

Dr Abraham Thomas

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

Outstanding 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Outstanding 

Are services well-led?

Outstanding 

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 Dr Abraham Thomas's practice, also known as Croft Surgery on 4 October 2016. Overall the practice is rated as outstanding.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Risks to patients were assessed, well managed and the practice adopted a range of processes, which enabled staff to take appropriate actions in the event of safety concerns.
- The practice had well established and effective systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Clinical audits demonstrated quality improvement in a number of areas.
- Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- The practice worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback

Summary of findings

from patients and from the patient participation group. For example, the practice improved their appointment systems, which improved patient access and experience.

- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about 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. The practice proactively sought feedback from staff and patients, which it acted on.
- The practice had a clear vision which had quality and safety as its top priority. Staff were clear about the vision and their responsibilities in relation to it.

- The practice had strong and visible clinical and managerial leadership and governance arrangements. Staff used their knowledge of the local community and patient population as levers to deliver high quality, person centred care. For example, the practice held a variety of health awareness days to raise patients' awareness of various health related issues; implemented a new appointment system based on local feedback and shared their knowledge with other practices.

There were an area of practice where the provider should make improvements. For example:

- Establish processes to increase the identification of carers.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good



- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- The practice used every opportunity to learn from internal and external incidents, to support improvement. Learning was based on a thorough analysis, investigations and the practice demonstrated a mature attitude to feedback to improve quality and safety within the practice.
- Information about safety was highly valued and was used to promote learning and improvement. For example, the practice carried out various clinical audits and took appropriate actions as a result of safety information received.
- Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. For example, the practice proactively worked with other health care professionals when assessing and responding to safeguarding concerns.
- The practice had adequate arrangements in place to respond to emergencies and major incidents.
- The practice maintained appropriate standards of cleanliness and hygiene; audits were carried out and actions taken to address any improvements identified as a result. Measures were in place to monitor and check whether medical and non-medical equipment were working appropriately.

Are services effective?

Good



- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. The practice used these guidelines to positively influence and improve practice and outcomes for patients.
- Data collected for the Quality and Outcomes Framework (QOF) showed that the practice was performing highly when compared to practices locally and nationally.
- Clinical audits demonstrated quality improvement in a number of areas.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. Staff understood the relevant consent and decision-making requirements of legislation.

Summary of findings

- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs. Regular meetings were held to discuss care plans.

Are services caring?

Good



- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- The practice analysed national GP patient survey results and developed action plans to improve survey results, which were below local and national averages.
- We found positive examples to demonstrate how patient's views about their experience were valued and acted on. For example, the practice reviewed and improved the support provided to families experiencing bereavement.
- Patients we spoke with as part of the inspection said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Outstanding



- 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.
- There were innovative approaches to providing integrated patient-centred care. For example, the practice operated a system of surgery initiated proactive home visiting which were coordinated with other health care professionals.
- The practice held various health awareness days to raise patients' awareness of various health related issues and used these days as an opportunity to shape their services.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and the patient participation group.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with appointments available the same day.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

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

Outstanding



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 offered proactive, personalised care to meet the needs of the older people in its population. Data provided by the practice showed that 91% of patients over the age of 75 had received a health check and all patients had a named GP.
- The practice was responsive to the needs of older people, and offered surgery-initiated home visits at regular intervals, which included assessments of daily living needs, health hazards and fire risks; with referrals to occupational health or social services as necessary. Same day appointments for those with enhanced needs were also available.
- Data provided by the practice showed that 40% of patients aged 65 and over had subscribed to electronic prescribing system (EPS). Pharmacists received paperless prescriptions and delivered medications to patients' homes.
- A dedicated 'hot-line' phone number was issued to care homes for residents at risk of hospital admission. Patients discharged were proactively contacted by a clinician within three working days of discharge.
- The practice was accessible to those with mobility difficulties.
- The practice held a health awareness day to increase; this resulted in 76% of patients over the age of 65 receiving a flu vaccination. The practice also facilitated aortic aneurysm screening clinics (a screening to detect swelling of the main blood vessel that runs from the heart, down through the abdomen to the rest of the body), for over 65s where the practice had capacity to screen up to 23 Walsall residents.

