Parkfield Wolverhampton Medical Services Ltd

Quality Report

Ettingshall Medical Centre
Herbert Street
Bilston
West Midlands
WV14 0NF
Tel: 01902 446788
Website: www.ettingshallmedicalcentre.co.uk

Date of inspection visit: 15 February 2016
Date of publication: 01/06/2016

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Parkfields Wolverhampton Medical Services Ltd. on Monday 15 February 2016. Overall the practice is rated as good.

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. All staff had received dementia friends training to support meeting the needs of older patients.
- 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.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by the management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the Duty of Candour.
- The practice maintained a register of vulnerable patients registered at the practice. The register included asylum seekers, patients with language or literacy requirements. The practice had access to translation and interpretation services to ensure patients were involved in decisions about their care.

There was one area where the provider should make improvement:

Summary of findings

- Ensure that records of significant events provide sufficient information to show that they are appropriately reviewed and monitored to demonstrate improvement.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. There was an effective system in place for reporting and recording significant events. Records of clinical and significant event meetings did not demonstrate that incidents were fully discussed and that ongoing monitoring of events had taken place to ensure that systems put in place were appropriate. When there were unintended or unexpected safety incidents, patients received reasonable support, relevant information, a verbal and written apology. They were told about any actions to improve processes to prevent the same thing happening again. The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from the risk of abuse. Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services. Data from the Quality and Outcomes Framework showed patient outcomes were at or above average for the locality and compared to the national average. Staff assessed needs and delivered care in line with current evidence based guidance. Clinical audits demonstrated quality improvement. Staff had the skills, knowledge and experience to deliver effective care and treatment. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs. For example, the practice was involved in the development of a service that would be responsive to delivering primary care services to patients.

Are services caring?

Good

The practice is rated as good for providing caring services. Data from the National GP Patient Survey results published on January 2016 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 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?

Good

The practice is rated as good for providing responsive services. Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical

Summary of findings

Commissioning Group to secure improvements to services where these were identified. The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs. For example, a service had been developed that was responsive to supporting care homes with nursing. A review of the service demonstrated improvements in care and reductions in hospital admissions.

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. Learning from complaints was shared with staff and other stakeholders. Urgent appointments were available the same day. Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by the management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. 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 directors encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken. 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

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. The practice offered home visits and urgent appointments for those older patients with enhanced needs. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice had a proactive working relationship with four nursing/ independent care homes. There was effective communication between the practice and care home staff and visits to the homes were made when requested. Weekly ward rounds were made to patients in two of the four care homes by the advanced nurse practitioner.

People with long term conditions

Good

The practice is rated as good for the care of 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 assessment and care was higher than the national average (97% compared to the national average of 89%). Longer appointments and home visits were available 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. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw positive examples of joint working with midwives. The practice's uptake for the cervical screening programme was 83%, which was comparable to the national average of 82%.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice appointment telephone line was open between 8.30am and 6.30pm and extended hours were offered two evenings per week. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients with a learning disability and carried out annual health checks for these patients. An easy read (pictorial) letter was sent to patients with a learning disability inviting them to attend the practice for their annual health check.

Staff had been trained to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The data showed that 87% of patients on the practice register who experienced poor mental health had a comprehensive agreed care plan in the preceding 12 months. This was comparable to the national average of 88%. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. The practice regularly worked with multi-disciplinary teams in the case management of people who experienced poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 90%, which was comparable to the national average of 84%. Staff had a good understanding of how to support people with mental health needs and dementia.

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 in line with local and national averages. A total of 403 surveys (13% of the patient list) were sent out and 88 (22%) responses, which is equivalent to 3% of the patient list, were returned. Results indicated the practice performance was comparable to other practices in most aspects of care, which included for example:

- 91% found it easy to get through to this surgery by phone compared to a Clinical Commissioning Group (CCG) average of 70% and a national average of 73%.
- 73% were able to get an appointment to see or speak to someone the last time they tried (CCG average 82%, national average 85%).
- 92% described the overall experience of their GP surgery as fairly good or very good (CCG average 81%, national average 85%).
- 82% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 71%, national average 78%).

