

Linkway Medical Practice

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?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Linkway Medical Practice on 3 October 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 a system in place for reporting and recording significant events.
- Staff understood their responsibilities to raise concerns and to report incidents and near misses. The practice had a formal system in place for the ongoing monitoring of significant events, incidents and accidents.
- Arrangements were in place to ensure that risks to staff and patients were assessed and managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- The practice had completed some clinical and administrative audits but there was no programme of internal audits in place to monitor quality and make improvements.
- The practice invested in staff development and training.
- 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 the management.
- The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

- The provider was aware of and complied with the requirements of the duty of candour.

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

- Ensure all patients on repeat medications receive regular reviews.
- Improve the signage offering a chaperone service to patients.
- Implement a programme of internal audits that monitor safety and drives improvement within the practice.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services:

- There was an effective system in place for reporting and recording significant events.
- Records of clinical and significant event meetings demonstrated that incidents were fully discussed. Records showed that ongoing monitoring of events had taken place to ensure that systems put in place were appropriate.
- When there were unintended or unexpected safety incidents, patients received reasonable support, relevant information and an apology. Patients were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems and practices in place to keep patients safe and safeguarded from the risk of abuse.
- Medication management was mixed. Patients who required ongoing monitored had not been systematically checked. For example, patients on repeat medication had not always received regular reviews. Shared care agreements for high risk medicines were in place and monitoring was carried out.
- There was an appointed lead for health and safety and a comprehensive assessment of risks to patients and staff. The practice carried out annual health and safety audits and had completed risk assessments. There was a recorded log of all risks which included review dates. The health and safety lead had completed additional training specific to the role.

Good



Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) for 2014/15 showed that the overall achievement of 97% of the available points was above average when compared to the locality average of 93% and the national average of 95%.
- The practice clinical exception rate of 9.2% was comparable with the local CCG average of 8.8% and the national average of 9.2%. (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.)

Good



Summary of findings

- Staff were aware of current evidence based guidance to deliver care and there was a system in place to check they were being followed.
- The practice had completed some audits but there was no internal programme in place to use clinical audits to monitor quality and make improvements.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. There was evidence of staff appraisals and personal development plans for all staff. Staff training was comprehensive.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs. For example, the practice held meetings with the professionals involved in the care of patients receiving palliative care.
- Arrangements were in place to gain patients' informed consent to their care and treatment.
- Patients were supported to access services to promote them living healthier lives.

Are services caring?

The practice is rated as good for providing caring services.

Good



- Data from the National GP Patient Survey results, published in July 2016, showed patients rated the practice similar to others for most aspects of care.
- Patients told us and were seen to be treated with dignity and respect and they were involved in decisions about their care and treatment. Systems were in place to protect patient confidentiality.
- Arrangements were in place to ensure that patients and carers received appropriate and effective support. This included young carers. There was a dedicated notice board for carers in the waiting area.
- The practice held a carers' register and systems were in place, which identified patients who also acted as carers. Carers identified were invited for annual health checks and immunisation against flu.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- 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.

Summary of findings

- Patients said they found it easy to make an appointment with a GP and there was continuity of care, with urgent appointments available the same day. The practice offered extended hours and telephone appointments to working patients.
- 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. The practice had responded quickly when issues were raised. Learning from complaints was shared with staff.

Are services well-led?

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

- The provider had a vision to deliver high quality care and support patients with education and information to be proactive with their health and wellbeing. Staff were aware of the vision and their responsibilities in relation to this.
- The provider had a five year business development plan that was reviewed annually.
- There was a clear leadership structure and staff felt supported by the management and their colleagues.
- The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There were arrangements for identifying, recording and managing risks and implementing mitigating actions to ensure that patients and staff were protected from the risk of harm. The health and safety policies and protocols were comprehensive and additional resources were planned to improve the safe management of medicines.
- The provider was aware of and complied with the requirements of the Duty of Candour. The GP 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 albeit small in numbers.

Good



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

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

Good



- The practice offered personalised care to meet the needs of the older people in its population and provided a befriending service to elderly patients.
- The practice offered GP, nurse and healthcare assistant to perform home visits to older people who were housebound only. For example to perform heart monitoring and diabetic foot checks
- Flexible appointments were available for older patients.
- All patients aged 65 and over were offered a health check including blood tests.
- A GP was allocated to each nursing and care home housing elderly patients. Staff had been trained and the practice had purchased machines to take blood samples and blood pressures in patients homes.