Outstanding



People with long term conditions

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was similar to the national average. For example, 86% had a specific blood glucose reading within acceptable range in the preceding 12 months (01/04/2014 to 31/03/2015) compared to the CCG and national average of 78%. With an exception reporting rate of 18%, compared to CCG average of 9% and national average of 12%.
- Following publication of NICE guidelines regarding the risk of hypoglycaemia (an abnormally low level of sugar "glucose" in

Outstanding



Summary of findings

the blood) the practice sent letters to at risk patients advising of the importance of self-monitoring their blood sugars, particularly if driving for long periods and invited patients to attend a consultation with clinicians to discuss this further.

- Longer appointments were available, for example, 20 minutes' were allocated for diabetic reviews and surgery-initiated home visits were scheduled at regular intervals when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The Advanced Nurse Practitioner offered evening appointments until 6.30pm aimed to help working patients manage their long-term conditions.
- At the time of inspection the practice were in the process of populating a list of patients at risk of developing diabetes. We saw that the practice had planned a health awareness day in November 2016 where a team from the local lifestyle service were invited to advise patients on topics such as healthy eating and exercise.

Families, children and young people

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Staff we spoke with were able to demonstrate how they would ensure children and young people were treated in an age-appropriate way and that they would recognise them as individuals.
- The practice's uptake for the cervical screening programme was 81%, which comparable to the CCG average of 81% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- Immunisation rates were for all standard childhood immunisations. To enhance uptake the practice offered flexible appointment times. The practice nurse proactively contacted patients who failed to attend and alerts were placed on patient's records.
- There were systems in place for ensuring all new babies were registered with the practice within three to four weeks, however where parent's choice were to register children at another practice, health visitors were informed.

Outstanding



Summary of findings

- We saw positive examples of joint working with midwives, health visitors and school nurses. For example, first antenatal contact were provided by GPs and subsequent follow up were arranged in liaison with the practice in-house midwifery team.
- The practice held a Chlamydia afternoon where patients under the age of 25 were invited. The practice encouraged uptake by offering free cinema tickets to patients who attended and were screened, however attendance was low. The practice had taken action to address this by providing a second day. To improve uptake staff explained that they sent letters to all eligible patients. A lead sexual health nurse attended the practice to provide information, advice and screening for Chlamydia and Gonorrhoea.

Working age people (including those recently retired and students)

Good



- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, early appointments from 7am and late evening appointments until 8pm were available one day per week.
- For accessibility, telephone consultation appointments were available with either a GP or Advanced Nurse Practitioner. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice provided new patient health checks and routine NHS health checks for patients aged 40-74 years. Data provided by the practice showed that 64% of patients had been invited for a health check in the past three years and 26% had attended. Data also showed that 98% had been offered smoking cessation advice and 57% had their blood pressure checked in the last 12 months.
- Data from the national GP patient survey indicated that the practice were above local and national average regarding phone access and comparable regarding opening times.
- Reception staff received customer service training; the July 2016 national GP patient survey showed that results relating to the helpfulness of receptionists were above local and national averages.

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- The practice operated a virtual Patient Participation Group to ensure they received feedback from this patient group. Data provided by the practice showed that 300 patient were enrolled to the virtual PPG. Staff explained that they sent emails and received feedback.

People whose circumstances may make them vulnerable

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability (LD).
- The practice offered longer appointments for patients with a learning disability and worked closely with the community learning disabilities nurse. Data provided by the practice showed that 93% of patients with a LD had a care plan in place, had a medication and a face-to-face review in the past 12 months.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients. For example, the practice worked with the local addiction service to manage the general health care of patients receiving interventions for substance and alcohol dependency.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Interpretation facilities were provided by an external service. In addition, two clinicians were able to converse in other languages, including Punjabi, Hindi, Urdu, German and French.
- Staff we spoke with knew how to recognise signs of abuse in vulnerable adults and children.
- Carers of patients registered with the practice had access to a range of services, for example annual health checks, flu vaccinations and a review of their stress levels. Data provided by the practice showed that 1% of the practice list were carers; 100% had received a health check in the last two years.

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People experiencing poor mental health (including people with dementia)

- Nationally reported data for 2014/15 showed 90% of patients diagnosed with dementia had their care reviewed in a face-to-face meeting in the last 12 months. This was above the local and national average.
- Performance for mental health related indicators was above the national average. For example, 93% had an agreed care plan

Outstanding



Summary of findings

documented in the record, in the preceding 12 months compared to CCG average of 92% and national average of 88%. With a 17% exception reporting rate, compared to CCG average of 5% and national average of 12%.

