Rushall Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Rushall Medical Centre on 8 November 2016. Overall the practice is rated as good.

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

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

We saw one area of outstanding practice:

Summary of findings

- We saw that all incidents and complaints were RAG rated (Red, Amber, Green) in order to monitor the level of risk. A log of all incidents was maintained, and we saw that 17 had been recorded since January 2016. All incidents and complaints were categorised, for example, clinical, medication, administration and communication. The practice carried out a thorough analysis of the significant events in order to identify trends and areas for further learning. The practice told us that all incidents relating to medicines were reported to the Clinical Commissioning Group (CCG) in order to share the learning. The Practice were proactive in identifying areas for further improvement.
- Processes were in place for handling repeat prescriptions which included the review of high risk medicines. High risk medicines and antidepressants were not included in the repeat prescription policy and process. These were available on acute prescription and were only issued following a telephone or face to face consultation with a clinician.

The areas where the provider should make improvement are:

- Increase the number of identified carers. The practice had identified 0.72% patients as carers which was less than 1% of the practice list.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events
- All incidents were reviewed, analysed and lessons learnt were shared internally to make sure action was taken to improve safety in the practice. Where appropriate incidents were shared externally in order to share learning
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. All staff had received the appropriate level of safeguarding training for their role.
- The practice regularly reviewed and monitored the safety of prescribing and medicines to ensure safe practice.
- Risks to patients were assessed and well managed. Regular fire drills were carried out.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- The practice made use of the patient record system to ensure effective needs assessments were in place.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- There was a schedule of audits which demonstrated quality improvement was consistently reviewed.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

- Data from the national GP patient survey showed patients rated the practice in line with others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice ran a number of services in addition to its General Medical Services Contract which included anticoagulation clinics which had 403 patients receiving the services, substance misuse services which included an alcohol adviser seeing patients from the practice and spirometry services.
- The practice had independently employed a full time clinical pharmacist who developed person centred integrated pharmaceutical care plans for individual patients, managed patients and older patients with more complex long term conditions such as hypertension and ensured compliance with lipid-lowering therapy.
- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- The practice told us that they had a register of approximately 200 patients who routinely required a home visit. We saw that in excess of 20 home visits were completed daily.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

Summary of findings

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included effective arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty.
- The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

- The practice had a higher percentage of patients aged over 75 than the CCG and national average and offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs. The practice told us that they held a register of approximately 200 patients who routinely required home visits.
- An alert on patient records highlighted elderly patients who were particularly vulnerable.
- The Integrated Care Team (ICT) which included a GP from the practice case managed elderly patients at risk of admissions through weekly meetings and review of care plans.
- The practice had implemented an alert on patient records for patients who were at high risk of falls. Clinicians were prompted to complete a falls risk assessment tool which followed NICE guidance. The practice told us that 107 patients had this alert placed on their medical record.
- The practice supported local care and nursing homes with approximately 100 registered patients. Doctors at the practice attended each care home weekly to provide a ward round, with daily visits as requested. We were told that the clinical pharmacist would visit the homes to review patient's medication following a discharge from hospital when necessary. Where medication had been prescribed outside of the practice the pharmacist would provide the care home with directives to ensure safe dispensing.
- 73% of patients over 65 had received their flu vaccine.

People with long term conditions

Good

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

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- There were alerts for long term conditions on patient records.

Summary of findings

- At 85%, the percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2014 to 31/03/2015) was comparable to the CCG and national averages of 77% and 77%.
- Longer appointments and home visits were available when needed. The practice actively reviewed patients with long term conditions to enable reviews and consultations to be completed during one appointment.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice had implemented an alert on patient records for patients on a specific anticoagulation medicine. Clinicians were prompted to ensure that specific blood tests had been completed prior to issuing prescriptions. This system was audited monthly and the practice were able to confirm that all 150 patients on this medication had been appropriately monitored.
- Patients with chronic obstructive pulmonary disease (COPD) and in receipt of a rescue pack (steroids and antibiotic) were coded in the patient record system. If a patient had experiences exacerbation and requested a replacement pack the code triggered a telephone consultation by the COPD lead nurse to ascertain if further intervention was required. The practice confirmed that 100% of these patients had received either a face to face or telephone consultation.
- The practice had an in house anticoagulation service. 270 Patients regularly used this service. Alerts were placed on patient records to ensure appropriate monitoring took place.