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 22 comment cards which were all positive. Patients said they received good care from the practice, staff were very helpful, doctors listened to their problems, excellent care and advice was given to them by the doctors and staff were very professional.

We also spoke with three 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 over the last six months, August 2015 to January 2016 showed that of the 108 responses received 81 patients were extremely likely to recommend the practice to friends and family if they needed similar care or treatment and 25 patients were likely to recommend the practice and two neither likely or unlikely. The comments made by patients in teir responses were extremely positive. Patients said that they received clear instructions, referrals were promptly made, staff were friendly and professional and were very pleased with the late opening hours.

Areas for improvement

Action the service SHOULD take to improve

Ensure that records of significant events provide sufficient information to show that they are appropriately reviewed and monitored to demonstrate improvement.

Parkfield Wolverhampton Medical Services Ltd

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 Parkfield Wolverhampton Medical Services Ltd

Parkfield Wolverhampton Medical Services Ltd (also known as Ettingshall Medical Centre) is one of two practices in Wolverhampton that was set up by three GPs who are also the directors for the practices. The practice is located in a deprived area of Wolverhampton and provides Primary Medical Services (PMS) to a population of approximately 3,882 patients. The practice operates from a purpose built healthcare facility. The practice has a higher proportion of patients between the ages of 0-4 years, 20-39 years and 85+ years compared with the practice average across England. There is a higher practice value for income deprivation affecting children and older people in comparison to the practice average across England.

One of the GP/directors (female) works at this practice and is supported by two salaried GPs, (one female and one male). Further clinical support is provided by an advanced nurse practitioner, a practice nurse prescriber, a nurse practitioner, a practice nurse and a healthcare assistant. In total there are 18 staff employed either full or part time hours. The practice is a training practice for GP registrars to gain experience and higher qualifications in general practice and family medicine.

The practice is open from 8am to 8pm Monday and Wednesday, 8am to 6.30pm Tuesday, Thursday and Friday and 8am to 12pm on Saturday. Extended surgery hours are from 6.30pm to 8pm on Mondays and Wednesday and Saturday morning. The practice is also open during the lunch period to support patients who work to access the practice during their lunchtime. 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, NHS111, Primecare and the local Walk-in centre.

The practice has a contract to provide Alternative Provider Medical Services (APMS) for 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 minor surgery. The practice provides a number of clinics for example long-term condition management including asthma, diabetes and high blood pressure.

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 15 February 2016.

During our visit we:

- Spoke with a range of staff including 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 CQC at that time.

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach to learning and a computerised system was in place for reporting and recording significant events. Staff told us they would inform the directors and or practice manager of any incidents to ensure appropriate action was taken. The practice carried out a thorough analysis of the significant events.

We reviewed safety records, national patient safety alerts and incident reports where these were reported and discussed. We looked at records that showed an annual review of significant events had been carried out. The annual review showed what lessons were shared to make sure action was taken to improve safety in the practice. The review showed that seven significant events, both clinical and operational had occurred between January 2015 and January 2016. One of the events reported showed that one of the fridges used to store vaccines was not working correctly and found to be above the maximum temperature. This meant the cold chain was not maintained. Appropriate action was taken to ensure the refrigerator was working correctly. Relevant procedures were followed for the safe destruction of the vaccines where this was advised and a list of the vaccines destroyed completed. All staff received training and were assessed on how to check the fridge temperature and how to reset it.

We found that significant event records were maintained and systems put in place prevented further occurrence. Significant event records were well documented at the time they were reported. The minutes of monthly clinical and significant event meetings did not fully demonstrate the discussions, action required, person responsible, learning and ongoing monitoring of events to ensure that new or improved systems put in place were appropriate. However the annual review records were more detailed and showed that learning 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 the risk of abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. One of the GP directors was the lead for safeguarding. Staff we spoke with demonstrated that they understood their responsibilities and told us they had received training relevant to their role. Certificates of safeguard training at the appropriate level were seen for all staff. 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. This involved where necessary providing reports and meetings with external agencies, such as social workers and the community mental health team.

There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. 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. Clinical waste disposal contracts were in place. One of the practice nurses was the clinical lead for infection control. 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.