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice worked closely with the community psychiatric nurse (CPN) and had enhanced access to a consultant psychiatrist to discuss cases over the telephone. Regular clinical meetings with the consultant psychiatrist and mental health care teams were held. Data provided by the practice showed that 100% had received a face-to-face review in the past 12 months.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff we spoke with had a good understanding of how to support patients with mental health needs and dementia and there was a designated lead responsible for this population group.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice was performing above local and national averages in most areas. 303 survey forms were distributed and 104 were returned. This represented 34% completion rate.

- 99% of patients found it easy to get through to this practice by phone compared to the CCG average of 76% and national average of 73%.
- 87% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 82% and national average of 85%.
- 95% of patients described the overall experience of this GP practice as good compared to the CCG average of 86% and national average of 85%.
- 91% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 76% and national average of 79%.

As part of our inspection, we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 59 comment cards which were all positive about the standard of care received. Staff were described as good listeners, helpful, polite and respectful; patients felt they were treated with dignity and respect. Patient were complimentary of the appointment system and felt this worked well.

We spoke with 12 patients during the inspection (including two members of the practice's patient participation group). Patients and PPG members said they were satisfied with the care they received and thought staff were approachable, committed, compassionate and caring.

Areas for improvement

Action the service **SHOULD** take to improve

- Establish processes to increase the identification of carers.

Dr Abraham Thomas

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr Abraham Thomas

Dr Abraham Thomas also known as Croft Surgery is located in Walsall, West Midlands situated in a multipurpose modern built Private Finance Initiative (PFI) owned building, providing NHS services to the local community.

Based on data available from Public Health England, the levels of deprivation in the area served by Dr Abraham Thomas are below the national average, ranked at two out of 10, with 10 being the least deprived. Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial. Based on Public Health England data the estimated ethnicity of the practice patient population are 4% mixed, 12% Asian, 3% black and 1% other non-white ethnic groups. The practice serves a higher than average patient population aged from birth to nine years old, 25 to 34, and 45 to 50. The practice serves a below average of patients aged 65 to 85 and over.

The patient list is approximately 4,450 of various ages registered and cared for at the practice. Services to patients are provided under a General Medical Services (GMS) contract with the Clinical Commissioning Group (CCG). GMS is a contract between general practices and the CCG for delivering primary care services to local communities.

The surgery has expanded its contracted obligations to provide enhanced services to patients. An enhanced service is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients.

The surgery is situated on the ground floor of a multipurpose building shared with other health care providers. Parking is available for cyclists and patients who display a disabled blue badge. The surgery has automatic entrance doors and is accessible to patients using a wheelchair.

The practice staffing comprises of two male GPs, one female GP, one practice nurse, one advance nurse practitioner (independent & supplementary prescriber), one health care assistant (HCA), a practice manager, a secretary and four receptionists. The practice is also an approved training practice and provided training to medical students. There were one female trainee GP registrar (GPs in training).

The practice is open between 8am and 8pm on Mondays, 8am and 6.30pm Tuesdays, Thursdays, Fridays; 7am and 6pm on Wednesdays.

GP consulting hours are from 8am to 8pm on Mondays, 8am to 6.30pm Tuesdays, Thursdays, Fridays; 7am to 6pm on Wednesdays. The practice has opted out of providing cover to patients in their out of hours period. During this time, services are provided by NHS 111.

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

Detailed findings

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 4 October 2016. During our visit we:

- Spoke with a range of staff such as GPs, nurses, health care assistant, receptionists, administrators, managers and spoke with patients who used the service.
- Observed how patients were being cared for.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Are services safe?

Our findings

Safe track record and learning

There were well established and effective systems in place for reporting and recording significant events. The practice demonstrated a proactive approach when responding to incidents and maximised learning opportunities.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system.
- The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- There was a designated clinical lead responsible for reviewing and monitoring significant events to ensure they were acted on. Lessons from incidents and significant events were routinely shared through clinical meetings and staff we spoke with were able to provide detailed examples of incidents that had been discussed and acted on.
- We saw evidence that when things went wrong with care and treatment, the practice took prompt actions, patients were informed of the incident, received reasonable support and truthful information.
- The practice carried out a thorough analysis of the significant events and we saw clear evidence to support that patients received a written apology and were told about any actions to improve processes to prevent the same thing happening again. The practice took appropriate action and made changes to internal systems and processes as a result of significant events. For Example, the practice had reported incidents through to Walsall Clinical Commissioning Group (CCG) relating to secondary care discharge summaries, which were being received with incomplete lists of patient medicines. Although the practice had an effective process for managing incoming letters, we saw that the practice improved them further following this incident.