Families, children and young people

Good

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

Summary of findings

- At 81%, the percentage of women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding 5 years (01/04/2014 to 31/03/2015) was comparable to the CCG and national averages of 81% and 81%.
- Appointments were available outside of school hours and the premises were suitable for children and babies. Children and babies were prioritised for same day appointments.
- We saw positive examples of joint working with midwives and health visitors.
- The practice offered an open access family planning clinic with walk in appointments at both sites. Patients requiring contraceptive implants were always accommodated in line with their menstrual cycle regardless if clinics were full.

Working age people (including those recently retired and students)

Good

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- Repeat prescriptions could be requested electronically. The practice told us that 80% of repeat prescriptions were issued via the electronic prescription service (EPS) directly to the pharmacy of the patient's choice.
- Same day appointments were available.
- The practice was open from 7.30am Monday to Friday to accommodate working people.
- Telephone consultations were available where patients could speak to a clinician of choice.
- Online appointment booking and prescription requests was available.

People whose circumstances may make them vulnerable

Good

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

- The practice held a register of patients living in vulnerable circumstances. There was also an alert on the patient records where a patient was identified as vulnerable.

Summary of findings

- The practice provided care and treatment to approximately 40 patients with a learning disability living in a local residential home. Doctors from the practice visited the home weekly to review patients care needs. The practice also offered longer appointments for patients with a learning disability.
- Prescriptions for high risk medicines and antidepressants were only issued with either a telephone or face to face consultation, ensuring appropriate monitoring had been completed.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients. A community psychiatric nurse was based on site and was working with the practice to reduce the number of DNAs of patients in this population group.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

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

- 92% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2014 to 31/03/2015). This was comparable to the CCG average of 91% and the national average of 88%.
- Patients with severe mental health conditions were offered weekly appointments with a named GP and were also referred to the community psychiatrist nurse who held clinics at the practice on a monthly basis.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice were practice in offering dementia screening for appropriate patients attending the flu clinics. The practice told us that 44% of eligible patients had received screening for dementia.
- The practice carried out advance care planning for patients with dementia.

Summary of findings

- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- The practice told us that they held a register of patients with poor mental health; where appropriate they ensured crisis planning was in place and carers details recorded.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 6 January 2016. The results showed the practice was performing in line with local and national averages. Two hundred and sixty nine survey forms were distributed and 118 were returned. This represented 0.84% of the practice's patient list.

- 81% of patients found it easy to get through to this practice by phone compared to the national average of 72%.
- 82% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 84% of patients described the overall experience of this GP practice as good compared to the national average of 75%.
- 75% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 54 comment cards which were all positive about the standard of care received. Patients commented on the kind and caring nature of all staff and stated that they were treated with dignity and respect.

We spoke with 10 patients during the inspection. All 10 patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. In the friends and family test 100% of patients recommended this practice.

Areas for improvement

Action the service SHOULD take to improve

- Increase the number of identified carers. The practice had identified 0.72% patients as carers which was less than 1% of the practice list.

Outstanding practice

- We saw that all incidents and complaints were RAG rated (Red, Amber, Green) in order to monitor the level of risk. A log of all incidents was maintained, and we saw that 17 had been recorded since January 2016. All incidents and complaints were categorised, for example, clinical, medication, administration and communication. The practice carried out a thorough analysis of the significant events in order to identify trends and areas for further learning. The practice told us that all incidents relating to medicines were reported to the Clinical Commissioning Group (CCG) in order to share the learning. The Practice were proactive in identifying areas for further improvement.
- Processes were in place for handling repeat prescriptions which included the review of high risk medicines. High risk medicines and antidepressants were not included in the repeat prescription policy and process. These were available on acute prescription were and were only issued following a telephone or face to face consultation with a clinician.

Rushall Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, a practice manager specialist adviser and an Expert by Experience.

Background to Rushall Medical Centre

The practice is based at 107 Lichfield road, Rushall, Walsall, WS4 1HB. There is a branch site located in Pelsall which has one GP available and this increased to two GPs during busier periods. Patients can request to be seen at either site. The practice is situated in a residential area and car parking was available to the front and rear of the premises. The practice was well served by local buses. Rushall Medical Centre is a modern, purpose built building.

The practice staff includes four GP partners (three female and one male) and three salaried GPs (all female), three locums GPs (two female and one male), a registrar GP (male), a clinical pharmacist one nurse practitioners and five practice nurses (female), three of which were nurse prescribers, two practice managers and five healthcare assistants and 15 reception/administrative staff. The practice was a training practice.

