Newbridge Surgery

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. (The practice was rated as good at our previous inspection on the 6 May 2015)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) - Good

We carried out an announced comprehensive inspection at Newbridge Surgery on 10 January 2018. We carried out this inspection as part of our inspection programme.

At this inspection we found:

- The practice had systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. The practice introduced innovative approaches to improve care and access to services and shared these locally with other practices. These approaches were particularly related to the needs of older patients, young people and students.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- The practice worked proactively with the voluntary sector, community services and the patient participation group to support meeting the holistic needs of their patients.

Summary of findings

- There was a clear leadership structure and staff felt supported by management.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

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

- Consider pro-actively identifying carers and establishing what support they are provided with.

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

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

Newbridge Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser and a Practice Manager specialist adviser.

Background to Newbridge Surgery

Newbridge Surgery is registered with the Care Quality Commission (CQC) as a GP partnership. The practice is part of the NHS Wolverhampton Clinical Commissioning Group. The practice holds a General Medical Services contract with NHS England. A GMS contract is a contract between NHS England and general practices for delivering general medical services. In May 2016, the practice became part of Wolverhampton Total Health Primary Care Home. The Primary Care Home, known as (PCH1) consists of individual Wolverhampton GP practices. All the practices continue to maintain their own practice list.

Newbridge Surgery operates from 255 Tettenhall Road, Wolverhampton, WV6 0DE. The practice provides a number of clinics such as long-term condition management including asthma, diabetes and high blood pressure. It also offers child immunisations and travel health as well as minor surgery.

There are approximately 4,751patients of various ages registered at the practice. The practice is in an area considered as a fifth most deprived when compared nationally. Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial. People living in more deprived areas tend to have greater need for health services. The practice has a higher proportion of patients aged 65 years and above (35%) than the expected England average (27%). This could increase the demand for flexible appointments such as home visits.

The clinical staff team currently comprises three GP partners (Two females and one male) one working full time (nine sessions) the other two GP partners work part time, one doing five sessions and the other six sessions. Other clinical staff are a practice nurse and a healthcare assistant who both work part time hours. Clinical staff are supported by a practice manager, office manager, four reception staff and three administrative staff, employed either full or part time hours. The practice is a training practice for GP registrars to gain experience and higher qualifications in general practice and family medicine.

Newbridge Surgery opening times are Monday to Friday (except Thursday) 8am to 6.30pm and 8am to 5.30pm on Thursday. The practice offers extended opening hours for booked appointments on Wednesday between 7am and 8am. The practice has an open access clinic, where patients are invited to turn up before 11am each day to see a GP without an appointment. The practice offers extended hours on alternate Saturday mornings alternating with another local GP practice within the primary care home hub. All patients with GPs within the hub can make an appointment on any Saturday for a GP consultation between the hours of 8am and 2pm. At all other times 6.30pm to 8am patients are advised to call the NHS 111 telephone service where telephone calls are directed to Vocare, the out of hours service.

Additional information about the practice is available on their website www.newbridgesurgerywolverhampton.nhs.uk

Good

Are services safe?

Our findings

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

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had a suite of safety policies, which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and ongoing training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly, who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. For example, the practice held meetings with the identified health visitor for the practice at six weekly intervals. These meetings were held to discuss at risk children and children new to the practice and their families. This was included in the Wolverhampton Clinical Commissioning Group (CCG) Safeguarding Bulletin as an example of good practice.
- Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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 who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control (IPC). The local CCG IPC had carried out an audit in November 2017. The practice achieved one of three gold standard awarded within the CCG. An action plan to address issues identified had been developed. There were systems for safely managing healthcare waste.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. For example, records available showed that portable appliance testing (PAT) had been carried out. This involved an examination of electrical appliances and equipment to ensure they were safe to use at the practice.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. At our previous inspection in May 2015, we saw that the practice had arrangements in place to manage emergencies, with the exception of oxygen in the practice for use during a medical emergency. A risk assessment had not been completed to demonstrate how patients would receive the appropriate care and treatment in acute asthma attacks and other causes of hypoxia (insufficient oxygen in the blood and tissues). At this inspection the practice had ensured staff had access to oxygen, which was now included as part of the emergency equipment.
- At this inspection, we found that emergency equipment was not organised to ensure that it could be easily accessed in the event of an emergency. Following the inspection the practice sent photographs of the changes made. These showed that the equipment had been appropriately organised and stored to ensure ease of access.
- Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. The GP partners and the practice nurse were aware of the correspondence from NHS England alerting all practices about sepsis. Systems had been put in place to ensure an appropriate assessment of patients with presumed sepsis could be completed in line with NICE guidance. For example, the practice patient information system showed alerts when certain information was entered to alert the GPs to consider sepsis. The healthcare