There was a designated lead responsible for reviewing safety alerts received and sharing them with other clinical staff, these were all documented with evidence of action taken. We saw evidence of how safety alerts had triggered internal audits.

We reviewed the process for managing patient safety alerts received from Medicines and Healthcare products Regulatory Agency (MHRA) and minutes of meetings where these were discussed. We saw evidence that appropriate actions were taken to improve safety in the practice. For example, we saw that appropriate searches had been carried out to identify patients in receipt of a specific medicine used to help relieve specific infections and appropriate actions had been taken.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined whom to contact for further guidance if staff had concerns about a patient's welfare. Staff we spoke with provided examples where they had followed practice processes when raising concerns. For example, the practice worked closely with secondary care staff regarding concerns relating to a recent non-accidental injury, the practice also identified learning points.
- There was a lead member of staff for safeguarding. Safeguarding was a standing agenda item on the monthly practice meetings. The GPs attended external safeguarding meetings when possible and we were told that they provided reports where necessary for other agencies. Staff clearly demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. For example, GPs were trained to child protection or child safeguarding level three. Nurses and the health care assistant had received level three safeguarding children and adults training.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check.

Are services safe?

(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 maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training.
- Annual infection control audits were undertaken by an external infection control specialist. An audit carried out within the last 12 months showed that the practice had scored 100% for management, governance and vaccination storage; and had achieved an overall score of 95%. We saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. Prescription stationery including blank prescription forms and pads were securely stored and there were well established and effective systems in place to monitor their use.
- The practice received support from the local CCG pharmacy team two half days per week who carried out regular medicines audits to monitor cost efficiency and ensure prescribing was in line with best practice guidelines for safe prescribing. The practice participated in the CCG improvement scheme for medicines optimisation (a scheme aimed at encourage and reward GP practices to improve prescribing to further enhance its quality, safety and cost effectiveness) there were evidence of where the practice achieved set prescribing targets. For example, 2015/16 data provided by the practice showed that a target of 80% of patients on combined inhalers who had received an asthma review using recommended guidelines had been achieved.
- One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. She received mentorship and support from the medical staff for this extended role.

Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.

- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills.
- Electrical equipment was checked by a professional contractor to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. We saw that labels were attached to electrical equipment, which evidenced that they had been checked within the last 12 months.
- The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. Staff told us that they would cover for each other's leave and sickness.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.

Are services safe?

- All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice recognised risks associated with the absence of medicines to treat slow heart rate, acute allergic reaction or nausea and vomiting and carried out comprehensive risk assessments, which included details of existing control measures in place to mitigate risks. For example, the practice kept a stock of first line medicine used to treat acute allergic reactions, all staff had received appropriate training and two local hospitals were within short distance from the practice.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. The plan also included agreements with a neighbouring practice that the lead GP had buddied up with. Staff we spoke with provided examples of where the practice had followed the business continuity plan to ensure continuity of care following a computer outage.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had clear communication systems in place to keep all clinical staff up to date with evidence based and nationally recognised guidelines. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. For example, we saw that the practice shared guidance and conducted an audit regarding the maximum dose for patients over the age of 65 who may be in receipt of a specific antidepressant medicine. Findings from the audit were circulated to staff throughout the practice and staff were made aware of appropriate prescribing guidelines.
- Staff we spoke with demonstrated on-line access to the Green Book (a resource which has the latest information on vaccines and vaccination procedures) and accessed monthly publications produced by Public Health England regarding changes to immunisation programmes. Updates were shared during clinical meetings.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.
- Regular clinical meetings were held which enabled the clinical staff to discuss and share best practice and some of the more complex cases they had seen. We saw examples where the practice had discussed guideline updates during monthly clinical meetings.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed the practice had achieved 99% of the total number of points available; this was above the national average of 95%.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed:

- Performance for diabetes related indicators was similar to the national average. For example, 86% had a specific blood glucose reading within acceptable range in the preceding 12 months (01/04/2014 to 31/03/2015) compared to the CCG and national average of 78%. With an exception reporting rate of 18%, compared to CCG average of 9% and national average of 12%.
- Performance for mental health related indicators was above the national average. For example, 93% had an agreed care plan documented in the record, in the preceding 12 months compared to CCG average of 92% and national average of 88%. With a 17% exception reporting rate, compared to CCG average of 5% and national average of 12%.

