

Bilston Urban Village Medical Centre

Quality Report

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Requires improvement 

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 Bilston Urban Village Medical Practice on 1 July 2016. Overall the practice is rated as good.

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

- There were systems in place for reporting and recording significant events. Some significant event records were not available which made it difficult to track the events.
- Staff understood their responsibilities to raise concerns and to report incidents and near misses.
- Risks to patients were assessed but the practice did not maintain records of the safety alerts it received to confirm the alerts had been reviewed and appropriate action taken.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- The practice had a programme of continuous clinical and internal audit in order 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 experienced problems getting an appointment. Urgent appointments were available on 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.
- The provider was aware of and complied with the requirements of the duty of candour.
- The practice had governance arrangements in place, but effective arrangements were not in place to ensure records were maintained for the required time period before they were destroyed.

Summary of findings

The areas where the provider should make improvements are:

- Review the arrangements for the maintenance, security and destruction of records.
- Review the arrangements for recording the receipt and action taken in response to alerts received from relevant bodies such as the Medicines and Healthcare products Regulatory Agency (MHRA).
- Review the arrangements for checking the ongoing accuracy of fridge temperature monitoring records to ensure that medicines requiring refrigeration are stored in line with the manufacturer's guidance.
- Consider pro-actively identifying carers and establishing what support they need.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services.

Good



- There was a system in place for reporting and recording significant events. Records showed that reviews had taken place to ensure that actions taken had improved services. However records of significant events examined at the inspection were different to those detailed in the significant events log. The records were not available and were said to have been destroyed which made it difficult to track the events.
- When things went wrong patients received reasonable support, relevant information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed but the practice did not maintain records of the safety alerts it received to confirm that the alerts had been reviewed and appropriate action taken if required.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework (QOF) showed that the overall achievement of 99% of the available points was above average compared to the locality average of 92% and the national average of 95%.
- Staff assessed patient needs and delivered care in line with current evidence based guidance.
- Clinical audits carried out demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs. For example, the practice worked with consultants from the local hospital to manage and monitor the care and treatment of patients with long term conditions such as diabetes.
- Arrangements were in place to gain patients' informed consent to their care and treatment.

Summary of findings

- 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.

- Data from the national GP patient survey results published in January 2016 showed patients rated the practice similar to others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice carers register was small and only represented 0.16% of the practice population, which was significantly lower than the expected percentage of at least one percent.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example the practice worked closely with secondary care professionals on initiatives to improve the care of patients with long term conditions.
- Patients were concerned that they could not always get through to the practice on the telephone. The practice was aware of this and was actively trying to address patients' concerns.
- Patients said they did not find it easy to make an appointment with a named GP and there was not always continuity of care. Urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised.

Good



Are services well-led?

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

Requires improvement



Summary of findings

- The practice had a vision and strategy to deliver high quality care and promote good outcomes for patients.
- There was a clear leadership structure and staff felt supported by the management.
- The practice had a number of policies and procedures to govern activity.
- The practice had some governance arrangements in place, however:
 - Effective arrangements were not in place to ensure records were maintained for the required time period before they were destroyed.
 - There was no evidence to confirm that the practice maintained a record of alerts received with details of action taken and completed to show that appropriate action had been taken where required.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

The six population groups and what we found

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

Older people

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

- The practice offered personalised care to meet the needs of the older people in its population. Home visits and flexible appointments were available for older patients.
- Patients aged 75 years plus were offered annual health checks, allocated a named GP and were included on the practice hospital admission avoidance register.
- The practice maintained a register of housebound older patients and older patients who required a home visit.
- Older patients were offered urgent appointments for those with enhanced needs plus longer appointments which gave them more time to discuss health issues with a clinician.

Good



People with long term conditions

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

- The GPs, nurses and healthcare assistants had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The GPs and nurses worked with relevant health care professionals to deliver a multidisciplinary package of care to patients with complex needs.
- The practice Quality and Outcomes Framework (QOF) score for the care of patients with long-term conditions was higher overall compared to the local and national average. For example the practice performance for diabetes related clinical indicators overall was higher than the local Clinical Commissioning Group and England average (95% compared to the local average of 82% and England average of 89%).
- Longer appointments and home visits were available when needed.

Good



Families, children and young people

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

- Immunisation rates were relatively high for all standard childhood immunisations.

