Thornley Street Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection at Thornley Street Medical Centre on 21 October 2016. Overall the practice is rated as good.

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

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients told us that they were able to get appointments when they needed them, with urgent appointments available the same day.
- There was an effective system in place for reporting and recording significant events.
- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses.
- Information about services and how to complain was available and easy to understand. We saw that all complaints, both written and verbal, were recorded, investigated and responded to. Learning from complaints was shared with staff.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had governance arrangements in place which supported the delivery of the strategy and good quality care.
- The provider was aware of and complied with the requirements of the duty of candour.
- The practice managed most risks well; although further action was needed to demonstrate the action taken to address safety alerts about medicines.

There were areas where the provider should make improvements:

- Introduce a formal recorded system to demonstrate the action taken to address alerts about medicines that may affect patients' safety.
- Improve the uptake of cervical screening.
- Continue to identify carers and establish what support they need.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure appropriate action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, relevant information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- The practice managed most risks well; although further action was needed to demonstrate the action taken to address safety alerts about medicines.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were above average when compared to the England average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- 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.

- Data from the national GP patient survey showed that patient satisfaction with the services they received were mostly similar to the local and national averages.
- 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.

Summary of findings

- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- There were 87 (0.9%) carers on the practice carers register, which represented just below one percent of the practice population. The practice was actively reviewing this.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example the practice worked closely with secondary care professionals on initiatives to improve the care of patients with long term conditions.
- Patients said that they found it easy to get an appointment. Urgent appointments were available the same day.
- The practice had completed audits of appointments and could demonstrate a significant reduction in the number of patients who did not attend an appointment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had ensured its website was totally multi-lingual to support the language needs of its diverse population.
- Information about how to complain was available and easy to understand.

Are services well-led?

Good

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients.
- There was a clear leadership structure and staff felt supported by the management.
- The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- Governance arrangements for most clinical risks were in place with the exception of written records to demonstrate the action taken to address safety alerts about medicines.
- 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 proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.

Summary of findings

- 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.

- There were fewer patients in this population group than local and national averages.
- The practice offered personalised care to meet the needs of the older patients in its population.
- Older patients who were housebound were able to request a home visit from a GP.
- Patients aged 75 years plus were offered annual health checks and allocated a named GP.
- Home visits and flexible appointments were available for older patients. Older patients were offered urgent and longer appointments for those with enhanced needs which gave them more time to discuss health issues with a clinician.

People with long term conditions

Good

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

- The GPs, nurses and healthcare assistants had lead roles in chronic disease management.
- The GPs and nurses worked with relevant health care professionals to deliver a multidisciplinary package of care to patients with complex needs.
- Patients with long-term conditions received a health review of their condition at appropriate intervals.
- The practice had provided care plans for 2% of patients at risk of unplanned admission to hospital, many of which had long-term conditions.

Families, children and young people

Good

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

- Immunisation rates were broadly similar to 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

- The practice's uptake for the cervical screening programme was 68% which was lower than the local Clinical Commissioning Group (CCG) average of 78% and England average of 82%. The practice had plans in place to address this.
- Children of all ages and children aged under the age of five were given priority and seen on the day. Appointments were available outside of school hours and urgent appointments were available for children.
- There was a small area of the waiting area with child friendly toys designated for children
- We saw positive examples of joint working with other professionals.

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 practice maintained a register of 1500 students from a local university, which represented 15% of the practice population. This group of patients were from diverse international backgrounds. Some of the students were members of the virtual patient participation group and provided feedback to support the practice in meeting their health needs. Support provided included sexual health education and chlamydia screening.
- The practice was proactive in offering online services which included making online prescription and appointment requests.
- Patients were sent telephone texts to remind them about their appointment and to send test results.
- Patients were signposted to a full range of health promotion and screening that reflects the needs for this age group.

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 population of asylum seekers and new immigrants represented approximately 10% of the practice population. The patients were mainly young adults and more men than women. The practice worked closely with the local migrant and refuge centre to support the care of these patients.