Staff we spoke with were aware of the practice QOF performance and the reason why exception reporting mental health related indicators were above local and national averages. When asked staff we spoke with told us that designated staff monitored QOF domains. We were told that staff were contacting patients who were overdue QOF related reviews. Clinicians were monitoring outstanding alerts and the practice aimed to review patients diagnosed with diabetes every three to six months. The practice's approach was to send three letters of invitation for a review and operated a call and recall system. Staff we spoke with told us that GPs would only exception report after all options had been explored and we saw evidence to support this. The QOF lead reviewed registers yearly and the practice were following the seven invite health check programme (a national risk assessment and management programme for patients aged 40 to 74). This enabled the practice to target the top seven causes of preventable mortality for example, high blood pressure, cholesterol and obesity. Latest published data from 2015/16, provided by the practice showed that 76% of patients had a specific blood glucose reading within acceptable range, with a 0% exception reporting rate.

There was evidence of quality improvement including clinical audit.

- There had been eight clinical audits completed in the last two years, three of these were completed audits where the improvements made were implemented and monitored.

Are services effective?

(for example, treatment is effective)

- Findings were used by the practice to improve services. For example, recent actions taken as a result included a search of patients who may be affected by the co-prescribing of medicines used to lower cholesterol and some commonly used concurrent medicines. The practice held a joint meeting with the CCG pharmacist and appropriate actions were taken to switch patients to alternative medicines and reduce dose to recommended range. New processes were implemented to ensure ongoing monitoring of this patient group.
- The practice attended Walsall CCG locality meetings and participated in local audits, benchmarking, accreditation and peer review. The GP clinical lead played an active role within Walsall CCG.

Effective staffing

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

- The practice had a comprehensive induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. Staff administering vaccines and taking samples for the cervical screening programme had received specific training, which had included an assessment of competence.
- Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

- The practice had been a training practice since 2004 and staff we spoke with were enthusiastic about supporting staff and sharing knowledge. For example, the lead GP mentored a palliative care nurse and pharmacist, supporting them to gain a master in prescribing. We were also told that staff and other health care professionals had nominated the lead GP for the Royal College of General Practitioners (RCGP) quality award which the GP successfully received. The award recognises the contribution made by people towards postgraduate medical education for General Practice.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Staff we spoke with told us that meetings took place with other health care professionals on a regular basis when care plans were routinely reviewed and updated for patients with complex needs. We saw minutes of health visitor meetings, district nurses, community matrons and social workers; and mental health meetings with consultant psychiatrist. Clinicians also attended multi-disciplinary team meetings for patients with end of life care needs. Evidence of these meetings and action plans were well documented and staff we spoke with provided clear examples of joint care management with the consultant psychiatrist.

Consent to care and treatment

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

Are services effective?

(for example, treatment is effective)

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

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example, patients receiving end of life care, carers, those with long term conditions and those at risk of developing a long-term condition such as diabetes.

- The practice provided access to services such as family planning, health promotion, healthy lifestyle and coronary heart disease prevention clinics. The practice made use of health trainers, smoking cessation and weight management services.
- The percentage of patients with atrial fibrillation (an irregular and sometimes fast pulse) treated using recommended therapy was 100%, with a zero percent exception reporting rate.
- There were dedicated leads for diabetes, women's health and family planning; asthma Chronic Obstructive Pulmonary Disease (COPD), Bowel Cancer and patients with learning disability. There were patient specific clinics for vulnerable patients, for example patients on the learning disability register.
- The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using recognised methods was 95%, compared to CCG average of 92% and national average of 90%.
- There was a range of health promotion information displayed in the practice to support patients. Information was also available on the practice website.