Good



Summary of findings

- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Babies were given their first immunisations on the same day as mothers were offered their six week postnatal check.
- The practice's uptake for the cervical screening programme was 79% which was comparable to the local Clinical Commissioning Group (CCG) average of 78% and England average of 82%.
- Protected daily appointments were available for children of all ages and children aged under the age of one were given priority and seen on the day. Appointments were available outside of school hours and urgent appointments were available for children.
- We saw positive examples of joint working with other professionals.

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 practice offered on telephone consultations specifically for workers.
- Extended hours appointments were available each weekday between the hours of 8am and 8pm and on Saturday from 8am to 12 mid-day.
- The practice was proactive in offering online services which included making online prescription and appointment requests.
- Patients were sent telephone texts to remind them about their appointment and to send test results.
- Patients were signposted to a full range of health promotion and screening that reflects the needs for this age group.

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.

- The practice held a register of patients with a learning disability and offered this group of patients longer appointments.
- The practice was alerted to other patients whose circumstances may make them vulnerable or may present a risk to ensure that they were registered with the practice if appropriate.
- The practice supported patients who were identified as being homeless and provided both health and social professional support.

Good



Summary of findings

- The practice had told vulnerable patients about how to access various support groups and voluntary organisations.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.

People experiencing poor mental health (including people with dementia)

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

- The practice worked with multi-disciplinary teams in the case management of people who experienced poor mental health, including those with dementia.
- The practice maintained a register of patients diagnosed with dementia
- The practice held a register of patients who experienced poor mental health. Clinical data for the year 2014/15 showed that 96% of patients on the practice register who experienced poor mental health had a comprehensive agreed care plan in the preceding 12 months. This
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Counselling clinic sessions were held at the practice with an experienced mental health counsellor based in the community.
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 86%, which was higher than the national average of 84%.

Good



Summary of findings

What people who use the service say

The national GP patient survey results published in January 2016 showed the practice was performing similar to the local and national averages in several areas. A total of 411 surveys (6.9% of patient list) were sent out and 97 (23.6%) responses, which is equivalent to 1.6% of the patient list, were returned. Results indicated the practice performance was similar or lower than other practices in some aspects of care, which included for example:

- 53% of the patients who responded found it easy to get through to this surgery by phone compared to the local Clinical Commissioning Group (CCG) average of 70% and a national average of 73%.
- 49% of the patients who responded were able to get an appointment to see or speak to someone the last time they tried (CCG average 70%, national average 76%).
- 70% of the patients who responded described the overall experience of their GP surgery as fairly good or very good (CCG average 81%, national average 85%).
- 54% of the patients who responded said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 73%, national average 79%).

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 32 comment cards which were mostly positive. Patients said they were happy with their care, staff were extremely helpful, professional, courteous and friendly and doctors listened to their problems. There were some less positive comments related to the length of time taken to get through to the practice on the telephone, problems getting an appointment and that appointments run late.

We also spoke with two patients on the day of our inspection, which included a member of the patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. Their comments were in line with the comments made in the cards we received.

The practice monitored the results of the friends and family test monthly. The results for the period July 2015 to June 2016 showed that 84 responses were received by the practice. There were 51 patients who were extremely likely to recommend the practice to friends and family if they needed similar care or treatment, 22 patients were likely to recommend the practice, two patients were neither likely nor unlikely, seven patients unlikely and two patients extremely unlikely to recommend the practice.

Areas for improvement

Action the service SHOULD take to improve

- Review the arrangements for the maintenance, security and destruction of records.
- Review the arrangements for recording the receipt and action taken in response to alerts received from relevant bodies such as the Medicines and Healthcare products Regulatory Agency (MHRA).
- Review the arrangements for checking the ongoing accuracy of fridge temperature monitoring records to ensure that medicines requiring refrigeration are stored in line with the manufacturer's guidance.
- Consider pro-actively identifying carers and establishing what support they need.

Bilston Urban Village Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Bilston Urban Village Medical Centre

Bilston Urban Village Medical Centre is one of two GP practices in Wolverhampton owned by Intrahealth, a corporate provider of NHS primary care services. The practice has good transport links for patients travelling by public transport. There is ample parking spaces available for patients travelling by car. The premises are a single storey building. All areas are easily accessible by patients with mobility difficulties and families with pushchairs or prams.