assistant and receptionists had access to 'red flag' alerts, which included an awareness of sepsis symptoms that might be reported by patients and how they should respond. Patient information on sepsis was displayed and easily accessible to patients in consulting and waiting rooms.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. For example, care plans developed by the practice, multi-disciplinary team (MDT) were kept in patients homes so they were easily accessible to all health and social care professionals.
- We saw that the practice had active systems in place for sharing information with staff and other agencies. This included effective systems for sharing information with the out of hours service for patients nearing the end of their life and if they had a do not attempt cardiopulmonary resuscitation plan in place.
- Examples of referral letters looked at included all the necessary information needed to be shared to support safe care and treatment.
- Laptops used at the practice were encrypted to ensure security of patient and staff information.

Safe and appropriate use of medicines

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

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.
- We saw that the practice had carried out a risk assessment to outline the rationale for not stocking all of the suggested emergency medicines. The list of suggested emergency medicines had recently been updated to include a medicine to treat croup in children, which the practice did not stock. The risk assessment had been discussed with clinical staff during a clinical meeting. The practice had an independent pharmacy based at the practice. The risk assessment identified that the medicine would be easily available to the practice as the pharmacy kept it in stock.
- The practice had audited antimicrobial prescribing with the support of the local Clinical Commissioning Group (CCG) pharmacy team. The local CCG pharmacist confirmed that the practice actively managed antibiotic prescribing and records available confirmed this. We saw that antibiotic prescribing was discussed at clinical meetings. Records showed that the level of antibiotic prescribing was below the CCG and national averages.
- Patients' health was monitored to ensure medicines were being used safely and followed up appropriately. The practice involved patients in regular reviews of their medicines. The practice had an effective system in place to ensure that repeat prescriptions were not issued when a medicine review was overdue. All changes to patient medicines were checked by a GP before the prescription was issued to the patient.
- Processes were in place for handling repeat prescriptions.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses and felt supported by the management team to do so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. The practice could evidence a safe track record over time. We

Good

Are services safe?

reviewed records of events that had occurred during the last 12 months. The records showed that 27 significant events had been recorded and these had been shared at practice meetings and with individual staff and other agencies where appropriate. Eighteen of the recorded events identified information governance concerns. Seven of these raised concerns about patient confidentiality where patient information was issued to the wrong patient or health professional. These concerns were investigated, discussed at practice meetings and with relevant staff and measures put in place to prevent further occurrence. Changes made were followed up and reviews completed to confirm that these were embedded.

- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts. Alerts were discussed at practice meetings and there were systems in place to ensure they were acted on.

Good

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

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

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The practice was following guidance and prescribing effectively in areas for hypnotic prescribing and antibiotic prescribing, which included the percentage of high risk antibiotics prescribed.
- The practice used equipment to improve treatment and to support patients' independence. For example, ambulatory blood pressure monitoring and monitoring of blood clotting levels.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- The practice used the Electronic Frailty Index (eFI) tool to identify patients who were frail. The senior GP partner had researched this nationally recognised assessment tool for frailty in older patients and developed it to suit the needs of the practice. The practice presented a business case to the Clinical Commissioning Group (CCG) and successfully obtained funding to develop a designated clinic for the assessment of patients identified as frail or vulnerable. The CCG awarded funding to pilot the clinic for one year and patients under the age of 65 years were included in the trial. The funding ensured staff received appropriate training. The frailty clinic was set up in May 2017 and was called the 'Proactive Care Clinic' because patients objected to being labelled as frail. The clinic was led by the healthcare assistant and local CCG clinical pharmacist advisor. It was also planned that the clinic would be rolled out to other practices within Primary Care Home Group 1 (PCH1).
- Patients identified as frail or vulnerable were invited to attend the clinic for a full assessment. A four month trial of the clinic was successfully carried out at the practice. The practice had screened 194 patients identified as eligible for the clinic. Ninety one (47%) of these patients were seen over a four month period, 75 were assessed at the practice by the healthcare assistant and clinical pharmacist and 16 patients were seen by the GPs at their homes. An external audit completed after six months showed that the average number of GP appointments for this group of patients had gone down from 81 appointments over six months to 68. A full review of the clinic following the roll out of the clinic to other practices within PCH1 was due to take place. These clinics were also led by the practice healthcare assistant and local CCG clinical pharmacist advisor as part of the trial.

