standards of 70 per cent.

We saw that there was a range of health promotion information displayed in the waiting area. Including information on healthy eating, flu vaccination and breast feeding. Although the practice did not directly offer smoking cessation or weight management services we saw that they had referred patients on to other providers for this.

The practice had eight patients with a learning disability registered with the practice. We saw from records that the majority of these patients had received a health check within the last 12 months.

Staff told us that they would undertake opportunistic screening when patients came in for appointments and would contact patients who did not attend for their appointment.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, the practice's own in-house annual patient survey 2014 in which 67 patients responded and the NHS Choices website. The evidence from all these sources showed that patients were satisfied with how they were treated and that the practice showed compassion, dignity and respect. For example in the national patient survey the practice performed better than the national average for overall experience and for treating patients with care and concern . There were similar findings with the practice's survey. All patients who responded to the practice's 2014 patient survey were satisfied with the service they received. We also reviewed the feedback from patients on the NHS Choices website. Three reviews had been left, all were positive and rated the practice five out of five stars.

As part of the inspection process patients completed CQC comment cards to provide us with feedback on the practice. We received 76 completed cards, all were positive. Patients told us that they were very happy with the service they received, that staff were friendly, helpful, caring and treated them with respect. We received comments from carers who told us that the staff understood their needs and went out their way to help them. One carer described how the doctor visited their elderly mother at a time of crisis on their day off. Others described situations where appointments for partners were made together to make it easier for them. During our inspection we had patients requesting to speak with us to tell us how satisfied they were with the practice and the confidence that they had in the staff. One patient told us how they believed the GP's actions had saved their life.

We saw that consultations and treatments were carried out in the privacy of the consulting room. We noticed that the doors to the consulting rooms were kept closed during consultations and conversations taking place could not be overheard. Examination couches were positioned behind a curtain or in a separate room within the consulting room. This offered patients some privacy and helped to maintain their dignity during examinations, investigations and treatments.

The reception area was shielded by glass partitions which helped to keep patient's information and telephone conversations private. Although we could overhear some conversations at the reception desk none of what we heard was confidential. We saw that this had been raised through the patient survey. Approximately half of the respondents said they could overhear conversations at reception but none minded. A notice was displayed by reception informing patients that a room was available if they wanted to discuss anything in private. Reception staff told us that there had been situations where they have done this.

We observed staff being polite and helpful to patients. Policies were available to staff in relation to dignity and respect and for ensuring religious beliefs were respected. We received feedback through the comment cards and in person from patients in vulnerable circumstances, such as people with the onset of dementia, people experiencing poor mental health and people with long term conditions. All of the patients were very complimentary about the way they were treated at the practice.

Care planning and involvement in decisions about care and treatment

Information from the national patient survey showed that patients responded positively to questions about their involvement in decisions about their care. The practice performed higher than the national average in this area. Results from the practice's patient survey 2014 were also positive in terms of patients being given enough time during a consultation to discuss their health problems.

All of the patients we spoke with on the day of our inspection were satisfied that they were involved in decisions about their health care and treatment. They also told us that information was given to them in a way in which they could understand to help them make choices about their healthcare. The practice operated the choose and book system for referrals to secondary care so that patients could choose where they received treatment.

Support was provided for patients where needed to help them understand and be involved in their care and treatment. The practice had an audio loop system for those with difficulty hearing. Staff had contact details so that they could access translation services for patients who did not

Are services caring?

have English as a first language. We saw evidence where translation services had been used. Staff told us that they did not need to access this often as most patients at the practice spoke English.

Patient/carer support to cope emotionally with care and treatment

The GP showed us protocols they used for the management of patients with specific health needs. These helped to ensure a consistent approach to care planning so that patients were offered and received the support and referrals they needed. For example we saw that the protocol for dementia spoke about care plans to address physical, mental health and social needs as well as offering support for their carers. The GP at the practice was also the lead GP for end of life care in Walsall.