The practice team consists of two medical directors who also undertake sessions as GPs at the practice, four GPs (four male and two female), who work across the two of the Intrahealth practices based in Wolverhampton. The practice also use regular GP locums to support the clinicians and meet the needs of patients at the practice. The clinical practice team includes two clinical pharmacists, an advanced clinical practitioner, three nurse practitioners, two practice nurses, a healthcare assistant and a phlebotomist. The clinical pharmacists and nursing staff also work over both sites. Practice staff also include a

practice manager, reception manager and six administration/ receptionist support staff. In total there are 24 staff employed either full or part time hours to meet the needs of patients. The practice is a training practice for GP trainees.

The practice is open between 8am to 8pm on a Monday to Friday and 8am to 12pm on Saturdays. 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 Vocare via the NHS 111 service.

The practice has a contract to provide Alternative Provider Medical Services (APMS) to approximately 6,200 patients. This allows the practice to have a contract with NHS and other non-NHS health care providers to deliver enhanced and primary medical services to meet the needs of the local community. They provide Directed Enhanced Services, such as the childhood vaccination and immunisation scheme and new patients' health checks. The practice provides a number of clinics for example long-term condition management including asthma and diabetes.

The practice has a significantly higher young population compared to the average across England. There is a high number of patients aged nine and below, female patients aged 20 to 24 years and patients between the ages of 25 to 39 years. The practice is located in one of the most deprived areas of Wolverhampton. People living in more deprived areas tend to have a greater need for health services. There is a higher practice value for income deprivation affecting children and older people in comparison to the practice average across England. The

Detailed findings

level of income deprivation affecting children of 37% is higher than the national average of 20%. The level of income deprivation affecting older people is higher than the national average (32% compared to 16%).

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 1 July 2016.

During our visit we:

- Spoke with a range of staff including the GPs, practice nurses, and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members.

- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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

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

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

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

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

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach to learning and a system was in place for reporting and recording significant events. Staff told us they would inform the GPs or practice manager of any incidents to ensure appropriate action was taken. One of the GPs was responsible for forwarding safety alerts to clinicians and a copy of these was forwarded to relevant staff. We were told that medicine alerts were actioned by the local pharmacy advisor linked to the practice. The pharmacist carried out the relevant searches to determine if patients were affected by the alerts and emailed the GP directors with the results. The practice did not maintain a record of alerts received with details of action taken and completed to demonstrate that the alerts had been discussed and appropriate action taken if required.

We reviewed safety records and incident reports where these were reported and discussed. The practice had recorded 14 significant events, both clinical and operational which had occurred between February 2015 and May 2016. One of the events showed that an incorrect appointment was booked for a patient with a similar name. This was investigated and the outcome identified that staff needed to ensure that patients' identification details were thoroughly checked and confirmed with the patient. It was noted that other similar incidents had occurred. The practice had updated its procedures for staff on the process to be followed when checking patients.

We found that records of significant events examined at the inspection were different to those detailed in the significant events log. It was therefore difficult to track the events and we were told that the original records may have been shredded. We discussed with the managers, records retention requirements which should be followed and reflected in the practice information governance arrangements. The minutes of practice meetings demonstrated that appropriate learning from events recorded had been shared with staff and external stakeholders. 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.

Overview of safety systems and processes

Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. One of the GPs and one of the nurse practitioners were the practice leads for safeguarding. Staff we spoke with demonstrated that they understood their responsibilities and told us they had received training relevant to their role. Certificates of safeguard training at the appropriate level were seen for staff. The practice routinely reviewed and monitored children who did not attend hospital appointments and immunisation appointments. The practice also monitored both adults and children who made regular visits to the accident and emergency department and included patients who were non-compliant with taking their medicines. Suspected safeguarding concerns were shared with health visitors and midwives linked to the practice and other relevant professionals. This involved where necessary providing reports for external agencies, such as social workers and the local safeguarding team. The practice had updated the records of vulnerable patients to ensure safeguarding records were up to date. The practice shared examples of occasions when suspected safeguarding concerns were reported to the local authority safeguarding team.

Posters advising patients they could access a chaperone were displayed in the waiting room, in the practice information leaflet and on the practice website. Posters were available in different languages and also pictorial format. This ensured that different patient groups were made aware that this service was available to them. All staff who acted as chaperones were 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.