Older people:

- The practice invited patients' aged over 75 for a health check and were referred to other services such as voluntary and community services patients and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- The practice held regular meetings with the local district nurses, matron and palliative care team to discuss and manage the needs of patients with complex medical conditions.
- All patients with long-term conditions had individual care plans in place.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed.
- The practice performance for all three diabetes related indicators was comparable to the local CCG and

national averages. For example, the percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) was 5mmol/l or less was 81% compared with the CCG average of 78% and national average of 80%. The practice exception reporting rate of 14% was comparable to the local average of 12% and the national average of 13%.

The practice was involved in a local initiative to support improvements in the management of patients with diabetes. A diabetic consultant at the local hospital led the project. The consultant reviewed the care and treatment of all patients with poorly controlled diabetes with the practice staff and jointly developed care management plans for each patient. Patients with diabetes were invited for an annual health review at which all monitoring checks required would be carried out.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given was 94%, which was above the target percentage of 90%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- The practice had responded to recent guidance on the risks of women of childbearing age taking a specific medicine. The practice had written to all women of childbearing age who were prescribed the medicine. The letter advised patients of the concerns of taking this medicine and the action they should take if they are planning a pregnancy or become pregnant.

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

- The practice's uptake for cervical screening was 81%, which was above the expected 80% coverage target for the national screening programme. The practice had followed up the number of inadequate smears reported on and ensured improvements were made. The practice nurse received additional training and the equipment used was changed and improved where appropriate. The practice noted a decrease in the number of inadequate smears reported.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time, to protect them from the risk of meningitis or septicaemia.
- The practice provided sexual health advice and contraceptive services, such as contraceptive implants and coils, to their own patients

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way, which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. There were 26 patients on the practice learning disability register. All patients with a disability had a care plan in place and had their care needs reviewed with the support of the community learning disability nurses.
- The practice maintained a register of 62 patients with varied vulnerability, homeless (adults and young people), substance misuse and domestic abuse. The practice ensured that patients had full access to treatment and health reviews to support their clinical needs and their mental and physical wellbeing.

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

- 83% of patients diagnosed with dementia had their care reviewed in a face-to-face meeting in the previous 12 months. This was comparable to the CCG average of 83% and national average of 84%.

93% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was higher than the CCG average and national average of 90%.

- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption was 98% compared with the CCG average of 92% and national average of 91%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, the percentage of

patients experiencing poor mental health who had received discussion and advice about alcohol consumption was 98% compared with the CCG average of 92% and national average of 91%.
- The practice worked with a local university to provide trainee counsellors with the opportunity to see patients at the practice as part of their training. The practice employed one of the counsellors for approximately four months. A review of the service was positive and patients liked that they were seen within a few weeks of referral.

Monitoring care and treatment

The practice used information about care and treatment to make improvements. The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

The most recent published Quality Outcome Framework (QOF) results were 99% of the total number of points available compared with the clinical commissioning group (CCG) average of 96% and national average of 97%. The overall exception reporting rate was 9.3% compared with a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate).

The practice was aware of areas which required improvement within QOF (or other national) clinical targets. The GP partners and practice nurse had lead roles in chronic disease management. We saw that the exception rates were higher in some of the clinical domains compared to the CCG and national averages. We reviewed the records of a number of patients who had been exception reported during 2016/2017. One of the GP partners reviewed these figures and found that some patients had been incorrectly coded.