People with long term conditions

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

Good



- A GP partner was the lead for diabetes and supported a specialist diabetic nurse employed by the practice. The advanced nurse practitioner had a lead role in chronic obstructive pulmonary disorder (COPD).
- Two per cent of patients had been identified at higher risk of hospital admission and were proactively managed using written care plans and regular discussions with other healthcare professionals.
- The practice Quality and Outcomes Framework (QOF) for the care of patients with long-term conditions was similar to or better than the local and national averages. For example the practice performance for diabetes related clinical indicators was higher than the local Clinical Commissioning Group and England average (97% compared to the local average of 88% and the national average of 90%).
- Longer appointments were available when needed and home visits made to patients who were housebound or too ill to attend the practice.
- The GP and practice nurses worked with relevant healthcare professionals to deliver a multidisciplinary package of care to patients with complex needs.

Summary of findings

- All newly diagnosed diabetic patients and patients with poorly controlled diabetes were provided a diabetic education programme.

Families, children and young people

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 did not attend hospital appointments.
- Immunisation uptake rates for standard childhood immunisations were similar to the local clinical commissioning group (CCG) and national averages.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice offered contraceptive services and the nurse provided condoms to patients and chlamydia testing kits.
- The practice's uptake for the cervical screening programme was 80%, which was comparable to the national average of 82%.
- All pregnant patients were contacted to provide prescriptions for folic acid.

Good



Working age people (including those recently retired and students)

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 offered extended opening hours and the appointment telephone line was easily accessible to patients who worked during the day.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

Good



People whose circumstances may make them vulnerable

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

Good



Summary of findings

- The practice held a register of 104 patients with a learning disability and annual health checks were carried out on 63 of these patients within the last 12 months. The practice experienced a high number of non-attenders and planned to pilot consultations by video link to improve the number of checks completed for this cohort of patients.
- Staff had been trained 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.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. For example the adult ability team, a service that included physiotherapy and counselling.
- Staff told us of a number of patients who were offered emergency appointments to reduce A&E attendances. Flexible appointments were offered to patients with learning disabilities.

People experiencing poor mental health (including people with dementia)

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

- The practice regularly worked with multi-disciplinary teams in the case management of people who experienced poor mental health, including those with dementia.
- The practice held a register of patients who experienced poor mental health. Clinical data for the year 2014/15 showed that 107 of 114 patients on the practice register who experienced poor mental health had a comprehensive agreed care plan. This was equivalent to 92%, higher than the CCG average of 87% and national average of 88%.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. For example, the community mental health team.
- The percentage of patients diagnosed with dementia, whose care had been reviewed in a face to face review in the preceding 12 months was 83%, which was comparable with the CCG and national average of 84%. The exception reporting rate was 2.4% which was lower than the CCG average of 8.4% and the national average of 8.3% meaning more patients had been seen.

Good



Summary of findings

What people who use the service say

The national GP patient survey results published in July 2016 showed the practice was generally performing above local and national averages. A total of 268 surveys (2.6% of the patient list) were sent out and 113 responses were received, a completion rate of 42% which is equivalent to 1.1% of the patient list. For example:

- 76% of the patients who responded said they found it easy to get through to this surgery by phone compared to a Clinical Commissioning Group (CCG) average of 60% and national average of 73%.
- 82% of the patients who responded said they were able to get an appointment to see or speak to someone the last time they tried (CCG average 75%, national average 85%).
- 86% of the patients who responded described the overall experience of their GP surgery as fairly good or very good (CCG average 75%, national average 85%).
- 80% of the patients who responded said they would definitely or probably recommend their GP surgery to someone who had just moved to the local area (CCG average 64%, national average 78%).
- 81% of the patients who responded said they found the receptionists at this practice helpful (CCG average 81%, 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 two comment cards which were overall positive. Patients said the practice was caring, and that they received an excellent service. The practice had a patient participation

group (PPG) consisting of three members who we met with on the day. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. They told us that they were satisfied with the care provided by the practice. They said they were always treated as an individual, respected, could always get an appointment and were given enough time to discuss their concerns and treatment. The PPG complimented the practice on maintaining a personal service following an increase in patients registered and the recent retirement of a longstanding GP partner.

The practice monitored the results of the friends and family test monthly. The results over a twelve month period (January 2015 to December 2015) showed that of the 130 responses received 65 (60%) were extremely likely or likely to recommend the practice to friends and family if they needed similar care or treatment and 36 (28%) patients had returned a do not know response. The remaining results showed that six patients were neither likely nor unlikely to recommend the practice, 11 patients were unlikely to recommend the practice and 12 patients stated they were extremely unlikely to recommend the practice. The comments made by patients in their responses were overall positive and aligned with the comments and responses received from comment cards, the patients spoken with and the GP survey results. We saw that the practice reviewed the comments received through the friends and family test and used these to make improvements.

Areas for improvement

Action the service **SHOULD** take to improve

- Ensure all patients on repeat medications receive regular reviews.
- Improve the signage offering a chaperone service to patients.