The practice had an infection control policy and supporting procedures were available for staff to refer to. One of the nurse practitioners was the clinical lead for infection control. The nurse practitioner had completed hand hygiene audits with staff, the results showed positive

Are services safe?

outcomes. There were cleaning schedules in place and cleaning records were kept. Treatment and consulting rooms in use had the necessary hand washing facilities and personal protective equipment which included disposable gloves and aprons. Hand gels for patients and staff were available in accessible areas within the practice.

Appropriate clinical waste disposal contracts were in place. Clinical staff had received occupational health checks for example, hepatitis B status and appropriate action taken to protect staff from the risk of harm when meeting patients' health needs.

The practice had systems for ensuring that medicines were stored in line with manufacturers guidance and legislative requirements. This included daily checks to ensure medicines were kept within a temperature range that ensured they were effective for use. We found that the records of the actual temperature of one of the fridges which stored vaccines was consistently recorded as being on the higher side of the maximum temperature level. We saw that the practice also used a thermometer which was kept in the fridge to continuously monitor the temperature. The data collected on this thermometer could be downloaded onto a computer and a report produced that would confirm the actual temperatures maintained by fridge over a period of time. The practice assured us that if concerns had been identified this would have been acted on. However the practice was unable to produce evidence of this at the time of the inspection to confirm the temperatures maintained by the fridge had been within the acceptable range at all times.

The practice had systems in place for the prescribing and monitoring of high risk medicines. There were shared care agreements in place with a local hospital for some patients, prescribed high risk medicines that needed to be monitored. Blood test results were accessible by the practice electronically but could not be downloaded to the patient computerised records held at the practice. The GPs told us that they looked at the test results every time a prescription was issued. Following the inspection the practice sent us a copy of the practice medication policy for the monitoring and issuing of high risk medicines. The policy detailed the process to be completed by staff for recording when tests were due and to ensure the results were added to individual patients records. The practice

also provided information to demonstrate the work being undertaken with the local hospital to move to a system which would allow patient hospital test results to be downloaded and linked to patients primary care records.

Prescription pads and forms were securely stored and appropriate systems were in place to monitor their use. Repeat prescriptions were authorised for up to three months, after this period of time prescriptions could not be issued until patient was reviewed by a GP. Regular medication audits were carried out with the support of the local Clinical Commissioning Group (CCG) pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. The local prescribing advisor linked to the practice had carried out medicine reviews with patients who were taking four or more medicines.

The practice had an advanced clinical practitioner and three nurse practitioners who were qualified independent prescribers. They could prescribe medicines for specific clinical conditions. The nurses received mentorship and support from the medical staff for this extended role. Specific medicine directions (Patient Group Directions for the practice nurses and Patient Specific Directions for the healthcare assistants) were adopted by the practice to allow the practice nurses and healthcare assistants to administer specific medicines in line with legislation.

We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). The practice used GP locums to support the clinicians and meet the needs of patients at the practice. The practice obtained sufficient and appropriate information such as DBS checks and confirmation of the locum GPs right to work in the United Kingdom. This information was used to confirm that locum staff were suitable to work with patients at the practice.

Monitoring risks to patients

Risks to patients were assessed and well managed. There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception area. The building where the practice was located was managed and maintained by NHS property services. They provided

Are services safe?

the practice with information to demonstrate that an up to date fire risk assessment had been carried out. Records available showed that fire safety training had been completed by staff and two fire drills had taken place over the previous two years. Regular fire safety checks of the environment and fire alarms, emergency lighting and fire extinguishers were carried out. Records showed that fire prevention equipment and fire alarms were serviced within the last year.

All electrical equipment was checked annually to ensure the equipment was safe to use and clinical equipment had been checked yearly to ensure it was working properly. It was noted that one of the electronic weighing scales had not been checked. The practice was aware of this and we saw that equipment that had failed the checks were removed for repair or disposal.

The property services team had a policy for the management, testing and investigation of legionella (Legionella is a term for a particular bacterium that can contaminate water systems in buildings). A report was available to show that a legionella risk assessment had been completed in February 2016. Information was not available to confirm that action had been taken to address the recommendations made. The practice manager told us that confirmation of this would be obtained.