We spoke with patients and carers who had been through difficult times. They told us about the compassion shown to them by practice staff. Two patients we received feedback from told us how the doctor had visited them on their day off and on a bank holiday. We found information displayed in the practice signposting patients and carers to support services such as bereavement counselling and for people who were lonely.

The GP told us how they supported patients who had suffered bereavement. These patients received follow up support and were offered counselling. There was also information about bereavement services available on the practice website. We spoke with one patient who had been bereaved and they spoke positively about the support they were given by the practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the practice population were understood by staff and systems were in place to address those identified needs. The GP attended meetings with the local commissioning group to discuss the needs of the local population. We received positive feedback from the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) about the performance of the practice in meeting the needs of its patients. Feedback received from patients indicated that the practice was meeting their individual needs.

The practice was aware that it had a higher proportion of elderly patients and presence of long term conditions. To support patients with long term conditions there were a range of protocols in place for staff to follow so that these patient received appropriate care. The range of information displayed in the practice reflected the population served. An audio loop had been installed and we spoke with patients who benefited from it. The GP was also the lead for end of life care.

Patients at the practice received good continuation of care from staff that knew them. The majority of staff had worked at the practice for a number of years and the GP was well established in the local area. There was only a choice of female doctors and nurses at the practice but none of the feedback from patients seen had raised this as a concern.

The service provided was flexible to the needs of patients. Patients we spoke with told us that they were able to get appointments when they needed them. The practice offered telephone triage for urgent appointments but staff told us that it was rarely used as patients could usually get appointments the same day if needed. We saw staff helpfully arranging appointments together for couples who both needed to be seen.

Tackling inequity and promoting equality

The practice was accessible to patients with physical or mobility difficulties. The practice had two designated disabled parking spaces. The entrance to the practice was via a ramp and two sets of doors. Only the first set of entrance doors were automatic. We noticed that there was a bell for patients who needed assistance to enter through the second set of doors but when we tested this we found it was not working. Staff told us that patients knew to tap on the office window, which was next to the entrance, if they wanted assistance. Consulting rooms were situated on the ground floor and disabled toilet facilities were available for people with mobility issues. We noticed that the reception desk was too high for patients who used wheelchairs. Staff told us that they would leave the reception to speak with the patients who could not reach the desk.

We spoke with staff about how they supported people in vulnerable circumstances to obtain the health support they might need. We saw that the practice provided annual health reviews for people with learning difficulties During 2013/2014 five out of the six patients with learning disabilities received their annual review. Although staff could not identify any examples where a homeless person had tried to access the service they told us that they would not turn anyone away. One member of staff explained how they had registered travellers from a fair as temporary residents so they could be seen.

Access to the service

Feedback from patient surveys and comments received during the inspection showed that patients were generally happy with the appointment system. Patients were able to access health care when they needed to. Staff told us that as it was a small practice they usually managed to make appointments for patients the same or next day and children or older people would be seen the same day.

The practice offered extended working hours on a Monday until 7pm for people with working or other commitments during the day. Telephone consultations and home visits were also available for patients who were unable to attend the practice for their appointment and we saw examples of these. Students who were away from their usual doctor were also able to be seen as a temporary resident.

Information about practice opening and clinic times, making an appointment and how to access out of hours healthcare services when the practice was closed was available in the practice leaflet and on the practice website. Patients were able to make appointments by telephone, in person or online whichever was most convenient to them.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. This was in line with recognised guidance and contractual obligations for GPs in England. There was a

Are services responsive to people's needs?

(for example, to feedback?)

designated responsible person who handled all complaints at the practice. We saw that the complaints process had been discussed with staff at a recent meeting to ensure all staff were aware of it. A complaints and comments form was on display for patients to take away which explained the process for making a complaint. This included details of external organisations the patient could contact if they were not satisfied with the way in which the practice managed their complaint. We also saw information available about the NHS complaints advocacy service which provides support to patients who wish to make a complaint.

The practice told us that they had not received any formal complaints in the last 12 months and none of the patients we spoke with raised any concerns about the practice to us. We asked if there were any processes in place for recording informal or verbal complaints, staff told us there were none but gave an example where immediate action had been taken in response to concerns raised about the leaves in the car park making the path slippery.