Summary of findings

- The practice offered patients whose first language was not English the use of interpreters daily. A weekly clinic supported by a Kurdish interpreter was carried out to support patients from a Kurdish background.
- The practice had a register of 66 patients with a learning disability and 87% had received an annual health assessment. The remaining patients had declined a health review.
- The practice had a register of patients receiving palliative care and had reviewed their care needs and updated their care plans.
- The practice had told vulnerable patients about how to access various support groups and voluntary organisations.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.

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).

- 93% of patients with enduring poor mental health had a recent comprehensive care plan in place compared with the clinical commissioning group (CCG) and national averages of 88%.
- 89% of patients with dementia had a face to face review of their condition in the last 12 months compared the CCG average of 82% and national average of 84%.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice worked with multi-disciplinary team in the case management of patients who experienced poor mental health, including those with dementia.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2016 showed the practice was performing similar to the local and national averages in several areas. A total of 372 surveys (3.8% of patient list) were sent out and 81 (21.8%) responses, which is equivalent to 0.8% of the patient list, were returned. Results indicated the practice performance was higher than other practices in some aspects of care. For example:

- 83% of the patients who responded said they were able to get an appointment to see or speak to someone the last time they tried (CCG average 80%, national average 85%).
- 83% of the patients who responded described the overall experience of their GP surgery as fairly good or very good (CCG average 83%, national average 85%).
- 70% of the patients who responded said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 73%, national average 78%).
- 88% of the patients who responded said they found the receptionists at this practice helpful (CCG average 84%, national average 87%).

As part of our inspection we also asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received 20 comment cards, which were mostly positive about the standard of care. Patients said that the staff were supportive, caring, helpful, and friendly and the GPs listened, responded positively to concerns and were thorough. Comments in four of the cards included concerns about getting through to the practice to make an appointment. We spoke with six patients and their comments were also in line with the comment cards responses. Two of these patients were members of the patient participation group (PPG) who described good care and treatment, they felt there was good communication between patients and the staff and they felt listened to.

The practice monitored the results of the friends and family test monthly. The results for the period January to September 2016 showed that 59 responses had been completed and of these, 42 (71%) patients were extremely likely to recommend the practice to friends and family if they needed similar care or treatment and 13 (22%) patients were likely to recommend the practice. The remaining results showed that one (1.7%) patient was neither likely or unlikely to recommend the practice, two (3.4%) patients unlikely to recommend the practice and two (3.4%) patients stated that they did not know if they would recommend the practice. Comments made by patients in the family and friends tests were in line with comments we received.

Areas for improvement

Action the service SHOULD take to improve

- Introduce a formal recorded system to demonstrate the action taken to address alerts about medicines that may affect patients' safety.
- Improve the uptake of cervical screening.
- Continue to identify carers and establish what support they need.

Thornley Street Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Thornley Street Medical Centre

Thornley Street Medical Centre is registered with the Care Quality Commission (CQC) as a partnership. The practice is located very close to the city centre of Wolverhampton and has good transport links for patients travelling by public transport and by car. The practice is made up of six adapted terrace houses and provides services for patients over two floors. There is access for patients who use wheelchairs. There is also a lift for the consulting rooms upstairs if required.

The practice team consists of five GP partners who work a total of 40.5 sessions per week. The GPs are currently supported by three practice nurse and a healthcare assistant. Clinical staff are supported by a practice manager, a deputy practice manager, a bookkeeper, two administration staff and 11 receptionists. There are also two cleaners employed by the practice. In total there are 27 staff employed either full or part time hours to meet the needs of patients. The practice also uses GP locums at times of absence to support the clinicians and meet the needs of patients at the practice. The practice is a teaching practice, teaching undergraduates and GP registrars.

The practice is open between 8am and 6.30pm. Appointments times for patients vary for the GPs and practice nurses and include both morning and afternoon clinic sessions. Appointments with the GPs are available from 8.30am to 12pm and 3pm to 5.50pm. The practice does not provide an out-of-hours service to its patients but has alternative arrangements for patients to be seen when the practice is closed. Patients are directed to the out of hours service Vocare via the NHS 111 service.