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 used locum GPs to help meet the needs of patients at times of GP absence such as annual leave. A GP locum recruitment and induction pack was available to ensure appropriate checks were carried out to confirm the suitability of potential staff to work with patients.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents. There was a panic alarm system in place at the front reception desk and in all the consultation and treatment rooms which alerted staff to any emergency. The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and copies of the plan were kept off site.

All staff received annual basic life support training and there were emergency medicines available. These medicines were stored in a secure area of the practice, were easily accessible to staff and all staff knew of their location. All the medicines we checked were in date. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book was available. Two of the staff were trained as first aiders.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed patients' needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. NICE guidelines were received by email and one of the GPs shared the guidelines with relevant staff if necessary by email or through informal discussions. Guideline summaries were laminated and displayed on the notice boards in clinical consulting rooms. The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and reviewed their performance against the national screening programmes to monitor outcomes for patients. The practice achieved 99% of the total number points available for 2014-2015 this was higher than the local Clinical Commissioning Group (CCG) average of 92% and the national average of 95%. The practice clinical exception rate of 12% was higher than the CCG average of 7.5% and national average of 9.2%. Clinical exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. Further practice QOF data from 2014-2015 showed:

- The percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was higher than the local and national average (94% compared to the local average of 87% and England average of 88%). The practice exception reporting rate of 7.3% showed that it was higher than the local average of 4.8% and just below the England average of 7.6%.

- 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 93%. This was higher than the local CCG average of 91% and England average of 90%. COPD is the name for a collection of lung diseases. The practice exception reporting rate of 4.3% showed that it was lower than the local average of 6.8% and national average of 11.1%.
- Performance for mental health related indicators was higher than the local CCG and national averages. For example, the percentage of patients experiencing mental health disorders who had a comprehensive, agreed care plan documented in their records in the preceding 12 months was 96% compared to the local CCG and England average of 88%. The practice clinical exception rate of 16.7% for this clinical area was higher than the local CCG average of 8.7% and England average of 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 higher than the national average (86% compared to the local CCG average of 82% and England average of 84%). The practice clinical exception rate of 12.5% for this clinical area was higher than the local CCG average of 7.7% and the England average of 8.3%.

The practice had performed well overall when compared to the local CCG and England averages and there were no clinical areas that showed a significant large variation. Clinical staff were aware however, that there were high clinical exception reporting in some areas. For example, the overall exception reporting rates for the diabetes clinical indicators was 18%. This was higher than the local CCG average of 8.8% and the England average of 10.8%. The practice had introduced a number of changes and was involved in local initiatives to support improvements in the review of patients with chronic health conditions. For example, additional staff had been employed to support improvements in the number of patients who received a review of their care and treatment. The practice worked closely with consultants who specialised in diabetes to promote community led care for patients diagnosed with diabetes. The responsibility for QOF performance monitoring was shared between practice staff. We saw that

Are services effective?

(for example, treatment is effective)

the CCG benchmarked the practice against other practices in the locality. The GPs attended peer review meetings with other local GP practices where clinical issues, treatments and performance were discussed.

Clinical audits were carried out to facilitate quality improvement and the practice encouraged all staff to carry out audits this included nurses and reception staff. We saw that 12 clinical and non-clinical audits had been carried out over the last 12 months. One of the audits looked at whether patients prescribed specific medicines that could have an adverse effect on their kidney function had blood tests completed every 12 months. The first audit identified 333 eligible patients and 18 of these patients had not had the tests carried out. Arrangements were put in place for patients to be contacted and alerts put onto patients files to ensure staff were made aware that the tests were needed. A second audit carried out two months later showed similar results to the first audit and the practice determined that regular ongoing searches would have to be completed.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. The practice had an induction programme for all newly appointed staff. Staff received a handbook which contained information such as policies and procedures related to working practices. All staff received training that included equality and diversity, chaperoning, safeguarding, mental capacity, fire safety, health and safety and basic life support. GP Locums also received a formal induction and were given a folder containing relevant information such as health and safety, clinics, equipment, contact numbers and staff roles to support them when working at the practice.