Are services well-led?

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

Our findings

Vision and Strategy

The GP was clear about the values and vision for the practice. They wanted to ensure that the practice provided patient centred, personalised care. These values were implicit in what we saw during our visit and from the feedback we received from patients and staff. There was awareness that the practice was small and that to develop a broader range of services they may need to work with other practices. The GP told us that they were currently in discussions with four practices to build a GP federation in which they would be able to offer a greater range of services. However, this was still in its early stages and there were no formally recorded plans available for this.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity at the practice. These could be accessed by staff on the computer or in a paper file. Reception staff showed us their staff manual which contained various operating procedures they could refer to when needed. We saw from the minutes of meetings that the practice held regular training session in which policies and procedures were discussed to refresh staff knowledge.

Staff meetings were the main forum through which issues relating to the practice were discussed and disseminated among staff. The meetings were held approximately every three months and all staff (clinical and administrative) were invited to attend. Additional meetings were held if needed for example when preparing the practice for the flu and shingles campaign. We saw from the minutes of four recent staff meetings that they were used to discuss performance issues and disseminate information. However, we did not see that there was any formal agenda in which standing items were discussed each time. The structure of the minutes did not provide an easy source of reference for staff or clearly identify any actions which needed to be followed up.

Risk assessments had been carried out where risks to the practice were identified and action plans produced. The manager showed us the risk assessment folder which included details of a health and safety and fire risk assessment that had been carried out within the last 12 months. We saw that actions had been identified and implemented such as the undertaking of six monthly fire drills and replacement of bins.

Leadership, openness and transparency

The practice was led by a single handed GP who told us that they liked to be kept informed but were happy to delegate. Most of the staff had worked together for a number of years. They told us that they were clear about their roles and responsibilities but knew who to go to for support and leadership. Staff that we spoke with told us that they felt valued and supported in their work. Staff spoken with described an open culture and found senior staff approachable if they needed to raise any issues.

Staff were aware that the practice had a whistleblowing policy should they need to raise concerns about the practice, this had been discussed with them at a recent training session. Whistleblowing is the process by which staff can raise concerns they may have about the practice and the conduct of other members of staff. This enables concerns raised to be investigated and acted on to help safeguard patients from potentially unsafe or inappropriate care.

Practice seeks and acts on feedback from users, public and staff

The practice had a Patient Participation Group (PPG) but were aware that the PPG needed to be strengthened. The PPG is a way in which patients and GP practices can work together to improve the quality of the service provided. The PPG had approximately 7 members but the last meeting was cancelled due to lack of interest. There had been some recent discussion with the PPG chair to look at implementing a virtual patient group that could feedback their views or comments by email. This has yet to be implemented.

In addition to the PPG the practice gained feedback from patients through national and in-house patient surveys, there was also a comment box in the waiting area for patients to use. The results of the latest survey was displayed the waiting area. Feedback from the surveys was generally very positive. We saw that the results from the latest in house survey had been discussed at a Patient Participation Group (PPG) meeting. Although there were no major concerns raised through the survey the practice agreed to trial a system in which two appointment slots

Are services well-led?

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

were blocked to allow the GP to catch up if appointments were running late. This was based on the comment from one person about waiting too long. Reception staff confirmed this was still in place.

Members of staff that we spoke with told us that they had opportunities to feedback their views on an individual basis or through staff meetings. One member of staff told us how they had asked for training with new computer templates and that this was given.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We saw evidence from training records that staff were able to maintain their skills and knowledge. New staff received induction training and regular training sessions were held in house which enabled knowledge and information to be shared. The GP told us that they gained support through peers on the Local Medical Council (LMC) group where they were a representative. The LMC is a professional organisation which represents GP interests. We saw from staff files that they received regular appraisals where personal development was discussed.

The practice had completed reviews of significant events and other incidents which were shared with staff at staff meetings. Actions taken by staff had helped improve outcomes for patients for example the identification of prescription queries being raised with appropriate staff.