The practice was open from 7.30am to 6.30pm Monday to Friday and until 7pm on Thursdays. Appointments were from 8am to 6.30pm daily. Outside of these hours, cover was provided by the out of hours GP service which operated from 7pm midnight, seven days a week and the NHS 111 service.

Rushall Medical centre is one of a number of GPs covered by Walsall Clinical Commissioning Group (CCG). It has a practice list of around 14081 .The practice's patient population has an above average number of adults aged from 75 to 79 years.

The practice provides the following regulated activities from Rushall Medical Centre, 107 Lichfield road, Rushall, Walsall, WS4 1HB:

- Treatment of disease, disorder or injury;
- Surgical procedures;
- Maternity and midwifery services;
- Family planning;
- Diagnostic and screening procedures

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 8 November 2016. During our visit we:

Detailed findings

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

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

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

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

Good

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We saw that all incidents and complaints were RAG rated (Red, Amber, Green) in order to monitor the level of risk. A log of all incidents was maintained, and we saw that 17 had been recorded since January 2016. All incidents and complaints were categorised, for example, clinical, medication, administration and communication. The practice carried out a thorough analysis of the significant events in order to identify trends and areas for further learning. The practice told us that all incidents relating to medicines were reported to the Clinical Commissioning Group (CCG) in order to share the learning. The practice also shared with us an example of an incident in relation to another care provider. We saw that the incident had been raised with the provider and with the CCG.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, following an incident where a patient's signed controlled drug prescription had not been locked away and left in reception after the reception staff had left the building. The incident was recorded as a near miss although no adverse harm was caused but the opportunity to reflect and change practice was identified by the practice and the incident was discussed at the weekly clinicians meeting as well as the monthly practice meeting. A lockable cabinet was installed for the GP's to use and for all to have an individual key to lock away all prescriptions at the end of the day. There had not been a repetition of such an incident since.

National patient safety alerts were disseminated by email and discussed in clinical meetings and then placed onto the intranet. We saw that the practice had responded to Medicines and Healthcare Products Regulatory Agency (MHRA) alerts to ensure best practice. The practice shared with us a schedule of audits which demonstrated audits completed in response to patient safety alerts. In addition to responding to patient safety alerts received the clinical pharmacist gave us examples of reports made to MHRA in relation to side effects experienced by patients.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. All the GPs also attended in-house safeguarding case protection and child at risk meetings with the Health Visitor. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three
- A notice in the waiting room and consulting rooms advised patients that chaperones were available if required. Information about chaperones was available in the practice leaflet. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Good

Are services safe?

- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. One of the practice nurses was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken. The most recent was in October 2016. We saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. High risk medicines and antidepressants were not included in the repeat prescription policy and process. These were available on acute prescription only which were only produced following a face to face or telephone consultation with a clinician.
- The practice had implemented an alert on patient records for patients on a specific anticoagulation medicine. Clinicians were prompted to ensure that specific blood tests had been completed prior to issuing prescriptions. This system was audited quarterly and the practice were able to confirm that all 150 patients on this medication had been appropriately monitored.
- The practice carried out regular medicines audits and had employed a full time clinical pharmacist working to the principles of the NICE Medicines Optimisation Guidelines with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Three of the practice nurses had also qualified as Independent Prescribers and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role.
- Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Serial numbers were logged in on receipt and out when taken by a GP or nurse. The practice manager checked uncollected prescriptions weekly. Prescriptions which were older than one week were returned to the GP to follow up with the patient.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- Arrangements for management of medicines management in care homes was supported by the clinical pharmacist. They explained that they would support the home with changes to medicines following a hospital discharge and producing directives for medicines prescribed outside of the practice.
- We reviewed six personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had an up to date fire risk assessments which was last completed in October 2016 and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). Legionella testing was completed bi-annually and the recent assessment instructed the practice to record flushing and water temperatures. We saw written evidence to demonstrate that this was checked and recorded.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. Cover for sickness, holidays and busy periods was provided in house. Two locum GPs were currently employed to provide cover.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff had received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. Copies were available on the practice's computer system and in the employee handbook.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.
- Clinical staff attended monthly protected time initiatives funded by the CCG. They also attended locality meetings which were attended by other local practices. Clinical guidelines and protocols were discussed at both of these meetings. All clinicians fed back summaries of learning from all events they attended at weekly clinical and monthly practice meetings
- The practice had implemented an alert on patient records for patients who were at high risk of falls. Clinicians were prompted to complete a falls risk assessment tool which followed NICE guidance. The practice told us that 107 patients had this alert placed on their medical record.
- The clinical pharmacist prescribed medicines for specific clinical conditions and developed integrated pharmaceutical care plans for individual patients. They also managed patients with more complex long term conditions such as hypertension and compliance with lipid-lowering therapy.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 100% of the total number of points available with a 6.3% exception rate. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 1 April 2015 to 31 March 2016 showed:

- Performance for diabetes related indicators was similar to the national average. For example the percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 95% against the national average of 88%.
- The percentage of patients on the register who had had an influenza immunisation in the preceding 1 August to 31 March was 98% against the national average of 94%.
- Performance for mental health related indicators was similar to the national average. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 97% against the national average of 88%.

Patients with chronic obstructive pulmonary disease (COPD) and in receipt of a rescue pack of medicines (steroids and antibiotic) were flagged in the patient record system. If a patient had experienced an exacerbation and requested a replacement pack they were contacted by the COPD lead nurse for a telephone consultation to ascertain if further intervention was required. The practice confirmed that 100% of these patients had received either a face to face or telephone consultation.

There was evidence of quality improvement including clinical audit.

- The practice shared with is a summary of 11 audits undertaken during the last two years, which were completed audits where the improvements made were implemented and monitored. We reviewed two of these audits and saw that they included clear aims and objectives, methodology and criteria together with recommendations and an action plan.
- We saw outcomes and learning from audits such the prescribing of oral diclofenac which was completed as a

result of NICE guidance. The review demonstrated a reduction in prescribing over a two year period and had identified further actions to support improved outcomes for patients.

- The practice had identified the need to audit the repeat prescribing system. This was to support Improved quality of prescribing, improve patient convenience and access to the medicines they needed and improve patient safety. The audit identified the need for further staff training on management of repeat prescriptions in order to prevent and manage the potential of over ordering. An action plan to address this was developed.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services. For example, as a result of a two cycle clinical audit of all new cancer diagnoses, resulted in ensuring palliative care was provided by a named GP and the correct codes were applied for all patients.

Information about patients' outcomes was used to make improvements such as: improved sexual health management for patients was achieved through GPs providing increased sexual health interventions, including coil and implant fittings. For example two female GPs had fitted 58 implant and 41 coils over the last 12 months. This meant more patients could be monitored and supported at the practice rather than at external services.

The Integrated Care Team (ICT) which included a GP from the practice case managed elderly patients at risk of admissions through weekly meetings and review of care plans. If required they visited the integrated care unit more than once weekly.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, the one of the GPs was trained in drug misuse and harm reduction and another GP was trained in female genital mutilation. One of the nurses had been awarded a Primary Care Respiratory Society UK Quality Award 2013 for the management of COPD at the practice. All six nurses had undertaken training in chronic obstructive pulmonary disease (COPD) and dementia training. Nurses also attended regular update training in cervical screening and immunisation. All clinical staff were encouraged to attend local monthly protected education events where they received education and updates from the Clinical Commissioning Group (CCG).
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included on-going support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- All Health care Assistants were provided with a mentor to support them in their role.
- Locum staff were provided with information packs to ensure they were equipped with the knowledge and information about the practice for their role.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

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

Outstanding ☆

Are services effective?

(for example, treatment is effective)

- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. For the last three years the practice had been redirecting administrative and coding work to free up clinical time to concentrate on patient care. All clinical correspondence was received and scanned by an administrator. The practice told us that all letters were passed to GPs for review, with the exception of changes to medication; these were passed to the clinical pharmacist. All correspondence was then passed to a clinical graduate to input relevant information onto the patient record, for example coding patients' diagnosis, blood test results and blood pressure readings. The practice said that this ensured an accurate, timely patient record and freed up clinical time. GPs monitored the system closely by providing regular support and supervision to the clinical pharmacist. The clinical pharmacist would redirect any areas of uncertainty back to the GPs to ensure patients were safeguarded and seen as appropriate.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan on-going care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital.

The practice supported local care, nursing homes and a learning disability home with approximately 140 registered patients. Doctors at the practice attended each home weekly to provide a ward round, with daily visits as requested. We were told that the clinical pharmacist would visit the homes to review patients' medication following a discharge from hospital when necessary. Where medication had been prescribed outside of the practice the pharmacist would provide the care home with guidance to ensure safe dispensing in a timely manner.