The practice has a General Medical Services contract with NHS England to provide medical services to approximately 9,729 patients. It provides Directed Enhanced Services, such as minor surgery, diabetic clinics, childhood immunisations and the care of patients with a learning disability. The practice has a higher proportion of children aged below four years, male and female patients aged 20-34 years and male patients aged 35-44. The practice is located in one of the most deprived areas of Wolverhampton. People living in more deprived areas tend to have a greater need for health services. There is a higher practice value for income deprivation affecting children and older people in comparison to the practice average across England. The level of income deprivation affecting children is 37%, which is higher than the national average of 20%. The level of income deprivation affecting older people is higher than the national average (39% compared to 16%).

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as

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

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 21 October 2016.

During our visit we:

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

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. Staff were instructed to report and record any accidents or near misses. Staff told us they would inform the practice manager of any incidents. An accident book was kept in the practice office and a recording form was 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, relevant information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.

Safety alerts were received by the clinicians, pharmacy advisor and practice manager. There was no defined lead for the management of safety alerts and staff we spoke with could not confirm that all alerts had been acted on. The practice relied on the pharmacy advisor who visited the practice most weeks to process safety alerts. One of the partners told us that alerts were discussed both informally and at practice clinical meetings. It was not clear that there was a formal system in place to demonstrate that all clinicians were made aware of and discussed the alerts. We saw however, examples of alerts and warnings that had been added to the electronic prescribing screen which were related to recent Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts. Information recorded showed that these had been reviewed. The GP was aware of a recent safety alert related to a specific medicine containing components that could be a risk to women of child bearing age. The GP felt that this would have been addressed at patient medicine reviews. The GP was unable to confirm that a systematic and proactive approach had been taken to identify and review patients taking this medicine.

The practice carried out a thorough analysis of the significant events. We reviewed safety records and incident reports and minutes of meetings where these were reported and discussed. The practice electronic file listed events from 2011 to date. Records we looked at showed that 37 significant events, both clinical and operational had occurred over the past 12 months. One of the events showed that three prescriptions for controlled drugs were missing. The prescriptions were found following a thorough investigation and reception staff reviewed the process to determine the possible reason why they went missing. The prescriptions were found with those that were ready for shredding. The procedures were reviewed to ensure that the GPs kept prescriptions that had been or needed to be signed separate from those that were for shredding and secure.

Overview of safety systems and processes

Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and 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. One of the GPs was the lead for safeguarding. Staff we spoke with demonstrated that they understood their responsibilities and told us they had received training relevant to their role. Safeguarding was a set agenda item for discussion at the weekly practice clinical meetings. The practice monitored both adults and children who made regular visits to the accident and emergency department. The practice also routinely reviewed and monitored children who did not attend hospital appointments and immunisation appointments. The practice had updated the records of vulnerable patients to ensure safeguarding records were up to date. Suspected safeguarding concerns were shared with other relevant professionals such as social workers and the local safeguarding team.

Posters advising patients they could access a chaperone were displayed in the waiting room, in the practice information leaflet and on the practice website. This ensured that different patient groups were made aware that this service was available to them. All staff had received chaperone training. Staff files showed that criminal records checks had been carried out through the Disclosure and Barring Service (DBS) for staff who carried out chaperone duties. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The practice had an infection control policy and supporting procedures were available for staff to refer to. One of the practice nurses was the clinical lead for infection control.

Good

Are services safe?

There was a detailed cleaning protocol referencing the safe management of clinical, domestic waste, cleaning of equipment and changing disposable curtains. There were cleaning schedules in place and cleaning records were kept. Treatment and consulting rooms in use had the necessary hand washing facilities and personal protective equipment which included disposable gloves and aprons. Hand gels for patients and staff were available in accessible areas within the practice. Appropriate clinical waste disposal contracts were in place. Clinical staff had received occupational health checks for example, hepatitis B status and appropriate action taken to protect staff from the risk of harm when meeting patients' health needs.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice had effective shared care systems in place to review and monitor patients prescribed high risk medicines. We looked at two high risk medicine registers. There were a total of 23 patients on these registers. A review of seven patients showed that all had had up to date specific tests completed. There was evidence that the GPs had accessed the results of tests carried out at the hospital before issuing a repeat prescription.