The learning needs of staff were identified through a system of appraisals, meetings and reviews of their individual development needs. All staff had had an appraisal within the last 12 months. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. The practice could demonstrate how they ensured role-specific training and updating for relevant staff was completed. Staff had the skills, knowledge and experience to deliver effective care and treatment. Staff had access to and made use of e-learning modules, in-house and external training opportunities. The GPs and practice nurse had all completed clinical specific training updates to support

annual appraisals and revalidation. The practice nurse received training and attended regular updates for the care of patients with long-term conditions, cytology and administering vaccinations. The practice nurse also attended local peer group meetings with other practice nurses to keep up-to-date with new practices.

Coordinating patient care and information sharing

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

This included care and risk assessments, care plans, medical records, clinical investigations and test results. Information such as NHS patient information leaflets were also available. The practice shared relevant information with other services in a timely way, for example when referring patients to secondary care such as hospital or to the out of hours (OOH) service. A computerised system was in place to share and communicate information to the OOH service.

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, including when they were referred, or after they were discharged from hospital. Formal multidisciplinary case review meetings where all the patients on the palliative care register were discussed were held every three to four months. Changes in the care to be delivered were transferred to patients care plans. Patients were referred for specialist care when needed, patients wishes on their place of death were observed and decisions related to resuscitation should their health deteriorate was documented. The practice worked closely with other professionals who also carried out clinics at the practice. These professionals included midwives and counsellors, who provided a service to patients who experienced poor mental health.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of

Are services effective?

(for example, treatment is effective)

legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment. The process for seeking consent was monitored through records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet and smoking. Patients had access to appropriate health assessments and checks. The practice actively promoted campaigns for flu vaccinations and sexual health. Patients were signposted to relevant health promotion services for example, smoking cessation clinics, dietary advice and health trainers. We saw that notice boards in the waiting area were themed to provide health related information on specific conditions such as diabetes. Health promotion information with details of support services was also available and accessible to patients on the practice website.

The practice offered travel vaccines, childhood immunisations and influenza vaccinations in line with current national guidance. Data collected by NHS England for 2014/15 showed that the performance for childhood immunisations was lower than the local CCG average overall for patients under two years of age. Data for the other two age groups was similar to the local CCG average. For example, the practice childhood immunisation rates for children:

- under two years of age ranged from 72% to 93%, (CCG average 74% to 96%),
- aged two to five 81% to 98%, (CCG average 84% to 96%)
- aged five year olds from 77% to 96%, (CCG average 77% to 95%)

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 83% which was higher than the local CCG average of 78% and the England average of 82%. The practice was proactive in following these patients up by telephone and sent reminder letters. Public Health England national data showed that the number of females aged 25-64; attending cervical screening within target period (3.5 or 5.5 year coverage) was higher than the England average (75% compared to the average across England of 74%). Data for other cancer screening indicators such as bowel cancer were comparable to the local CCG.

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. We saw that reception staff knew when patients wanted to discuss sensitive issues or appeared distressed and patients were offered a private area where they could not be overheard to discuss their needs. The practice had moved the phone that was used to receive patient calls to the back of the office to increase privacy when taking calls related to patients. Patients told us that they were treated with respect and dignity.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 32 completed cards. The cards contained positive comments about the care patients received at the practice. Patients commented that they received good care from caring staff. Patients felt that they were listened to and that staff gave them the time need to meet their care needs. We also spoke with two patients on the day of our inspection which included a member of the patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. Their comments were in line with the comments made in the cards we received.

Results from the national GP patient survey results published in January 2016 showed patients felt they were treated with compassion, dignity and respect. The practice results for consultations with GPs were below average for some areas or similar to the satisfaction scores particularly in those responses related to the practice nurses. For example:

- 81% of the patients who responded said the GP was good at listening to them compared to the local (CCG) average of 83% and national average of 89%.
- 86% of the patients who responded said the GP gave them enough time (CCG average 83%, national average 87%).

- 84% of the patients who responded said they had confidence and trust in the last GP they saw (CCG average 93%, national average 95%).
- 74% of the patients who responded said the last GP they spoke to was good at treating them with care and concern (CCG average 80%, national average 85%).
- 89% of the patients who responded said the last nurse they saw or spoke to was at listening to them (CCG average 90%, national average 91%).
- 89% of the patients who responded said the last nurse they saw or spoke to was at giving them enough time (CCG average 91%, national average 92%).
- 93% of the patients who responded said they had confidence and trust in the last nurse they saw (CCG average 93%, national average 95%).
- 89% of the patients who responded said the last nurse they spoke to was good at treating them with care and concern (CCG average 89%, national average 91%).