Multi-disciplinary team (MDT) meetings took place on a monthly basis where care plans were routinely reviewed and updated for patients with complex needs. Information was routinely shared with the Health visitors and the Integrated Care Teams (ICT).

The practice kept a list of all patients who were at risk of unplanned admissions to hospital. A risk assessment was carried out monthly to identify any new patients to add to the list. These patients were discussed at weekly clinical meetings. All discharges and A&E attendances were reviewed to identify any necessary changes to be made to their care plans. Once the practice became aware of an A&E attendance or discharge, any patients who were on the list were contacted by telephone or seen in person by a GP, practice nurse or the healthcare assistants.

Consent to care and treatment

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

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

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and substance misuse. Patients were seen in specialist clinics run by the practice itself or were signposted to the relevant local service. For example the practice ran anticoagulation clinics. A counselling service also held a clinic at the practice on a monthly basis.
- The practice provided a clinic where a community psychiatric nurse was available to see patients which resulted in 446 referrals being made between November 2015 and April 2016.
- Patients identified as requiring extra support were flagged on the computer system and prioritised for appointments.
- The role of the clinical pharmacist was to offer a holistic approach to the use and understanding of medicines

Outstanding ☆

Are services effective?

(for example, treatment is effective)

which included management of long term conditions and end of life care. Patients were also referred to this service for pain management. Patients could access this service by either face to face or telephone consultations.

The practice's uptake for the cervical screening programme was 81%, which was in line with the CCG average of 81% and the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 73% to 100% and five year olds from 73% to 100% above the CCG and national averages.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. The practice informed us that 18% of the practice list had attended for a health check. An additional 11% had received an over 75 year's health check.

The practice manager kept lists of patients with conditions such as learning disabilities, mental health and long term conditions. This included the dates reviews were due and whether a referral had been made if the patient had failed to attend their review. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 54 patient Care Quality Commission comment cards we received from Rushall Medical Centre and the branch site at Pelsall were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with four members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required. The PPG helped set up social events for practice patients. For example when a long standing GP retired the PPG supported to set up a farewell evening where patients where invited. The PPG also organised flu uptake days, to encourage patients to receive their annual flu vaccination.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice's achievement was in line with CCG and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 89% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 87% and the national average of 88%.
- 89% of patients said the GP gave them enough time in line with the CCG average of 86% and the national average of 86%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 86% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 90% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 90%.
- 86% of patients said they found the receptionists at the practice helpful compared to the CCG average of 87% and the national average of 86%.

Care planning and involvement in decisions about care and treatment

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

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

- 89% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 86%.
- 80% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 81%.
- 90% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

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

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Good

Are services caring?

- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 0.72% patients as carers which was less than 1% of the practice list size. A poster on display in the waiting area advised patients to identify themselves to the practice if they were carers. Patients who were carers were flagged on the practice's computer system and prioritised for appointments where necessary. Written information was available to direct carers to the various avenues of support available to them.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, having recognised the need to increase sexual health advice, the practice had successfully increased its level of sexual health advice and screening and in the last 12 months had fitted 58 implants and 41 coils, reducing the need for patients to attend external services.

The practice ran a number of services in addition to its General Medical Services Contract which included an in house anticoagulation clinic which had 270 patients regularly receiving the service. Alerts were placed on patient records to ensure appropriate monitoring took place. There was also an substance misuse service which included an alcohol adviser seeing patients from the practice and spirometry services.

The practice had independently employed a full time clinical pharmacist who developed person centred integrated pharmaceutical care plans for individual patients, managed patients and older patients with more complex long term conditions such as hypertension and ensured compliance with lipid-lowering therapy. They also offered a holistic approach to the use and understanding of medicines required for patients with long term conditions or end of life. They also facilitated access to medicines, for example managing secondary care referrals.

The clinical pharmacist was also an independent prescriber and prepared prescriptions to avoid GP appointments and conducted regular medicines management audits to facilitate access to medicines. The service improved outcomes for patients as they were offered a holistic approach to assessing their medication needs.

- The practice offered evening appointments until 7pm on Thursday for working patients who could not attend during normal opening hours. This included nurse appointments for vaccinations and cervical screening.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice, which were completed by GPs, practice nurses and the healthcare assistants. The practice told us that they had a register of approximately 200 patients who routinely required a home visit. We saw that in excess of 20 home visits were completed daily.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- Repeat prescriptions could be requested electronically. The practice told us that 80% of repeat prescriptions were issued via the electronic prescription service (EPS) directly to the pharmacy of the patient's choice.
- There were disabled facilities, a hearing loop and translation services available.
- Community services were available on site, for example hearing clinics, ultrasound access and physiotherapy.