- Implement a programme of internal audits that monitor safety and drives improvement within the practice.

Linkway Medical Practice

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 advisor.

Background to Linkway Medical Practice

Linkway Medical Practice is registered with the Care Quality Commission (CQC) as a partnership of two with a senior GP partner and a second GP partner. The practice is located in West Bromwich. The practice has good transport links for patients travelling by public transport but parking facilities are limited. The practice is situated within the Lyng Centre, a joint healthcare facility that houses four GP practices, phlebotomy, family planning and podiatry services as well as the District Nursing Team. The practice is situated on both the ground floor and second floor of the building and there is a lift for public use. The provider has dedicated rooms within the premises that included nine consulting rooms. There are three treatment rooms, two on the ground floor and one on the second floor. There is level access to the building and doors to the building are automated. All areas within the practice are accessible by patients who use a wheelchair or parents with a pushchair.

The practice team consists of two partners, both male. The partners are supported by three salaried GPs (two female, one male) working a combined 33 sessions per week. There are two GP registrars and one foundation year GP working a combined 24 sessions per week. The nursing team consists on an advanced nurse practitioner (ANP), one specialist practice nurse, two practice nurses and a healthcare assistant (HCA). Clinical staff are supported by a practice

manager, a deputy practice manager, administration and reception staff. In addition to the GP partners, there are a total of 27 staff employed either full or part time hours to meet the needs of patients.

The practice is open every week day between 8am and 6.30pm. Appointments are available from 8.30am to 1pm and from 3pm to 6pm. The practice does offer extended hours on a Saturday morning from 8am to 12.30pm. 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, provided by Primecare, via the NHS 111 service.

The practice has a General Medical Services contract with NHS England to provide medical services to approximately 10,400 patients. It provides Directed Enhanced Services, such as the childhood immunisations, extended hours and asthma and diabetic reviews. The Local Incentive Schemes (LIS) consist of a combined package of services coordinated through the primary care commissioning framework (PCCF). These include improving on patient survey results, access improvement and a falls service. Separately the practice provided a number of screening services that included cardiovascular disease (CVD) screening. The practice demographics were similar to national averages, for example the proportion of patients aged under 18 is 23% compared to the national average of 21%. The proportion of patients aged 65 and over is 17%, the same as the national average. The income deprivation affecting children of 31% was higher than the national average of 20%. The level of income deprivation affecting older people of 32% was higher than the national average of 16%.

Detailed findings

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 3 October 2016.

During our visit we:

- Spoke with a range of staff including GPs, nursing team, healthcare assistant, practice manager, administration staff and spoke with three patients who used the service.
- Observed how patients were being cared for.

- 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.

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach to learning and a computerised system was in place for reporting and recording significant events.

We found that significant event records were maintained and systems put in place prevented further occurrence. Significant event records were clearly documented at the time they were reported on the significant event forms or electronic messages were used to report significant events. All events were entered onto the 'Datix' system. Action points were recorded and staff informed at practice meetings. Documentation available demonstrated that any lessons learnt and action taken had been shared with staff and remedial action had been taken. Ongoing monitoring was demonstrated by minutes of meetings where actions taken were reviewed. Significant events were a standing agenda item at practice meetings and clinical meetings. Staff completed an incident recording form which supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). We found that when there were unintended or unexpected safety incidents, patients received reasonable support, relevant information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Records we looked at showed that 38 significant events, both clinical and operational had occurred between April 2015 and March 2016. The events were categorised to identify any trends. One of the events related to a home visit carried out when the summary care records had not been logged out or logged back into the practice in line with the policy. The incident was investigated and findings highlighted that when summary care records were given to another healthcare provider such as the ambulance service, the log had not been completed to account for the whereabouts. The policy was reiterated and ongoing spot checks carried out to ensure all notes could be accounted for.

The practice manager was responsible for disseminating safety alerts and there were systems in place to ensure they were acted on and seen in the practice manager's absence.

Alerts were screened and when appropriate, logged and forwarded to the appropriate practice staff. Alerts were a standing agenda item at the clinical meetings. Non-clinical alerts were disseminated to the administration team. For example, we were told that non-registered patients trying to access medication was communicated by email to the reception staff and to the prescription clerk. The practice manager was able to give an example of a drug alert for a medicine used to control glucose levels in the blood issued on 6th September, 2016. The deputy practice manager (the practice manager was on holiday at the time of receipt) had actioned the alert appropriately, a search had been run and ten patients had been sent a letter with a copy of the alert and advice on what action to take. Alerts were shared with the wider practice team at practice meetings and the clinical meetings both held weekly. The practice manager accessed an electronic database, Datix, used to share learning both locally and nationally to check no alerts had been missed.