A notice was displayed in the waiting room, advising patients they could access a chaperone, if required. 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 arrangements for managing medicines, including emergency medicines and vaccinations, in the practice kept patients safe (including obtaining, prescribing,

Good

Are services safe?

recording, handling, storing and security). 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 practice and local pharmacy had reviewed and monitored patients on multiply medicines due to concerns about overuse of medicines. Systems were put in place to help patients take medicines appropriately and prevent the risk of harm. Prescription pads and forms were securely stored.

The practice nursing team consisted of three independent prescribers. All the nurse practitioners received mentorship and support from an identified GP for this extended role. Patient Group Directions had been adopted by the practice to allow practice nurses to administer medicines in line with legislation.

We reviewed four personnel files, these were thorough and contained appropriate recruitment checks which had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

The practice had a robust risk assessment process in place. The practice had assessed risks to those using or working at the practice. For example, risk assessments had been completed on all consulting and treatment rooms, spillages, slips and trips and for pregnant workers. We looked at 16 comprehensive risk assessments which identified the level of risk using an identified coding system. The practice had completed a risk assessment log where specific risks related to the practice were documented. We saw that each risk was rated and mitigating actions recorded to reduce and manage the risk. The practice had a number of other risk assessments in place to monitor the 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).

There was a system to highlight vulnerable patients on the practice's computer records. This included children on a child protection plan, looked after children and adults with safeguarding concerns. The clinical staff confirmed they were able to identify and follow up children, young people and families. There were systems in place for identifying children and young people with a high number of A&E attendances. There were emergency processes in place for identifying acutely ill children and young people and staff. Staff we spoke with told us that children were always provided with an on the day appointment if required. Patients with a change in their condition were reviewed appropriately. Patients with an emergency or sudden deterioration in their condition were referred to a GP for quick assessment.

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 GP locums to support the clinicians and meet the needs of patients at the practice. There was a lack of information to confirm that locum staff were offered a formal induction. However, further information in records showed that robust systems were in place to confirm the suitability of potential staff to work with patients.

Arrangements to deal with 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. All staff had received recent annual update training in basic life support. The practice had a defibrillator (this provides an electric shock to stabilise a life threatening heart rhythm) available on the premises and oxygen with adult and children's masks. Systems were in place to ensure emergency equipment and medicines were regularly checked. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date.

The practice had a business continuity plan in place for responding to emergencies such as loss of premises, power failure or loss of access to medical records. The plan included emergency contact numbers for staff and mitigating actions to reduce and manage the identified risks.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and systems were in place to keep all clinical staff up to date. The practice 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 which was above the local Clinical Commissioning Group (CCG) average of 92% and national average of 93%. The practice clinical exception rate of 13% was higher than the local 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:

- Performance for diabetes assessment and care was higher than the national average (97% compared to the national average of 89%).
- The percentage of patients with hypertension having regular blood pressure tests was comparable to the national average (88% compared to the national average of 84%).
- Performance for mental health assessment and care was comparable to the national average (87% compared to the national average of 88%).
- The dementia diagnosis rate was comparable to the national average (90% compared to the national average of 84%).

The practice was performing well when compared to the local average. However there was one indicator that required further enquiry. Data for the period July 2014 to June 2015 showed that the practice had a higher average daily quantity of Hypnotics (medicines that initiate, sustain, or lengthen sleep) prescribed per specific patient groups than the national average (0.71 compared to the national figure of 0.26). The practice was aware of this and had identified the reasons for the large variation and the action required to improve. Regular meetings were held to monitor performance and an action plan was developed at each meeting to identify the areas of patients' care that needed to be reviewed. The practice was aware of the exception reporting rate. Evidence was available to show that the practice had a robust system in place to follow up patients that had not attended at least annual reviews of their condition when offered an appointment.