The practice's uptake for the cervical screening programme was 81%, which is comparable to the CCG average of 81% and the national average of 82%. Exception reporting for public health additional service domains such as Cervical screening was below CCG and national average. For

example, 3% compared to CCG average of 7% and national average of 6%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice demonstrated how they encouraged patients to attend national screening programmes for bowel and breast cancer screening by using information in different languages and for those with a learning disability. The practice ensured a female sample taker was available.

Data showed that the practice were performing comparable to local and national average in most areas. For example:

- Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) was 78% compared to CCG and national average of 72%.
- Females, 50-70, screened for breast cancer in last 6 months of invitation was 50% compared to CCG average of 68% and national average of 73%.
- Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %) was 52%, compared to CCG average of 53% and national average of 58%.
- Persons, 60-69, screened for bowel cancer within 6 months of invitation (Uptake, %) was 53%, compared to CCG average of 52% and national average of 58%.

The practice were actively communicating with local screening services, data provided by the practice showed that all patients who had missed their screening appointment had been sent a follow up appointment letter. Staff explained that they received notifications regarding patients who had not returned their blood testing kit. Staff provided evidence of letters, which had been sent to all identified patients. The letter included information leaflets and the offer to meet with a clinician for further discussion if appropriate. We were also told that when patients attend the surgery for general health related reasons the practice opportunistically discussed the benefits of screening programmes.

Childhood immunisation rates for the vaccinations given were above CCG and national averages in most areas. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 73% to 100%, compared to CCG average of between 74% to 99%

Are services effective? (for example, treatment is effective)

and national averages of between 73% to 95%.
Immunisation rates for vaccinations given to five year olds ranged from 69% to 100%, compared to CCG averages of between 75% to 99% and national averages of between 81% to 95%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

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

All of the 59 completed CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with 12 patients during the inspection (including two members of the practice's patient participation group). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 90% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 87% of patients said the GP gave them enough time compared to the CCG and the national average of 87%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.

- 86% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 85%.
- 91% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 91%.
- 99% of patients said they found the receptionists at the practice helpful compared to the CCG and national average of 87%.

Care planning and involvement in decisions about care and treatment

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

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

- 83% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 86%.
- 77% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national average of 82%.

However, there were questions where survey results showed that satisfaction scores were above the CCG and national averages. For example:

- 88% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and national average of 85%.

The practice were aware of the GP survey data, and we saw meeting minutes where the practice had analysed the results. Staff we spoke with told us about action which had been taken to improve survey results. For example, receptionists were required to book 20 minute appointments for the nursing team to complete certain

Are services caring?

procedures such as cervical smears, wound dressings and diabetic annual reviews. We also saw actions, which included GPs changing their consultation styles to ensure consultations, were more in line with the practice ethos of providing a shared person centred approach.

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

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Details regarding this service were also displayed on the practice website.
- Information leaflets were available in easy read format and fact sheets were available via the practice web site.

Patient and carer support to cope emotionally with care and treatment

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

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 81 patients as

carers; however, staff explained that a recent audit found that 44 patients were no longer carers therefore the list had reduced to 44 patients (0.91% of the practice list). Data provided by the practice showed that 100% received a health check, a review of their stress levels and 78% had a flu vaccination in the past two years. Staff we spoke with told us that GP appointments were offered to carers on the register; carers had access to annual health checks, flu vaccinations and a stress levels review. Written information was available within the reception area to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. 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. The practice acted on patient's views about how they were treated during their time of bereavement and developed a comprehensive bereavement information pack and implemented improved processes. For example, deaths were recoded within the practice computer system to ensure health care professionals were not sending further letters addressed to the deceased. The practice utilised funds received for carrying out non-NHS work; for example, medical reports and donated towards funeral costs.



Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The lead GP was the chair of Walsall Federation (a group of practices and primary care teams working together, sharing responsibility for developing and delivering high quality, patient focussed services for their local community). The GP lead was also a member of Walsall Together Board, which were looking at Primary Care access across Walsall and actively shared new ways of working. For example, the practice scored above local and national averages regarding patient access following the July 2016 national GP patient survey; as a result, the practice shared their appointment systems with CCG colleagues and neighbouring practices. We were told that staff provided training such as customer awareness and telephone manner to neighbouring receptionists and practice managers helping them to improve patient access and experience.