Overview of safety systems and processes

Arrangements were in place to safeguard adults and children from the risk of 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. A GP partner carried out the lead role for safeguarding adults and children. Staff we spoke with demonstrated that they understood their responsibilities and told us they had received training relevant to their role. The GP partners and nurses were trained to safeguarding level three and the non-clinical staff were trained to safeguarding level one. The GPs told us they provided reports where necessary for other agencies. The practice held registers for children at risk, and children with protection plans were identified on their individual computerised records. The practice had close links with the safeguarding team, health visitors were invited to meetings but the provider spoke of a problem with face to face engagement that had been reported to the safeguarding team. Children who had not attended a hospital appointment or had attended A&E were flagged to a GP and for those who did not attend the practice for childhood vaccinations and immunisations were followed up by recall letters. If problems continued the practice reported any concerns about children to a named health visitor and other relevant professionals. The practice gave an example about a temporary patient who was pregnant but had not

Are services safe?

been referred for antenatal care. The GPs had reviewed the patient in a practice meeting in September 2016 and had placed the patient onto the adult safeguarding register. This had been recorded and reviewed as a significant event. The safeguarding systems were audited annually by the safeguarding team from the local CCG. The most recent audit carried out in 2016 complimented the practice on its governance. All recommended actions had been completed.

A leaflet was displayed in the waiting room and on the reception desk advising patients they could access a chaperone, if required. However there were no posters in the consulting rooms or waiting area. Only clinical staff acted as chaperones and had been trained for the role. 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). Staff clearly described their role to us and knew where to stand. A chaperone policy was available to support staff. The policy made appropriate reference to recording on the patient records that a chaperone was present and summarised the role of a chaperone.

The practice was situated in a building maintained and serviced by NHS Properties and the landlord (Primary Health Properties plc). We observed the premises to be clean and tidy and appropriate standards of cleanliness and hygiene were kept. There were cleaning schedules in place and cleaning records and standards were reviewed and problems reported to the cleaning supervisor. The advanced nurse practitioner was the clinical lead for infection control and received update training and annual audits from the infection control leads from Sandwell and West Birmingham Clinical Commissioning Group Central Services Unit. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. The last one in September 2016 had identified five minor actions required, for example general waste paper bins in clinical rooms should be covered. 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.

Clinical waste disposal contracts were in place through the landlord of the property. The landlord was responsible for the disposal of the sharps bins and a protocol for needlestick injuries was in place. All boxes were seen to have been signed and dated with an assembly date and clinical waste bins had foot operated closure. 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. Immunisation was offered to all staff for hepatitis B and flu jab. The practice carried out monthly cleaning audits and annual audits on hand hygiene.

There were arrangements for managing medicines in the practice. Medicine prescribing practices we reviewed showed that systems in place for patients to receive a formal review of their medicines were not fully effective.

- The arrangements for managing repeat prescriptions for high risk medicines that required monitoring were effective although not systematic. There were audits performed for patients on high risk medication but these were done periodically. For example, the practice planned but had not carried out audits on patients prescribed a medication used to treat an irregular heartbeat that required regular monitoring. Checks made on the day evidenced that no patients were being put at risk. We reviewed shared care agreements where patients seen by a hospital consultant required monitoring by the practice. These were well managed through a patient recall system.
- The practice had an effective process for making changes to prescribed medicines in patient's records following a visit to hospital. The process worked with allocated daily roles assigned to GPs who added and removed patient repeat medication items following their discharge from hospital using the discharge letter.
- Formal arrangements for the review of patient medicines were in place but we saw that 28% of patients on four or more medications had not been reviewed in the preceding 12 months.

We found that blank computer forms and prescription pads were securely stored and their use monitored. The practice had systems for ensuring that medicines were stored in line with manufacturers guidance and legislative requirements. This included daily checks to ensure medicines such as vaccines were kept within a temperature range that ensured they were effective for use. Specific medicine

Are services safe?

directions (Patient Group Directions for the practice nurses) were adopted by the practice to allow the practice nurses to administer specific medicines in line with legislation. Patient specific directives (PSDs) were in place for the healthcare assistant.

We reviewed the staff files for three staff employed at the practice, a nurse and a GP and the deputy practice manager. We found that all files contained appropriate recruitment checks which 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 DBS. Records showed that all permanent staff had criminal records checks carried out through the DBS. The practice directly employed locum GPs. Their records showed that a check was carried out to confirm the locum was registered to practice with their professional body, the General Medical Council (GMC) and information was held on employment history, qualifications, references and appropriate checks through the Disclosure and Barring Service to confirm the suitability of the GP to work with patients. Staff had completed a health check as part of the induction programme.