The patient satisfaction with reception staff was lower than the local CCG and national average. Data showed that:

- 73% of the patients who responded said they found the receptionists at the practice helpful (CCG average 85%, national average 87%).

The practice recognised this and had ensured that all staff received training in customer services and specific areas such as equality and diversity and dignity and respect.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey published in January 2016 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Responses in these areas varied and showed that patient satisfaction was below average with how GPs involved them in planning and making decisions about their care and treatment and similar to the local and national average for nurses. For example:

- 75% of the patients who responded said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and national average of 86%.
- 72% of the patients who responded said the last GP they saw was good at involving them in decisions about their care (CCG average 76%, national average 82%).

Are services caring?

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

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

Patient and carer support to cope emotionally with care and treatment

The practice had 10 carers over the age of 18 years on its practice carers register. This represented 0.16% of the practice population. This was much lower than the

expected percentage of at least one percent of the practice population size. The practice determined that the reasons for this low number could be related to the younger age groups registered at the practice. The practice had also identified 39 patients (0.62% of the practice population) who had a named carer. These carers were not registered with the practice. There were notices and leaflets displayed in the waiting room that provided patients with information on carers. This information was also available in different languages. The information available informed patients on how to access a number of support groups and organisations. Carers were offered longer appointments, health checks and the flu vaccination.

Staff told us that if families had suffered bereavement, they were contacted by their usual GP. The practice had a bereavement pack which they gave or sent to patients. The pack signposted patients to local support services and also included a sympathy card which expressed the sympathies of staff at the practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

- The practice offered patients who experienced poor mental health continuity of care and appointments with a counsellor.
- The majority of the practice population (75%) were English speaking. Translation and interpreter services were available to patients whose first language was not English. Information was also displayed and available for patients to take away in different languages in the waiting area.
- Patients were able to receive travel vaccinations available on the NHS and were referred to other clinics for vaccines available privately.
- The practice had a high number of teenage pregnancies and worked closely with community midwives who carried out antenatal clinics at the practice twice a week.
- The practice offered extended clinic appointments each day throughout the week and Saturday mornings for working patients who could not attend during the normal opening hours. The practice also offered online access to making appointments and ordering repeat prescriptions.
- Telephone consultations were available every day after morning and evening clinics.
- Patients were sent telephone texts to remind them about their appointment and to send test results.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Facilities for patients with mobility difficulties included level access through automatic doors to the practice, adapted toilets for patients with a physical disability. The practice was easily accessible to patients who used wheelchairs and families with pushchairs or prams.
- There were longer appointments available for patients with a learning disability, older people and patients with long-term conditions.

- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Urgent access appointments were available for children and those with serious medical conditions.

Access to the service

The practice was open between 8am to 8pm on a Monday to Friday and 8am to 12pm on Saturdays. 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 Vocare via the NHS 111 service. This information was available on the practice answerphone, practice leaflet and website.

Two of the 32 comment cards we received contained concerns about getting through to the practice on the phone and waiting time at the practice to be seen at the appointment. Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was lower than the local and national averages.

- 76% of patients who responded were satisfied with the practice's opening hours compared to the local average of 79% and England average of 78%.
- 53% of patients who responded said they could get through easily to the surgery by phone (local average 70%, England average 73%).

The practice was aware through the outcome of surveys of the comments related to the length of time patients waited to get an appointment and the time spent waiting to be seen at an appointment. The practice discussed these issues at practice meetings and with the patient participation group (PPG). Access to the practice and the appointment system was continuously reviewed by the practice to make improvements and improve patients' experience. For example the practice had employed additional staff to increase the number of clinical appointments available.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager and one of the GPs were both responsible managing complaints at the

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

practice. We saw that information was available to help patients understand the complaints system including leaflets available in the reception area. This information was also available in different languages to meet the needs of patients registered at the practice. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

Records we examined showed that the practice responded formally to both verbal and written complaints. We saw records for 10 complaints received over the past three years and found that all had been responded to in a timely manner and satisfactorily handled in keeping with the practice policy. The records identified that lessons were learnt from individual concerns and complaints and action was taken to as a result to improve the quality of care.