The local CCG benchmarked the practice against other practices in the locality. Areas identified as good practice was shared with other practices and areas requiring improvement had also been discussed. The Primary Care Home one (PCH1) group held regular peer review meetings to review and discuss the clinical management of medical conditions and share good practice. For example, at a meeting in October 2017 the group discussed the care pathways of patients newly identified with cancer over a six month period.

The practice had undertaken clinical audits some of which were linked to NICE best practice guidelines. The practice also monitored the quality of their antibiotic prescribing with the support of the CCG pharmacist advisor. One audit looked at the practice management of patients prescribed anticoagulant medicine (A medicine used to make the blood take longer to clot to help prevent strokes specifically caused by an abnormal heart rhythm) and whether required tests were carried out and up to date in line with local and national guidance. A two cycle audit was completed and improvements noted in the completion of tests carried out and accuracy of the dose of medicine prescribed. Following the audits the management of patients' identified as needing their treatment updated were reviewed, tests carried out and changes to their treatment made where appropriate. The outcome of the audit also ensured clinical staff were aware that all patients prescribed this medicine should be weighed at least annually to support the accuracy of specific kidney test results.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. For example, the healthcare assistant was being supported to complete additional training to enhance their assessment and knowledge in supporting frail patients. The practice manger, practice nurse and a receptionist were also being supported to undertake diploma level courses to support the needs of patients.
- Staff training records we looked at showed that all the learning and training needs of staff had been met and were up to date. We looked at the training records for

Good

Are services effective?

(for example, treatment is effective)

two members of staff these showed that staff had received health and safety related training such as fire safety, infection control and training related to the Mental Capacity Act (MCA) 2005.

- The GP partners ensured the competence of the GP trainee and practice nurse by mentoring, clinical supervision and support for revalidation and audit of their clinical decision making.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, mentoring, clinical supervision and support for revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. For example, pain management plans had been developed for patients who received end of life care.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. For example, the practice ensured patients personal preferences on how they wished their end of life needs to be met were clearly documented and followed.
- The GP partners met regularly with other health and social care professionals for example, community nurses to discuss patients identified with palliative care needs and those identified as frail or vulnerable.

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients who were homeless, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. The practice nurse supported by the healthcare assistant was actively involved in health promotion and offered services, which included well woman and well man checks and advice and weight monitoring and management.
- Health checks were offered to new patients when they registered with the practice and any health concerns detected were followed up in a timely way.

- Data from Public Health England showed that 53% of new cancer cases (among patients registered at the practice) were referred using the urgent two week wait referral pathway. This was higher than the CCG average of 42% and the national average of 50%. Patients were also encouraged to attend national screening programmes for bowel cancer and breast cancer screening. The patient take up rate for screening in these areas showed that the practice performance was higher than the CCG and national averages. For example:

  - The practice uptake for females, aged 50-70, screened for breast cancer in last 36 months was 54% this was higher than the CCG average of 47% and the same as the national average.

  - The practice uptake for patients aged 60-69, screened for bowel cancer within 6 months of invitation was 78% this was higher than the CCG average of 67% and national average of 70%.

- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported patients to improve their health, for example, encouraging patients to stop smoking and tackling obesity at their health reviews. Patients were signposted to services in the local community.

Consent to care and treatment

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

Good

Are services effective?

(for example, treatment is effective)

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 42 patient Care Quality Commission comment cards we received contained positive comments about the service experienced. This was in line with the practice NHS Friends and Family Test results completed between February 2016 and October 2017 and the outcome of a patient survey carried out by the practice in 2017.
- Ninety four percent of patients who responded to the July 2017 annual national GP patient survey said that they would recommend the practice compared with the CCG average of 74% and the national average of 79%

Results from the July 2017 annual national GP patient survey was overall positive and showed patients felt they were treated with compassion, dignity and respect. 266 surveys were sent out and 103 were returned. This represented about 2% of the practice population. The practice had the highest satisfaction scores in its local area and was also one of the top ten highest scoring GP practices nationally. For example:

- 94% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 84% and the national average of 89%.
- 91% of patients who responded said the GP gave them enough time compared with the CCG average of 84% and the national average of 86%.
- 99% of patients who responded said they had confidence and trust in the last GP they saw compared with the CCG average of 94% and the national average of 95%.
- 94% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 81% and the national average of 86%.
- 91% of patients who responded said the nurse was good at listening to them compared with the CCG average of 90% and national average of 91%.
- 93% of patients who responded said the nurse gave them enough time compared with the CCG average of 91% and national average of 92%.
- 98% of patients who responded said they had confidence and trust in the last nurse they saw compared with the CCG and national averages of 97%.
- 91% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared with the CCG average of 90% and national average of 91%.
- 95% of patients who responded said they found the receptionists at the practice helpful compared with the CCG average of 84% and national average of 87%.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, these were available in languages other than English, informing patients of the services available.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.

The practice held a register of 42 patients who were carers (0.9% of the practice list). Practice staff had identified that they needed to be proactive about asking patients about caring responsibilities to ensure they identified changing circumstances.

- Patients were asked at registration if they had any caring responsibilities and the computer system alerted staff if a patient also had caring responsibilities. Notices in the patient waiting room and on the practice website signposted patients and their carers to support services available to them. The practice produced a monthly bulletin for carers.

Good

Are services caring?

- Receptionists had received care navigation training, this enabled staff to help patients and their carers access community and advocacy services.
- Staff told us that if families had suffered bereavement, the practice would contact them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were higher than the local average and mostly higher than the national averages:

- 95% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 83% and the national average of 86%.
- 89% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78% and the national average of 82%.
- 90% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 89% and the same as the national average of 90%.
- 90% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 86% and national average of 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.
- A leaflet was available for patients to explain how their health records were used, the information collected, how they could access information and how their information was secured and kept confidential.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs. For example, extended opening hours, online services such as repeat prescription requests and advanced booking of appointments.
- The Wolverhampton Total Health Primary Care Home Group (PCH1) provided extra clinics over bank holidays. The clinics were held over the Easter and May bank holiday periods. The uptake for the clinics ranged from 43% to 108% over both bank holiday periods and the outcome of a patient survey showed that approximately 97% of patients found the service excellent or good. Overall the clinics were a success and as a result access to clinics on Saturdays were offered to patients.
- The practice signposted patients to voluntary and other community health services appropriate to support their health and social care needs.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, telephone consultations and home visits were offered where appropriate. The practice had an open access clinic, where patients were invited to turn up before 11am each day to see a GP without an appointment. There were no limits on the number of patients that could be booked. The clinic operated on average between 8.50am and 2pm. One of the GPs ran the clinic up to 11am. After 11am all three GPs helped out to ensure patients were seen as quickly as possible.

Older people:

- The practice was responsive to the needs of older patients and was aware of its increasing older population. The practice offered home visits and rapid access appointments for those with enhanced needs.
- The practice had a larger number of older people compared with the local and national averages. The practice identified and assessed the physical, social and mental health needs of older and frail patients at the proactive care (frailty) clinic to improve their health and wellbeing.
- The practice worked with community services to support meeting the holistic needs of older patients and patients identified as frail. The healthcare assistant carried out baseline checks, which enabled them to signpost patients to community services. These services included for example, the fire service who carried out fire prevention checks and installed smoke alarms in patients' homes, befriending services, exercise groups, home improvement and handyman services and falls prevention.
- The practice offered urgent appointments for those with enhanced needs and on the day appointments and or telephone consultations where appropriate. The GP accommodated home visits for those who had difficulties getting to the practice. The practice also took part in a CCG residential home scheme, which involved undertaking weekly rounds at the homes.
- The practice liaised with social and voluntary agencies to provide extra support for older people. For example, Age Concern and the social prescribing service, (enables primary care services to refer patients with, emotional or practical needs to a range of local, non-clinical services, often provided by the voluntary and community sector). These support workers worked within the locality as part of the social prescribing service. The social prescriber helped patients improve their health and wellbeing and signposted or supported them to access services that could help with issues such as finances, housing and other social issues such as loneliness.
- Patients aged over 75 years had routine annual reviews carried out.
- The practice worked closely with families who were carers for their elders.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met.
- Patients with long-term conditions had access to phlebotomy services at the surgery.
- Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice offered extended asthma and Congestive Obstructive Pulmonary Disease (COPD) clinics at which a specialist nurse provided patients with 30 minutes asthma checks.