Monitoring risks to patients

The landlord of the property and the property owners were responsible for the maintenance and management of the premises. The practice had procedures in place for monitoring and managing risks to patient and staff safety. Minutes of practice meetings showed that health and safety was discussed when required and was a standing agenda item at the partners' meetings. The practice had a health and safety policy available and the mandatory programme poster was displayed in the reception area. The poster identified the named health and safety lead at the practice. The appointed leads had received additional training specific to this role and used an outside publication to keep up to date with the requirements of managing health and safety. An annual health and safety audit was carried out and we saw there was a comprehensive list of completed risk assessments relating to the premises, patients, visitors and staff working at the practice. For example, risk assessments for mobile/lone workers, display screen equipment and assessments by room. Records were available to demonstrate that a number of other risk assessments had been completed by the property landlord to monitor the safety of the premises. These included fire

risk assessments, checking of fire alarms (weekly) and emergency lighting. Control of Substances Hazardous to Health (COSHH) was managed by the nursing team and safety data sheets for each product were kept where the practice could access them. The practice evidenced that the landlord had carried a legionella risk assessment and ongoing checks were carried out. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

All electrical and medical equipment was checked annually to ensure the equipment was safe to use and working properly. Records showed equipment was maintained and calibrated in November 2015 and electrical safety checks had last been carried out in November 2015.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff and staff with appropriate skills were on duty. The practice occasionally used GP locums to support the clinicians and meet the needs of patients at the practice at times of absence. There was a policy followed that holidays were coordinated to minimise the numbers of staff who had annual leave at the same time. Each week at the partner's meeting; a month planner was reviewed working three months ahead. The number of GP and nurse appointments were added up per week and reviewed against pre-defined targets and adjustments were made to take into account specific days such as bank holidays. A documented plan advised which GP was responsible for any trainees working on given days. The same system was used to produce a reception rota.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents. There was an emergency panic button on each computer logged into the clinical system. Security manned the building 24 hours, seven days a week. The practice had a first aid box and accident book and staff were aware of their location. Staff training records showed that all staff had received recent update training in basic life support. The practice had a defibrillator (this provides an electric shock to stabilise a life threatening heart rhythm) on the premises. There was oxygen available with adult and children's masks. The practice had systems in place to ensure emergency equipment and medicines

Are services safe?

were regularly checked. 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.

The practice had undertaken a fire evacuation drill in the preceding 12 months (18th February, 2016). There was a fire warden who attended meetings with other staff in the building to review the fire evacuation drills.

The practice had a comprehensive business continuity plan in place for responding to emergencies such as loss of premises, power failure or loss of access to medical records. The plan included emergency contact numbers and arrangements to operate from neighbouring practices in addition to information for staff of mitigating actions to reduce and manage the identified risks. There were hard copies kept off site and electronic copies could be viewed in the practice or remotely.

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 GPs we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and systems were in place to keep all clinical staff up to date. The practice discussed any new guidelines in clinical meetings held weekly. There was a system to monitor and ensure guidelines were followed through risk assessments, audits or random sample checks of patient records. This had lapsed in February 2016 due to the sudden retirement of a GP partner on ill health but the provider planned to reintroduce in the coming months.

Management, monitoring and improving outcomes for people

The practice collected information for the Quality and Outcomes Framework (QOF) to measure its 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 showed that it had achieved 97% of the total number of points available. The practice QOF results were higher than the local Clinical Commissioning Group (CCG) average of 93% and the national average of 95%. The practice overall clinical exception rate of 9.2% was higher than the local CCG average of 8.8% and the same as the national average. (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 2014/15 showed:

- Performance for the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was within target was below the local and national average (74% compared to the CCG average of 77% and national average of 78%). The practice exception reporting rate of 8% showed that it was similar to the local CCG average of 7.9% and the national rate of 8.7%.

- Performance for the percentage of patients with Chronic Obstructive Pulmonary Disease (COPD) who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale (the degree of breathlessness related to five specific activities) in the preceding 12 months was 86% which was below the local CCG average of 89% and national average of 90%. COPD is the name for a collection of lung diseases. The practice exception reporting rate of 33% was higher than the CCG average exception rate of 11.8% and national average of 11.1%. The provider was aware and explained that the high number of patients on the COPD register exception reported was due to patients under the supervision of a hospital consultant, patients being housebound (unable to receive spirometry and referred to the community team), patients with lung cancer and patients with a low lung capacity.
- Performance for mental health related indicators was better 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 92% compared to the local CCG average of 86% and England average of 88%. The practice had exception reported seven of the 114 patients for this clinical area, equivalent to 6.1% (the local CCG average exception rate was 11.8% and England average was 12.6%).
- The percentage of patients diagnosed with dementia whose care had been reviewed in

a face-to-face review in the preceding 12 months was similar to the local CCG and national average (83% compared to the local CCG average and national average of 84%). The practice clinical exception rate of 2.4% for this clinical area was lower than the local CCG average of 8.4% and the national average of 8.3%. This represented three patients.