The practice carried out regular medicines audits, with the support of the local clinical commissioning group (CCG) pharmacy advisor, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Specific medicine directions (Patient Group Directions for the practice nurses and Patient Specific Directions for the healthcare assistants) were adopted by the practice to allow the practice nurses and healthcare assistants to administer specific medicines in line with legislation.

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 (DBS).

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. Risk assessments specific to the day to day operation of the practice were completed these included for example, managing sharps and the risks related to the looped cords on the blinds at the practice. Other risk assessments in place to monitor the safety of the premises included gas and electric tests, control of substances hazardous to health, infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The practice had up to date fire risk assessments, a notice described the precautions and responsibilities of staff in the event of a fire. The practice 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.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff and staff with appropriate skills were on duty.

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.

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 and copies of the plan were kept off site. Staff had access to protocols on how to manage emergencies for example, if a patient became unconscious or in the event that a patient experienced an anaphylactic shock (an allergic reaction to an antigen to which the body has become hypersensitive).

All staff received annual basic life support training. Emergency medicines were available at the practice, easily accessible to staff and all staff knew of their location. All the medicines we checked were in date and stored securely. The practice had a defibrillator available on the premises and oxygen with adult and children's masks.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed patients' needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. Examples of NICE treatment guidance referred to included diabetes, chronic obstructive pulmonary disease (COPD) the name for a collection of lung diseases and coronary heart disease. The practice used electronic care plan templates to plan and monitor the care of patients with long term conditions. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records. Clinical staff discussed this guidance informally and at practice meetings and could clearly outline the rationale for their approach to treatment.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and reviewed their performance against the national screening programmes to monitor outcomes for patients. The practice achieved 97% of the total number points available for 2014-2015 this was higher than the local Clinical Commissioning Group (CCG) average of 92% and the national average of 95%. The practice clinical exception rate of 13.4% was higher than the CCG average of 7.5% and lower than national average of 9.2%. Clinical exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. Further practice QOF data from 2014-2015 showed:

- The practice held a patient register of 390 patients with diabetes. The percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was higher than the local and national average (94% compared to the local average of 87% and England average of 88%). The practice exception reporting rate of 6.4% showed that it was higher than the local average of 4.8% but lower than the England average of 7.6%.
- The practice held a patient register of 157 patients with COPD. Performance for the percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale (the degree of breathlessness related to five specific activities) in the preceding 12 months was 96%. This was higher than the local CCG average of 91% and England average of 90%. The practice exception reporting rate of 10% showed that it was higher than the local average of 6.8% but lower than the national average of 11.1%.
- The practice held a patient register of 138 patients with mental health illnesses. Performance for mental health related indicators was higher than the local CCG and national averages. For example, the percentage of patients experiencing mental health disorders who had a comprehensive, agreed care plan documented in their records in the preceding 12 months was 93% compared to the local CCG and England average of 88%. The practice clinical exception rate of 3.2% for this clinical area was lower than the local CCG average of 8.7% and England average of 12.6%.
- The practice held a patient register of 65 patients with dementia. The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was higher than the national average (89% compared to the local CCG average of 82% and England average of 84%). The practice clinical exception rate of 3.4% for this clinical area was lower than the local CCG average of 7.7% and the England average of 8.3%.

The practice had performed well overall when compared to the local CCG and England averages. The practice was aware of one area where the ratio of reported versus expected prevalence for Coronary Heart Disease (CHD) was lower (0.45) when compared to other practices in the local CCG of 0.62 and England average of 0.71. Prevalence is the proportion of practice patient population likely to have a condition. The practice looked at the prevalence of long term conditions to ensure they would be appropriately monitored. The practice was aware that the overall clinical exception reporting rate was high 13.4% compared to the local CCG average of 7.5% and England average of 9.2%. To

manage this and keep the exception reporting rates down the practice ensured that an effective call and recall system was in place to ensure that patients who failed to attend appointments were followed up. We saw that the CCG benchmarked the practice against other practices in the locality. The GPs attended peer review meetings. Clinical issues, medicines, treatments and performance were discussed at these meetings.