The practice also monitored and responded to comments received through various online media. The practice had received a number of concerns related to staff attitude, especially reception staff, lack of available appointments, long wait for appointments and care and treatment. Where negative comments were received we saw that although an apology was offered some of the responses made were quite blunt. We discussed this with one of the GPs who felt that it was necessary to provide a detailed response. These concerns were not added and monitored as part of the practice complaints register.

Are services well-led?

Requires improvement 

(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 mission and values statement which was displayed in the reception area for patients and discussed at the patient participation group (PPG) meetings. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. The vision was also shared with patients through the practice newsletter. Staff and patients felt that they were informed and encouraged to be involved in the future plans for the practice. The practice was aware of plans in place to improve the local area which would impact on the practice. For example there were plans to build a new housing estate which would lead to an increase in the size of the practice population. In preparation for this the practice had plans to extend the building.

Governance arrangements

We found that although the practice had a governance framework to support the delivery of the practice's strategy for good quality care, some areas needed strengthening.

- There was a clear staffing structure and all staff were clear about their own roles and responsibilities. All staff were supported to address their professional development needs.
- We found that the management and leadership team had an understanding of the performance of the practice.
- Practice specific policies were implemented and were available to all staff.
- The practice held formal monthly meetings at which governance issues were discussed. There was a structured agenda and an action plan.
- The practice carried out internal audits, which were used to monitor quality and to make improvements.
- There were some arrangements for identifying, recording and managing risks and implementing mitigating actions were in place. However effective arrangements were not in place to ensure records were maintained for the required time period before they were destroyed. There was also no evidence to confirm that the practice maintained a record of alerts received with details of action taken and completed to show that appropriate action had been taken where required.

Leadership and culture

The directors (GPs) at the practice had the experience, capacity and capability to run the practice and ensure high quality care. The directors were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff. The provider was aware of and complied with the requirements of the Duty of Candour. The parent organisation, IntraHealth encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents. When there were unexpected or unintended safety incidents the practice gave affected people reasonable support, relevant information and a verbal and written apology.

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 felt comfortable enough to raise any concerns when required and were confident these would be dealt with appropriately. Staff described the culture at the practice as open, transparent and very much a team approach. This was encouraged and supported by corporate and team away events.

Regular practice, clinical and team meetings which involved all staff were held and staff felt confident to raise any issues or concerns at these meetings. All staff were involved in discussions about how to run and develop the practice, and the directors encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. Formal meetings were held at least every three months and minutes were available to confirm this. Topics discussed at the meetings included new staff recruitment, parking, complaints and satisfaction surveys. The practice had supported a suggestion made by the PPG to introduce a weight management group. The group was led and managed by the PPG and complemented the practice weight management clinic. The practice had varied methods in place to gather feedback from patients who used the service which included comments and suggestion

Are services well-led?

Requires improvement 

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

boxes. A quarterly newsletter was produced for patients to provide information on changes planned to take place at the practice and seek patients' views. The newsletter was also available in a suitable format for patients with a learning disability and patients who were visually impaired. Feedback from patients and the PPG through patient surveys included the need to improve the appointment system at the practice. The practice had looked at ways to improve patient access to appointments, which included increasing the number of clinical staff.

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

The practice had completed reviews of significant events and other incidents. We saw records to confirm this, however there was a lack of written information to show that these were followed up to ensure that learning and appropriate improvements had been made. The practice carers register was small and only represented 0.16% of the practice population, which was significantly lower than the

expected percentage of at least one percent. The practice told us that this could be related to the younger age groups registered at the practice, there was a lack of evidence to demonstrate how the practice was proactively addressing this. The practice was a training practice for GP trainees and provided mentorship for advanced nurse practitioners.

The practice was involved in a number of local pilot initiatives which supported improvement in patient care across Wolverhampton. The practice was involved in a local Clinical Commissioning Group (CCG) initiative and had employed two NHS funded practice based pharmacists. Their role involved carrying out medication audits, seeing patients with minor ailments, medication reviews and prescription queries. The clinical pharmacists worked as part of the general practice team.

The practice had reviewed the clinic appointment system for patients in response to the patient survey responses. The practice had appointed new staff to improve patient access to clinic appointments by increasing the number of clinical sessions available. New staff appointed included a healthcare assistant, practice nurse and clinical pharmacists. The practice had plans to introduce minor surgery as one of the services it offered.