The practice had fully effective call and recall system to invite patients with long term conditions for regular reviews. The practice had reviewed and introduced appropriate care plans where required for the ongoing management of these patients. Monthly multi-disciplinary team meetings were held to monitor performance and an action plan was developed to identify the areas of patients'

Are services effective?

(for example, treatment is effective)

care that needed to be reviewed. Evidence was available to show that the practice had systems in place to follow up patients that had not attended reviews of their condition either at the practice or at the hospital.

We saw that six clinical audits had been completed in the last year; these were a mix of single phase and cyclical audits both clinical and administrative. One of the audits carried out by the practice nurse reviewed smear samples taken over a six month period (August 2015 to January 2016). The audit concluded that all samples had been taken correctly. There was no plan or schedule of audits and three of the six were carried out by outside health professionals, for example, pharmacists employed by the local clinical commissioning group (CCG) checking prescribing followed CCG guidelines.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Staff had access to and made use of e-learning training modules and external and in-house face-to-face training.

The practice had developed an effective appraisal system which included detailed appraisal documents. Staff had received a recent appraisal and records detailed development plans for all staff. The GPs and practice nurses had all completed clinical specific training updates to support annual appraisals and had personal development plans to support revalidation. The practice nurses received training and had attended regular updates for the care of patients with long-term conditions and administering vaccinations. Administration staff had received annual appraisals and staff we spoke with said that they felt supported and highlighted teamwork as a strength.

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 shared computer drive. The provider was able to demonstrate that staff were aware of their responsibilities for processing, recording and acting on any information received. The practice tracked referrals such as urgent scan requests.

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 treatment. This included when patients moved between services. For example, when referring patients to secondary care such as hospital or to the out of hours service. Information was shared with the out of hours service so they were aware of the patient's wishes and treatment choices when the practice was closed. There was a system of special patient notes done online through a hard copy faxed to out of hours providers to advise of any patient specific requirements. The practice completed a daily check on patients who attended the out of hours service. Staff told us that they could discuss any concerns about children and families with a named health visitor. Multi-disciplinary team meetings were used to discuss patients on the practice palliative care register. Detailed minutes of the meetings were maintained and care plans were routinely reviewed and updated following the meetings. A copy of the care plan was kept in the patient's home. The practice managed the care of palliative patients through care plans completed by the community palliative care team and inclusion on the internal at risk register.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. We found that staff understood and had an awareness of 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, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and where appropriate, recorded the outcome of the assessment. We saw that patients' consent had been recorded clearly using nationally recognised standards. For example, when consenting to certain tests and treatments such as vaccinations and in do not attempt cardio-pulmonary resuscitation (DNACPR) records. Audits were carried out to check that consent was obtained.

Supporting patients to live healthier lives

The practice had identified patients who may be in need of extra support. This included patients with conditions that may progress and worsen without the additional support to monitor and maintain their wellbeing.

Are services effective?

(for example, treatment is effective)

- 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 alcohol cessation.
- Patients were signposted to relevant health promotion services for example, for smoking cessation and substance misuse.
- Patients had access to appropriate health assessments and checks. These included health checks for new patients, NHS health checks for patients aged 40-74 years and patients aged 75 years. This service was provided by one of the practice nurses with support from a GP when required.

The practice had a comprehensive screening programme. A full range of travel vaccines, childhood immunisations and influenza vaccinations were offered in line with current national guidance. Data collected by NHS England for 2014/15 showed that the performance for all childhood immunisations was comparable to the local CCG average. For example, childhood immunisation rates for the vaccination of children under two years of age were 92% (with the exception of the Infant Meningitis C vaccination where the uptake rate was 0.8% having been implemented

during the year in which the data was captured). Children aged two to five ranged from 90% to 98%, and five year olds from 86% to 93% and children aged five years vaccination uptake rates ranged between 92% and 98%.

We saw that the uptake for cervical screening for women between the ages of 25 and 64 years for the 2014/15 QOF year was 80%, which was comparable to the national average of 82%. The practice was proactive in following patients up by annual reminder letters sent the following year to patients who had not attended. Patients who were overdue a test were flagged on the clinical system to advise clinicians of non-attenders. Public Health England national data showed that the number of females aged 50-70 years, screened for breast cancer in last 36 months was 67% compared to the average across England of 72%. Data for other cancer screening indicators such patients between the ages of 60 and 69 years screened for bowel cancer in the last 30 months was 51%, above the local CCG average of 46% but below the national average of 58%.

We saw that health promotion information was displayed in the waiting area and also made available and accessible to patients on the practice website. The nurses carried out health screening checks on all new patients registering at the practice.