Clinical audits were carried out to facilitate quality improvement. We saw that eight clinical audits had been carried out over the last 12 to 24 months. One of the audits looked at the number of contraceptive implants removed within a year due to side effects. This was a four cycle audit; the first had been carried out in 2011 and showed that 55% of implants fitted had been removed because of side effects. The second audit showed that the number of patients who had the implant removed due to side effects had decreased to 20% and this decreased further following the third audit to 15%. The most recent audit (2016) showed that of the 40 patients 10 (25%) had been removed due to side effects. This was an increase on the previous two years. The practice planned to make improvements by ensuring that patients received improved and appropriate counselling, education and effective management of any symptoms and patient concerns.

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 topics such as equal opportunities, health and safety, child and adult safeguarding, fire safety and infection control. New staff were issued with an employee handbook and relevant practice specific information such as general information about the practice, managing complaints and fire precautions.

The learning needs of staff were identified through a system of appraisals, meetings and reviews of their individual development needs. All staff had had an appraisal within the last 12 months. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. The practice could demonstrate how they ensured role-specific training and updating for relevant staff was completed. Staff had access to and made use of e-learning modules and in-house and external training opportunities. All staff had completed training that included equality and diversity, chaperoning, safeguarding, mental capacity, fire safety, health and safety and basic life support. The practice nurses and GPs had all completed clinical specific training updates and competency assessments to support annual appraisals and revalidation. Clinical staff had received training to support the review of patients with long-term conditions. Staff administering vaccines and taking samples for the cervical screening programme had received specific training, which had included an assessment of competence.

The practice had been a teaching practice since 1992 for medical students from Birmingham University and GP registrars. There were two dedicated trainers. The GP registrars were issued with a formal programme during the first two weeks of their induction.

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

Coordinating patient care and information sharing

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

This included care and risk assessments, care plans, medical records, clinical investigations and test results. The GP partners did their own letters and reports and there were templates on the electronic system to support this. Letters and test results related to patients were actioned by a GP normally within 24 hours of receipt at the practice. We did not see any outstanding correspondence at the inspection. The practice shared relevant information with other services in a timely way, for example when referring patients to secondary care such as hospital or to the out of hours (OOH) service. A computerised system was in place to share and communicate information to the OOH service. Records showed that the correspondence received from the local hospital and the out of hours service were actioned within 24 hours. We also saw that test results received electronically were actioned on the day of receipt and urgent referrals were tracked to ensure they were acted on in a timely way.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and

Good

Are services effective?

(for example, treatment is effective)

treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Multidisciplinary meetings were held every two weeks to discuss patients on the palliative care register. A formal meeting was also held two to three monthly where all the 26 patients on the palliative care register were discussed. Patients were referred for specialist care when needed. Patients wishes on their place of death where observed and decisions related to resuscitation should their health deteriorate was documented. Families and carers were also involved in discussions. The practice worked closely with other professionals who also carried out clinics at the practice. The practice provided a service to 88 older people living in three local care homes. One of the homes was a care home for patients with dementia. The practice had a register of 65 patients with dementia. Records showed that to date for the 2016/17 performance year, 85% of these patients had received a review of their care and updated care plans were in place. We spoke with the manager of one of the care homes who told us that they were happy with the service they received from the practice. The manager confirmed that weekly ward rounds to review patients' wellbeing had taken place.

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 the auditing of records.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet and smoking. Patients had access to appropriate health assessments and checks. Patients were signposted to relevant health promotion services for example, smoking cessation clinics, dietary advice and health trainers. Health promotion information with details of support services was also available and accessible to patients in the waiting area and on the practice website.