A**ccess to the service**

The practice was open from 7.30am and 6.30pm Monday to Friday. Appointments were from 8am to 6.30pm daily. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them. Outside of these hours, cover was provided by the out of hours GP service which operated from 7pm to midnight, seven days a week and the NHS 111 service. Information about out of hours services was available in the practice leaflet and was on display in the reception area.

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

- 84% of patients were satisfied with the practice's opening hours compared to the national average of 79%.
- 81% of patients said they could get through easily to the practice by phone compared to the national average of 72%.

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

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The urgency of the need for medical attention.

Patients who required a home visit were advised to contact the practice. The GP would then contact the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. The practice advised that children should be brought in to the practice as they would be prioritised for appointments rather than waiting for a home visit. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager was the designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. For example, information was available in the practice leaflet which was on display and given to new patients. A comments and complaints box was in reception.

We looked at four complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way and with openness and transparency. Complaints were graded in terms of the level risk. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken as a result to improve the quality of care. For example, in response to a complaints patients were written to with an apology and a description of the action that would be taken. The complaints were discussed at monthly practice meetings.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice's mission statement was compassionate care at their heart of the community.

  Staff knew and understood the practice's values.

- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained. Benchmarking data was presented at team meeting where action plans for further improvement were agreed.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. We saw that there was a schedule of audits which included an analysis, a conclusion and reflection together with recommendations and action plans. We saw that re audit findings were also recorded.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- All clinical correspondence was received and scanned by an administrator. The practice told us that all letters were passed to GPs for review, with the exception of changes to medication; these were passed to the clinical pharmacist. All correspondence was then passed to a graduate to input relevant information onto the patient record, for example coding patient's diagnosis, blood test results and blood pressure readings. The practice said that this ensured an accurate, timely patient record and freed up clinical time.

Leadership and culture

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

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

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

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

- The management team had been developed based on required skills and knowledge. There were two practice managers, one for each site, as well as administration managers. These were newly appointed and incorporated IT skills into the team. The practice had introduced the role of clinical pharmacist whose remit included quality improvement.
- Staff told us the practice held regular team meetings where quality and performance were discussed.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the GPs in the practice. All staff were

Are services well-led?

Good

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

involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, in May 2016 the PPG had raised issued with problems with telephone access where patients were left waiting a long time before their call was answered The practice took note of this and in July 2016 a new telephone system was installed.
- The practice had gathered feedback from staff through staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. Examples included a pilot which focussed on reducing admissions for patients aged over 65 years with long-term conditions, employing a full time clinical pharmacist who had increased GP availability by triaging patients who required medication input instead of requiring an appointment with the GPs, which allowed GPs to see more patients.

The practice was proactive in identifying was to ensure patient safety. We saw that the electronic patient system had been utilised to search for patients meeting certain criteria, following which an alert was placed on the patient record to prompt clinical staff during consultations or medication reviews. For example alerts had been created for all patients identified as being at risk of falls. Additional searches were being developed for patients with diabetes who had a low HBA1C, and for all patients over 75 who had a low blood pressure recorded.

In response to the three year pilot to test the role of clinical pharmacist in general practice the practice had recruited a pharmacist. The pilot was developed by NHS England, Royal Pharmaceutical Society, Health Education England, Royal College of General Practice and British Medical Association. The role incorporated, for example medicines management and quality improvement, with a focus on improved patient safety and outcomes. With the support of the practice the pharmacist had been successful in becoming a mentor for other practice based pharmacists which enabled them to share good practice.

Staff were encouraged to develop their careers and were well supported by the practice management to do so. One of the nurses had recently received an award for their professional achievements in the management of COPD. The recognition was awarded to Rushall Medical Centre as they had met the standards that defined high quality patient centred respiratory care and recognised that Rushall Medical Centre provided a high standard of care for people with respiratory disease. The practice diagnosis rate for COPD was 68%, higher than the national average which was 63% and had 430 patients diagnosed with COPD. The nurse receiving the award provided support, guidance and mentorship to colleagues. The practice demonstrated a proactive approach to COPD care with 100% of patients experiencing exacerbation receiving a nursing consultation.