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 open. To promote confidentiality telephone calls could be responded to away from the front desk to support the privacy of patients when 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.

We spoke with three patients on the day of the inspection and collected two Care Quality Commission comment cards completed by patients to tell us what they thought about the practice. Patients were positive about the service they received. Patients said that they received good care from all staff, the GPs were caring and staff were polite, considerate and helpful. The patient we spoke with were all members of the patient participation group (PPG).

Results from the national GP patient survey published in July 2016 showed patients felt they were treated with compassion, dignity and respect. The practice ratings were consistently above local and national practice averages for satisfaction scores on consultations with GPs. For example:

- 94% of the patients who responded said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 83% and national average of 89%.
- 94% of the patients who responded said the GP gave them enough time (CCG average 82%, national average 87%).
- 98% of the patients who responded said they had confidence and trust in the last GP they saw (CCG average 93%, national average 95%).
- 97% of the patients who responded said the last GP they spoke to was good at treating them with care and concern (national average 85%).

The practice satisfaction scores on consultations with the nurse were consistently above local and national averages. For example:

- 97% of the patients who responded said the last nurse they spoke to was good at treating them with care and concern (CCG average 86%, national average 91%).
- 95% of the patients who responded said the last nurse they saw or spoke to was good at listening to them (CCG average 87%, national average 91%).
- 96% of the patients who responded said the last nurse they saw or spoke to was good at giving them enough time (CCG average 87%, national average 92%).

The patient satisfaction with reception staff was the same as the local CCG average but below the national average. Data showed that:

- 81% of the patients who responded said they found the receptionists at the practice helpful (CCG average 81%, national average 87%).

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.

Results from the national GP patient survey published in July 2016 showed patients response to their involvement in care planning with a GP or nurse was the same or above the national averages. For example:

- 86% of the patients who responded said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and national average of 86%.
- 86% of the patients who responded said the last GP they saw was good at involving them in decisions about their care (national average 82%).
- 91% of the patients who responded said the last nurse they saw or spoke to was good at explaining tests and treatments (national average 90%).
- 88% of the patients who responded said the last nurse they saw was good at involving them in decisions about their care (national average 85%).

Patient and carer support to cope emotionally with care and treatment

Are services caring?

The practice had a carers' policy in place, which staff were aware of. Written information was available for carers to ensure they understood the various avenues of support available to them. This included notices in the patient waiting room which told patients how to access a number of support groups and organisations. There were 239 carers on the practice carers register, which represented 2.3% of the practice population. The practice's computer system alerted the GPs and nurses if a patient was also a carer and patients were offered a flu vaccination and health checks. There was a recall system in place for carers to be invited for their flu vaccination and health check. Patients who are young carers were identified separately and signposted to a local service, Sandwell Young Carers, a dedicated service to

support young carers. The practice had identified a digital resource for carers and planned to add the link to the website and display on the dedicated carer's notice board situated in the waiting area.

Staff told us that if families had suffered bereavement, patients were offered an appointment with a bereavement support officer employed by the local CCG who attended the practice weekly and patients could self-refer. Leaflets and other written information on bereavement was available for patients in the waiting area and on the practice website. Families and carers were signposted to support services such as 'CRUSE' a local service that offered bereavement counselling. Staff were made aware of any death through discussion at the next clinical meeting as a standing agenda item and an alert was sent out to all providers of care recently involved.

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:

- Patients with a learning disability were offered longer appointments (between 30 minutes and one hour) at a time which was suitable to them and their carer.
- With administration support, the nurses followed up all patients on the admission avoidance register following their discharge from hospital and discussed at the weekly clinical meetings.
- The practice had access to appointments for patients who worked. We found that patients were offered online access to book appointments, request repeat prescriptions, access test results and view a summary care record.
- Facilities for patients with mobility difficulties included a ramp for ease of access to the entrance of the practice. The front doors to the practice were automatically operated to assist patients with poor mobility. Adapted toilet facilities were available for patients with a physical disability.
- The practice referred patients experiencing memory loss to the local community memory loss clinic.
- Access was available to translation and interpretation services to ensure patients were involved in decisions about their care. The practice website was available in a number of languages.
- Baby changing and breast feeding facilities were available.
- There were longer appointments available for older people and patients with long-term conditions.
- The practice made patients aware that home visits were available for patients who were unable to attend the practice.
- There was a policy to offer same day face to face appointments for sick children as well as patients assessed as requiring an urgent appointment.

Access to the service

The practice was open each week day between 8am and 6.30pm. Appointments were available from 8.30am to 1pm

and from 3pm to 6pm. Extended hours were offered at the practice each Saturday from 8am to 12.30pm. 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, provided by Primecare, via the NHS 111 service. The nearest hospital with an A&E unit was Sandwell District General Hospital. The nearest walk in centre was in West Bromwich.