The practice offered travel vaccines, childhood immunisations and influenza vaccinations in line with current national guidance. Data collected by NHS England for 2015/16 showed that the performance for childhood immunisations was similar to the local CCG average. For example, the practice childhood immunisation rates for children:

- under two years of age ranged from 95% to 96%, (CCG average 95% to 97%),
- aged two to five 91% to 96%, (CCG average 93% to 96%)
- aged five year olds from 87% to 94%, (CCG average 89% to 94%)

We saw that the uptake for cervical screening for women between the ages of 25 and 64 years for the 2014/15 was 68% which was significantly lower than the local CCG average of 78% and the England average of 82%. The practice was proactive in following these patients up by telephone and sent reminder letters. The practice had completed audits of their current performance and introduced letters for patients in other languages such as Kurdish and Arabic. Public Health England national data showed that the number of females aged 25-64; attending cervical screening within target period (3.5 or 5.5 year coverage) was also lower than the England average (59% compared to the average across England of 74%). Data for other cancer screening indicators such as bowel cancer was lower than the local CCG. The practice ensured that it encouraged and educated patients to attend health screening appointments.

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. The area around the reception desk was kept clear to promote confidentiality. Patients were encouraged to queue away from the desk and not stand directly behind a patient speaking to reception staff at the desk. If patients wanted to discuss something privately or appeared distressed a private area was available where they could not be overheard.

The 20 Care Quality Commission comment (CQC) cards we received were positive about the service patients experienced. Comment cards highlighted that staff treated patients with respect and responded compassionately when they needed help. Patients we spoke with said they received excellent care and they were happy with the service provided by the practice. These responses aligned with comments in the comment cards.

Results from the national GP patient survey published in July 2016 showed that the patient responses to their satisfaction with consultations with GPs were below average in most areas. The responses for nurses were similar to the local and national averages. For example:

- 86% of patients said the GP was good at listening to them compared to the local clinical commissioning group (CCG) average of 85% and the national average of 89%.
- 76% of patients said the GP gave them enough time compared to the local CCG average of 83% and the national average of 87%.
- 88% of patients said they had confidence and trust in the last GP they saw compared to the local CCG average of 93% and the national average of 95%
- 79% of patients said the last GP they spoke to was good at treating them with care and concern compared to the local CCG average of 81% and the national average of 85%.
- 93% of patients said the nurse was good at listening to them compared to the local CCG and England averages of 91%.
- 92% of patients said the nurse gave them enough time compared to the CCG average of 91% and the national average of 91%.
- 97% of patients said they had confidence and trust in the last nurse they saw compared to the local CCG average of 96% and the national average of 97%.
- 87% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the local CCG average of 88% national average of 91%).

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

- 89% of patients said they found the receptionists at the practice helpful compared to the local CCG average of 84% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey published in July 2016 showed that patient satisfaction was similar to the local CCG and national averages for how GPs and nurses involved them in planning and making decisions about their care and treatment. For example:

- 84% of the patients who responded said the last GP they saw was good at explaining tests and treatments which was similar to the local CCG average of 83% and the national average of 86%.
- 76% of the patients who responded said the last GP they saw was good at involving them in decisions about their care (CCG average 78%, national average 82%).
- 90% of the patients who responded said the last nurse they saw or spoke to was at explaining tests and treatments (CCG average 89%, national average 90%)
- 85% of the patients who responded said the last nurse they saw was good at involving them in decisions about their care (CCG average 84%, national average 85%).

The practice had discussed patients concerns about GP consultations. The practice had reviewed these results through patient surveys and held discussions at staff

Good

Are services caring?

meetings and at PPG meetings. In response to the findings the practice had re-visited customer care training and looked at ways it could further support its diverse patient population.

The practice provided facilities to help patients be involved in decisions about their care. The practice provided patients whose first language was not English with access to translation and interpreter services to help them understand their care and treatment. We saw notices in the reception areas informing patients this service was available. The practice also used the services of the migrant and refugee centre to understand patients' cultures in relation to health and provide support when discussing their health care needs. We saw notices in the reception areas informing patients this service was available. Information leaflets and notices were available in easy read format and in different languages. The practice also provided patients whose first language was Kurdish with access to a specialist Kurdish translator clinic one afternoon per week. The practice had collated information to show that 482 (5%) patients needed the support of an interpreter in the last 12 months. These figures identified the number of patients and not how many times the patients had used an interpreter at health consultations.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and a carer's pack were available for carers in the patient waiting area which told patients how to access a number of support groups and organisations. There were 87 (0.9%) carers on the practice carers register, which represented just below one percent of the practice population. The practice had identified two of these carers as aged under 18 years old. The practice's computer system alerted the GPs if a patient was also a carer. Patients who were identified as carers were offered a flu vaccination and health checks. Written information was available to direct carers to the various local community support services available to them. There was also a dedicated page on the practice website for carers. The practice was actively working to identify other carers.