- The practice offered extended opening for appointments Mondays 4pm to 8pm and Wednesdays from 7am for patients who could not attend during normal weekday opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had difficulty attending the practice. The practice operated a system of surgery initiated proactive home visiting which were coordinated with other health care professionals. For example, the practice regularly reviewed elderly, housebound, nursing and residential care patients. Scheduled home visits were initiated based on risk and at regular intervals agreed by clinicians, patients and their family/carers. Staff explained that these appointments involved assessments of daily living needs, falls risk, assessing the need for appliances and aids; and also fire hazards assessments. The practice had a notice board showing dates of the last visit and dates of scheduled follow up visits. We saw meeting minutes where patients care and action plans had been discussed with other health care professional. The practice reported that this initiative had reduced the demand for appointments.

- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS; staff sign posted patients to other services for travel vaccinations only available privately.
- The practice had a hearing loop and made use of translation services when needed. Staff told us that if patients had any special needs this would be highlighted on the patient system.
- There were disabled facilities and the premises were accessible for pushchairs, baby changing facilities were available and a notice displayed offered patient privacy for breast feeding.
- Patients with no fixed abode were able to register at the practice and we saw evidence of this.
- The practice worked with the local addiction service under a shared care agreement to manage the general health care of patients receiving interventions for substance and alcohol dependency. Data provided by the practice showed that 100% of patients receiving support for drug dependency had care plans in place, received a medication review and had a face-to-face review in the past 12 months. Data provided also showed that 63% of patients receiving support for alcohol dependency had a care plan in place, 89% received a medication review and had a face-to-face review in the past 12 months.
- The practice held a health awareness day where they offered flu vaccinations and Abdominal Aortic Aneurysm (AAA) screenings (a screening to detect swelling of the main blood vessel that runs from the heart, down through the abdomen to the rest of the body). Data provided by the practice showed that 90% of patients aged 65 and over had received a flu vaccination and 47% of eligible patients under the age of 65 had received the flu vaccination. We were also told that as a result of the huge uptake of patients screened for (AAA) the practice were facilitating a session once a week for any Walsall patient to be screened.
- The practice held a Chlamydia afternoon where a lead sexual health nurse attended the practice to provide information, advice and screening for Chlamydia and Gonorrhoea. Staff we spoke with said that the practice encouraged uptake by offering free cinema tickets to patients who attended and were screened. Although uptake was low, staff we spoke with told us that the



Are services responsive to people's needs?

(for example, to feedback?)

practice were planning to repeat the event in November 2016 and were promoting it via the practice newsletter, website and PPG. To improve uptake staff explained that they sent letters to all eligible patients.

Access to the service

The practice is open between 8am and 8pm on Mondays, 8am and 6.30pm Tuesdays, Thursdays, Fridays; 7am and 6pm on Wednesdays. Appointments were from 8am to 8pm on Mondays, 8am to 6.30pm Tuesdays, Thursdays, Fridays; 7am to 6pm on Wednesdays. In addition to pre-bookable appointments that could be booked up to four weeks in advance, same day appointments were also available for people that needed them.

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

- 92% of patients were satisfied with the practice's opening hours compared to the CCG average of 77% and national average of 78%.
- 99% of patients said they could get through easily to the practice by phone compared to the CCG average of 76% and national average of 73%.

During our inspection patients advised that they were able to get appointments when they needed them. Staff we spoke with told us that the practice had studied various appointment systems; visited neighbouring practices to observe their systems and sought feedback from patients. As a result, the practice introduced a number of new measures. For example, advanced appointment bookings were reduced from eight weeks to four weeks to reduce the volume of missed appointments. The practice moved away from blocking out urgent appointments and staff explained that 50% of appointments were available for same day booking. Furthermore, clinical skill mix was utilised to maximise choice and efficiency. Appointments were monitored, adjusted depending on demand and regularly audited to identify emerging patterns and themes. For example, the practice offered more available slots after bank holidays and more walk in surgeries during times of flu epidemics or winter pressures.

The practice had a system in place to assess, whether a home visit was clinically necessary and the urgency of the need for medical attention. Staff we spoke with advised us that patients who requested a home visit would be triaged

by a GP. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, staff explained that alternative emergency care arrangements were made by the GP. Clinical and non-clinical staff we spoke with were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a well established and effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. For example, during our reception observation, we saw posters displayed in the reception area and the practice had a complaints leaflet available for patients to take away. This explained the complaints process, expected timescales for managing the complaint and what to do if they are unhappy with the response from the practice. Copies were placed in the new patient registration pack.