Results from the national GP patient survey showed that patient's satisfaction rates were better than local and national averages for indicators on how they could access care and treatment. For example:

- 84% of patients were satisfied with the practice's opening hours which was above the CCG average of 71% and national average of 76%.
- 76% patients said they could get through easily to the surgery by phone (CCG average 60%, national average 73%).

The practice had a system in place to assess whether a home visit was clinically necessary. The named GP had the responsibility for coordinating the patient's care and made the decision on the urgency of the patients need for care and treatment and the most suitable place for this to be received. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits. Non-clinical staff would refer any calls which caused concern or they were unsure of to a clinician for advice. Information in the patient leaflet and on the practice website informed patients to contact the practice if they required a home visit. Further information informed patients that home visits would be made to patients who were housebound or too ill to attend the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints at the practice. We saw correspondence for 21 complaints (written and verbal) received over the past 12 months and found that all had been responded to, satisfactorily handled and dealt with in a timely way. Written responses from the practice included details of who to contact if not satisfied with the response from the practice.

Are services responsive to people's needs? (for example, to feedback?)

Records showed that complaints were categorised and documented and evidence was seen of actions and outcomes completed. Complaints were included as a standing agenda item to be discussed at weekly practice meetings. We saw that lessons were learnt from concerns and complaints and action was taken to improve the service. For example, the practice had received a complaint from a patient who had been cut off while on the telephone and on calling back felt the attitude shown by a member of the reception team to be inappropriate. The member of the

team was made aware of the complaint and reminded that similar incidents of verbal complaints should be documented in future. The patient received a written apology from the practice.

We saw that information available to help patients understand the complaints system included leaflets available in the reception area and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

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 written set of values that included improved patient education and patient information to encourage them to be pro-active in their health and wellbeing. Staff felt that they were involved in the future plans for the practice. The practice produced a five year business development plan that was reviewed annually. The plan included succession planning and identification of additional services that could be offered in primary care. A summary of the plan was documented in a tabular format that included the individual responsible, timeframes and a budget cost. The practice sought the views of patients and input of the patient participation group (PPG) on improvements that could be made at the practice. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services.

Governance arrangements

Governance arrangements within the practice were generally comprehensive and inclusive. We saw evidence of minutes from meetings and a programme that provided regular communication and cohesive working:

- There was a clear staffing structure and staff were aware of their own roles and responsibilities and all staff were supported to address their professional development needs.
- Practice specific policies and procedures were implemented and were available to all staff. An internal shared drive was used to advise staff when key policies were updated or of any new policies.
- We found that systems were supported by a strong management structure and clear leadership.

Where governance could be improved, the provider was aware and included improvement as specific objectives in the five year business development plan. For example: there was a priority objective to employ extra resource to improve the safe management of medicines through more regular face to face reviews on those patients on repeat medication.

Leadership and culture

The GP partners and practice manager were visible in the practice and staff told us they were approachable and

always took the time to listen to all members of staff. There was a clear leadership structure in place and staff felt supported by the management. Staff we spoke with were positive about working at the practice. They told us they morale and teamwork were strengths and felt comfortable enough to raise any concerns when required and were confident these would be dealt with appropriately.

The provider was aware of and complied 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. When there were unexpected or unintended safety incidents the practice gave affected people reasonable support, relevant information and a verbal and written apology.

Staff told us that regular practice meetings were held which involved all staff and staff we spoke with felt confident to raise any issues or concerns at these meetings. Topics on the agenda included significant events, complaints, safeguarding, health and safety and other governance arrangements. There was a practice whistle blowing policy available to all staff to access on the practice's computer system. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this and how they would be protected and this was confirmed in discussions we held with staff.

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

The practice encouraged and valued feedback from patients, the public and staff. The practice had an active patient participation group (PPG), formal meetings were held every three months and minutes were available to confirm this. The provider proactively sought patients' feedback and engaged patients in the delivery of the service although they stated that interest in the PPG was difficult to generate and membership had reduced to three patients. The practice had gathered feedback from patients through the friends and family test and complaints received. The PPG produced annual reports, published on the practice website. The most recent example from 2015 included the introduction of music in the waiting area to help patients relax while waiting to be seen. The five year business development plan included how the practice

Are services well-led?

Good 

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

could deliver more services to patients in a primary care setting and how technology could be used to improve both the patient experience and the workplace for staff employed.

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. 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 had completed reviews of significant events and other incidents and had ensured that lessons learned from these were used to make improvements and prevent further reoccurrence. The practice was an established training practice and the new partners planned to continue and develop the training provided. The provider explored how technology could enhance patient care. For example, there was a pilot project planned to use video link for consultations with patients who had learning disabilities.