The practice had a bereavement policy in place. This detailed the action to be taken when a patient registered with the practice died. All staff were notified of a patient's death. The family was contacted and staff ensured that any outstanding appointments were cancelled. Staff said that patients were offered a consultation at a flexible time and location, which could be a visit to the family home if appropriate. Leaflets and other written information on bereavement were available for patients in the waiting area and on the practice website. Families and carers were signposted to support services such as bereavement counselling.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local Clinical Commissioning Group (CCG) to plan services and to improve outcomes for patients in the area. Services were planned and delivered to take into account the needs of different patient groups, flexibility, choice and continuity of care. For example:

- The inner city location of the practice meant that the practice was a primary referral site for people who were homeless, street dwellers, asylum seekers and new immigrants. The practice had approximately 175 who experienced problems with drugs and alcohol. Homeless patients were encouraged to register at the practice by the local police.
- The practice population of asylum seekers and new immigrants represented approximately 10% of the practice population. The patients were mainly young adults and more men than women. The practice found that this group of patients offered challenges due to cross cultural issues and language barriers. The practice worked closely with the local migrant and refuge centre to support the care of these patients.
- The practice had an increasing number of patients whose first language was not English. Practice staff (both clinical and non-clinical) spoke a variety of languages. There was access to telephone, online and face-to-face interpreting service. The practice had put a case forward to the CCG to prevent a decrease in access to face to face interpreters. The practice offered patients the use of interpreters and carried out a specialist Kurdish translator clinic on Monday afternoons.
- The practice held a register of approximately 138 patients who experienced severe and enduring mental illness, which was reflective of its inner city location. The practice provided continuity of care and counselling for these patients.
- The practice maintained a register of 65 patients diagnosed with dementia.
- The practice had provided care plans for 2% of patients at risk of unplanned admission to hospital, many of which had long-term conditions.
- The practice maintained a register of 1500 students from a local university. These patients represented 15% of the practice population and were from diverse international backgrounds. Some of the students were members of the virtual patient participation group and provided feedback to support the practice in meeting their health needs. Support provided included sexual health education and chlamydia screening.
- The practice offered online access to making appointments and ordering repeat prescriptions. Telephone consultations were available every day after morning clinics and at the beginning of afternoon clinics.
- The practice released 75% of its appointments daily which made same day appointments available to all patients which included children and those patients with medical problems that require same day consultation.
- Facilities for patients with mobility difficulties included level access to the practice, adapted toilets for patients with a physical disability. The practice was easily accessible to patients who used wheelchairs and families with pushchairs or prams. A lift was available to ensure patients could access consulting rooms on the first floor.
- The practice maintained a register of 66 patients with a learning disability and 87% had received an annual health assessment. The remaining patients had declined a health review.
- There were longer appointments available for patients with a learning disability, older people and patients with long-term conditions.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.

Access to the service

The practice was open between 8am and 6.30pm. Appointment times for patients varied for the GPs and practice nurses and included both morning and afternoon clinic sessions. Appointments with the GPs were available from 8.30am to 12pm and 3pm to 5.50pm. The practice did not provide an out-of-hours service to its patients but had alternative arrangements for patients to be seen when the practice was closed. Patients were directed to the out of hours service Vocare via the NHS 111 service. The practice had a designated duty GP daily. The duty GP had booked appointments and followed up patients who visited the practice on the day. Patients accessing this clinic included

Good

Are services responsive to people's needs?

(for example, to feedback?)

children under one year old and patients over the age of 75 years, telephone appointments, emergencies, prescription requests and managed the review and allocation of home visit requests.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment varied. For example:

- The responses from patients when asked if they were satisfied with the opening hours were in line (77%) with the local CCG average of 77% and national average of 76%.
- The practice scored lower (67%) than the CCG average of 70% and the national average of 73% when patients were asked how easy it was to get through to the practice by phone.