Records we viewed showed that the practice had thoroughly recorded complaints and sent patients a detailed response. For example, we looked at two complaints received in the last 12 months and found that; these were satisfactorily handled, dealt with in a timely way, openness and transparency with dealing with the complaint. The practice aimed to fully investigate and fully respond to complaints within 10 working days and we saw examples where the practice kept patients updated on progress when investigations fell outside of the 10 working day timeframe. Lessons were learnt from individual concerns, complaints and from analysis of trends. Actions were taken as a result to improve the quality of care. For example, we saw where the practice reviewed confidentiality policy; provided staff with confidentiality refresher training where necessary and there were a signed record, which demonstrated that staff had read the Caldicott policy (a set of principles aimed at improving the way health care professionals handles and protects patient information).

Are services well-led?

Outstanding



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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice used the strategy as a lever to connect internal and practice initiated programmes aimed at improve access to patients from a range of different groups, including young people and the ageing population.

- The practice had a mission statement, which was displayed in the waiting areas, and staff knew and understood the values.
- The practice had a strategy and supporting business plans, which reflected the vision and values and were regularly monitored.
- During our inspection, we saw that staff understood the needs of their patient population and strived to deliver services, which reflected those needs.
- The practice maintained a strong involvement with the local community by organising a variety of health awareness days to raise patients' awareness of various health related issues and used these days as an opportunity to shape their services.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. Staff were actively engaged in activities to monitor and improve quality and outcomes.
- Practice specific policies were implemented, regularly reviewed and were available to all staff. There were a common focus on improving quality of care and patients experiences through a systematic use of incidents, safety alerts and clinical audits.
- A comprehensive understanding of the performance of the practice was maintained
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.

- There were effective arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- The GP lead played an active role within Walsall CCG and shared ideas, knowledge and implementing new ways of working to secure improvements to services. As a result, the July 2016 national GP patient survey showed that the practice scored above local and national averages in a number of areas.

Leadership and culture

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

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

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

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

- Staff told us the practice held regular team meetings and held meetings with other healthcare professionals.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partner in the practice. All staff were

Are services well-led?

Outstanding



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

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

- Staff retention were very high, for example, a number of staff we spoke with were long standing staff members who were very complimentary about the team and their experience working at the practice. We observed positive examples of team working and staff had a wide understanding of patient's needs.

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

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

- The practice had gathered feedback from patients through the physical patient participation group (PPG), virtual PPG and through surveys and complaints received. Data provided by the practice showed that they had 300 patients signed up to the virtual PPG where they received regular feedback. The physical PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the practice consulted with patients regarding the request to offer clinics from 7am. Following the discussion, the practice introduced extended opening times on a Wednesday from 7am. The practice also liaised with PPG who carried out a survey regarding a proposal to increase the use of online services to place medicine orders in order to increase phone access. Survey outcomes showed that patients agreed to this proposal and were happy to use online services to request medicines.
- The practice had gathered feedback from staff through team building days and generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any

concerns or issues with colleagues and management. For example, appointments were adjusted to ensure nurses had sufficient time to thoroughly carry out patient reviews.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and working with local organisations and health care professionals to improve outcomes for patients in the area. There was a continuous program of clinical audits, which demonstrated improvements made. The level and quality of incident reporting showed that incidents were thoroughly investigated and staff actively participated in learning and the review of processes to improve safety.

The practice had studied various appointment systems; visited neighbouring practices to observe their systems and sought feedback from patients, which resulted in the introduction of a new appointment system to improve appointment access. Appointments were monitored, adjusted depending on demand and regularly audited to identify emerging patterns and themes.

The practice proactively worked with other health care professionals. For example, staff engaged with local breast screening service and sent letters to identified patients to increase uptake.

Following a health awareness day the practice started facilitating a clinic accessible to all Walsall residents where patients were screening to detect swelling of a blood vessel in the abdominal in men aged 65 and over.

As part of the lead GPs engagement with Walsall CCG we were told that the practice were one of the few practices in Walsall involved in an initiative to increase awareness and promote the uptake of NHS health checks as it had been identified as an area for improvement both locally and nationally. The lead GP explained that the practice were taking part in a short film where staff would be featured talking about NHS checks and demonstrating what the health check involved.