Families, children and young people:

- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, a register for children and young people with safeguarding concerns was maintained, and had alerts on their care records. Records we looked at showed that health reviews were up to date and evidence of multidisciplinary care reviews and discussions held with schools and the health visitor for example where appropriate.
- A weekly midwife led antenatal clinic was held at the practice.
- Young people were offered access to sexual health screening advice and chlamydia screening testing equipment was easily accessible in the reception area.
- In October and November 2017, the practice was involved in making one of a series of five short films aimed at raising awareness about sexual health and contraceptive services for young people in Wolverhampton. The film involved a high level of young people participation in its co-production to ensure their perspective and perceptions were inclusive in the making of the film. The lead GP partner was actively involved in organising the event at the practice and took part in the film, which was facilitated by Public Health. The film was not ready for release at the time of the inspection, however the practice was praised for putting the young people and other professionals at their ease. The producers had told us that this enabled a very informative and accessible short film to be produced. It was intended that the completed series of films would be used as a teaching/learning resource in the new Wolverhampton secondary school Relationships & Sex Education (RSE) curriculum, at local schools. The film clips would also be made available on online learning websites.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours and a flexible range of appointments throughout the day if urgent.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The practice worked closely with a local football academy to ensure a comprehensive suite of services could be provided. For example, consent to share information where appropriate and ensured timely access to Meningococcal (ACWY) vaccinations that would not impact on match days. Meningococcal infection is a very rare but serious disease. It can cause meningitis, an infection of the fluid/lining of the brain and spinal cord and septicaemia, a blood infection.
- The practice identified that students needed to be made aware of the registration process if they registered with a GP nearer to the university they attended. The practice ensured students were made aware of this when letters to attend the practice for a Meningococcal (ACWY) vaccination were sent out.

People whose circumstances make them vulnerable:

- The practice worked closely with and signposted vulnerable patients to community social agencies and community health professionals. Receptionists had received care navigation training to enable them to signpost patients directly to the most appropriate source of help. They were able to refer to information about services at the practice, other NHS providers and the wider care and support sector. Information about these services were also available on the practices website.
- Social prescribing reviews were offered to vulnerable patients. These reviews were carried out in the patients home or at the practice.
- The practice provided services to four hostels for the homeless.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The practice held a register of patients experiencing poor mental and or dementia.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- All patients experiencing poor mental health (including people with dementia) had a care plan completed.
- The practice ensured patients experiencing poor mental health (including people with dementia) had care reviews and worked closely with the community mental health team to ensure appropriate and timely management. Patients who failed to attend appointments were proactively followed up by a phone call from a GP or the practice nurse.
- The practice found that patients experiencing poor mental health valued the access to the open access clinic at the practice.

Timely access to the service

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

- Patients had timely access to an initial assessment, test results, diagnosis and treatment.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was higher than local and national averages. 266 surveys were sent out and 103 were returned. This represented about 2% of the practice population. This was supported by observations on the day of inspection and completed comment cards.

- 88% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) and national averages of 80%.
- 95% of patients who responded said they could get through easily to the practice by phone compared to the CCG average of 68% and national average of 71%.
- 94% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared to the CCG average of 67% and the national average of 76%.
- 92% of patients who responded said their last appointment was convenient compared to the CCG average of 77% and the national average of 81%.
- 91% of patients who responded described their experience of making an appointment as good compared to the CCG average of 69% and the national average of 73%.
- 78% of patients who responded said they don't normally have to wait too long to be seen compared to the CCG average of 57% and national average of 58%.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was accessible to patients through leaflets at the practice and on the practice website.
- The complaint policy and procedures were in line with recognised guidance. The guidance available ensured staff treated patients who made complaints compassionately.
- The practice had received three formal written complaints in the last year. Records we looked at showed that these had been appropriately responded to in a timely way. Patients and staff told us that verbal concerns received were documented and reported to the practice manager or GP. Staff advised that most concerns raised verbally were resolved immediately.
- The practice learned lessons from individual concerns and it acted where appropriate to improve the quality of care.