The practice was aware of the responses related to the difficulties patients had when trying to get through to the practice on the phone. The practice discussed these issues at practice meetings and with the patient participation group (PPG). Access to the practice and the appointment system was continuously reviewed by the practice to make improvements and improve patients' experience. The practice had reviewed the availability of appointments both emergency and routine and the number of patients who had failed to attend appointments.

Listening and learning from concerns and complaints

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

Records we examined showed that the practice responded formally to both verbal and written complaints. We saw records for 34 complaints received April 2015 and March 2015 and found that all had been responded to in a timely manner and satisfactorily handled in keeping with the practice policy. The practice any trends in these complaints which showed that 16 (47%) were related to staff communication and attitude concerns. The records identified that lessons were learnt from individual concerns and complaints and action was taken as a result to improve the quality of care. The practice also monitored patient feedback from external platforms such as NHS Choices and responded as appropriate.

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. Staff and patients felt that they were involved in the future plans and development of the practice. The statement of purpose described the vision for the practice as driven by practicing good medicine in a challenging area. The practice worked as a team and ensured the vision was shared and discussed at both staff and patient participation group (PPG) meetings. The GP partners and staff we spoke with demonstrated the values of the practice and a commitment to improving the quality of the service for patients.

Governance arrangements

The practice had a governance framework which supported the operation of the practice and promoted good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and all staff were clear about their own roles and responsibilities. All staff were supported to address their professional development needs.
- We found that the management and leadership team had an understanding of the performance of the practice.
- The practice held formal weekly and monthly meetings at which governance issues were discussed. There was a structured agenda and an action plan.
- The GP partners and nurses had designated clinical lead roles. For example one of the GPs was the lead for health and safety, learning disability and the care of patients living in nursing home. Both clinical and non-clinical staff also held additional responsibilities which supported the day to day operation of the practice.
- Practice specific policies and procedures were implemented and were available to all staff.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- Arrangements were in place for identifying, recording and managing risks and implementing mitigating actions. There was one area of governance that needed strengthening to ensure that patients and staff were protected from the risk of harm at all times. This was related to the way medicines alerts were received and handled.

Leadership and culture

The partners at 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 said they felt respected, valued and supported, particularly by the partners in the practice. The GP partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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). The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment affected patients received reasonable support and a verbal and written apology.

The practice had a programme of regular formal meetings which included clinical meetings, business, individual staff team meetings and practice wide meetings. All meetings were minuted to enable staff that were not present to update themselves on discussions. 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.

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 an active patient participation group (PPG). The group had been in place for three years and there were six to eight regular members who attended the formal meetings, which were held at least every three months. We spoke with two members of the PPG they told us that the group was also made up of a virtual group which included university students and patients of different ages. This helped to support the diversity of the practice population. The PPG had a noticeboard in the waiting area

Are services well-led?

Good

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

where the dates of meetings, the agenda and minutes of meetings were displayed for patients. The group encouraged patients to complete surveys and family and friends comment cards and were involved in fund raising for charities with the practice. The practice had acted on suggestions made by the PPG for example; the group had identified the need for a separate repeat prescription desk, which was acted on.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and the management team. The practice staff worked effectively as a team and their feedback was valued. Staff told us they felt involved and actively encouraged by the management team to improve how the practice was run.

Continuous improvement

The practice had completed reviews of significant events and other incidents. We saw records to confirm this and had used the outcome of these to ensure that appropriate improvements had been made.

The practice was a training practice for GP trainees and medical students. The GPs could demonstrate involvement in clinical meetings with their peers to enable them to discuss clinical issues they had come across, new guidance and improvements for patients. The practice took part in a number of university linked research projects and had achieved 'Research Ready' accreditation issued by the Royal College of General Practice (RCGP). RCGP Research Ready is an online quality assurance framework, designed for use by any general practice in the UK actively or potentially engaged in research, on any scale. The accreditation enabled the practice to demonstrate their legal, ethical, professional, governance and patient safety responsibilities at all stages of the research process.

The practice was involved in a number of local pilot initiatives, which supported improvement in patient care across Wolverhampton. For example, the practice was involved in an initiative to provide continuity of care to patients in local care homes.