Are services well-led?

Good

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

Our findings

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

Leadership capacity and capability

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

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it. They were knowledgeable about issues and priorities related to the quality and future of services. They understood the challenges and were addressing them. For example, there were plans to extend the premises to support meeting the holistic needs of patients.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. Staff we spoke with were very positive about the support provided by the GP partners, practice manager and office manager.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. The lead GP partner, practice nurse and practice manager had completed a NHS leadership course (triumvirate training). This training was designed to empower the leaders and the team to develop their practice. The three leaders had to work together to achieve a common vision.
- The lead GP partner was the lead for the Wolverhampton Total Health Primary Care Home Group (PCH1) of GP practices.

Vision and strategy

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

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. For example, the development of the 'Proactive Clinic' to support the holistic care and support of frail patients and the involvement in sexual health awareness for young people and students.
- The practice encouraged feedback from patients, staff and external partners in the planning of its vision, values and strategy.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population. For example, the practice had an onsite independent pharmacy, which provided convenient access for patients. There were plans to extend this further when the approved work on the extension to the GP practices commenced. The extension of the premises would also enable the practice to improve patient access to enhanced services and professionals in the wider community for example, community psychiatric nurses, physiotherapy and leg ulcer clinics.

Culture

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

- Staff stated they felt respected, supported and valued and were proud to work at the practice. Staff were enthusiastic about their role in caring and supporting patients. They told us that the management proactively supported and encouraged staff to access training.

- Leaders and managers acted on behaviour and performance which was inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received had received an annual appraisal in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- All staff were considered valued members of the practice team. The practice nurse and GP ensured they had protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.

Are services well-led?

Good

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

- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they and patients were treated equally.
- It was evident that there were positive relationships between all the staff working at the practice.

Governance arrangements

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

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

Managing risks, issues and performance

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

- There was a process in place to identify, understand, monitor and address current and future risks including risks to patient safety.

- The practice had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. The GP had oversight of MHRA alerts, incidents and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents. During training and drills simulation exercises were carried out.
- The practice implemented service developments and encouraged involvement from all staff.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- Reported information was used to monitor performance and the delivery of quality care. This information was shared with staff and plans were put in place to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care. For example, alerts were on the patient computer systems to alert staff to patients at risk and texts were used to contact patients.
- The practice submitted data or notifications to external organisations as required.
- Arrangements in place were in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Records we looked at showed that these arrangements were regularly audited.

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. To encourage full and diverse views from patients of all groups the practice targeted these groups, for example, ethnic minority groups, carers and patients in care homes and parents with babies/young children by postal surveys or directly at the practice.
- The friends and family test (FFT) was regularly monitored. The practice used feedback from the FFT, the national patient survey and the practice survey to support improvements at the practice. For example, the practice changed the name of the frailty clinic to the proactive care clinic in response to objections from patients to being labelled as frail.
- There was an active patient participation group (PPG) that met every three months. There was also an email group. We spoke with a member of the PPG after our

Are services well-led?

Good

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

inspection. They told us the practice listened and acted on issues they raised. For example, providing children's books in the waiting room and identifying designated no smoking areas in the grounds of the practice. The practice PPG chairperson was very active in various groups within the community and they shared this knowledge and experiences with the wider PPG group.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- The practice was part of Wolverhampton Total Health Primary Care Home. The group, known as (PCH1) consisted of eight Wolverhampton GP practices. The aim of this group of GP practices was to work together as an extended team to share specialist skills and offer new services. Patients were reassured that they would continue to receive care at their existing GP practice.
- There were systems and processes for learning, continuous improvement and innovation. The practice was part of the local Clinical Research Network, West Midlands.
- There was a focus on continuous learning and improvement at all levels within the practice.
- The practice used innovative and proactive methods to improve patient outcomes. For example, the practice had piloted in house psychotherapy with newly qualified counsellors.
- The practice was not only proactive in managing, monitoring and improving outcomes for its own patients but it shared its learning locally and nationally to drive improvements.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance. There was a formal system in place to encourage peer appraisal and reward.