The practice had developed a focussed plan of audits to be carried out over the year which would facilitate quality improvement. All staff were involved in the practice aim to improve care and treatment and patient outcomes. Both clinical and non-clinical staff were named as the lead person to lead on the audits. We saw eight clinical audits carried out over the last 12 months. All audits were ongoing and were identified for re-audit to review whether improvements had been made. One of the audits was carried out to ensure safe prescribing of medicines used to control pain due to the risk of patients becoming reliant on the medicines. There were 124 patients who had received repeat prescriptions of these medicines. The audit showed that the reasons for prescribing for four patients were unclear and 37 patients required a review. Action was taken to ensure patients were offered an appointment with a GP to review their treatment and clinical staff were instructed to ensure patient records clearly identified the reasons for prescribing. The audit was planned to be repeated in 12 months.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. All staff had annual appraisals that identified their learning needs from which personal development plans were identified. All staff had had an appraisal within the last 12 months. Our interviews with

Good

Are services effective?

(for example, treatment is effective)

staff confirmed that the practice provided training opportunities. Staff had also received training that included safeguarding, fire procedures, basic life support, information governance awareness and all staff had received dementia friends training. The practice was a training practice for GP registrars to gain experience and higher qualifications in general practice and family medicine. A GP registrar had recently started working at the practice and was completing a structured induction programme.

The practice could demonstrate how they ensured clinical staff attended role-specific training and updating for relevant staff. The GPs had all completed clinical specific training updates to support annual appraisals and revalidation. The practice nurses received training and attended regular updates for the care of patients with long-term conditions and administering vaccinations.

A training passport had been developed for all staff. The training passport was owned by the individual member of staff. This was a comprehensive and robust tool which detailed the training and supervision staff needed for their role. For example, mandatory training, personal learning development and objectives agreed through the appraisal process. There was a training schedule in place to demonstrate what training staff had received or were due to receive. Staff had access to and made use of e-learning training modules and external and in-house training. The practice was discussing with the practice nurses the support needed for revalidation (A process to be introduced in April 2016 requiring nurses and midwives to demonstrate that they practise safely).

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their shared computer drive. This included risk assessments, care plans, medical records and investigation 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 patient's to secondary care such as hospital or to the out of hours 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 joint working with midwives and health visitors at baby immunisation and wellbeing check clinics. Further examples included providing a service to patients in care homes. Multi-disciplinary team meetings to discuss patients on the practice palliative care register took place on a three monthly basis. The practice maintained regular contact with hospital consultants specialising in diabetes and care of the elderly, local mental health teams and substance misuse liaison services.

Consent to care and treatment

We found that staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and where appropriate, recorded the outcome of the assessment. We saw that patients' consent had been recorded clearly using nationally recognised standards. For example, when consenting to certain tests and treatments such as vaccinations and in do not attempt cardio-pulmonary resuscitation (DNACPR) records.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. This included patients with conditions that may progress and worsen without the additional support to monitor and maintain their wellbeing. 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 were then signposted to the relevant service for example, smoking cessation clinics and dietary advice was available from the healthcare assistant. We saw that information was displayed in the waiting area and also made available and accessible to patients on the practice website. Patients had access to appropriate health assessments and checks.

The practice had sought the support of the local learning disability team to complete health assessments for patients with a learning disability. Patients had access to appropriate health assessments and checks. Patients with a learning disability who could not or were reluctant to attend the practice were seen in their own home.

Good

Are services effective?

(for example, treatment is effective)

The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. Data collected by NHS England for 2014 -2015 showed that the performance for all childhood immunisations was comparable to the local CCG average. For example, childhood immunisation rates for the vaccination of children under two years of age ranged from 82% to 99%, children aged two to five 87% to 100% and five year olds from 80%% to 92%

We saw that the uptake for cervical screening for women between the ages of 25 and 64 years for the 2014-2015 QOF year was 83% which was comparable to the national 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 practice was comparable with local and national averages for screening for cancers such as bowel and breast cancer.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard. 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.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 22 completed cards. The comments received were overall positive about the practice and staff. Patients commented that the service was fantastic, excellent, happy with the level of service they received, they were treated with respect and dignity and that GPs and staff were knowledgeable, very kind, caring and friendly. We also spoke with three 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 was above average or similar to the satisfaction scores on consultations with GPs and nurses. For example:

- 80% said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 83% and national average of 89%.
- 80% said the GP gave them enough time (CCG average 83%, national average 87%).
- 95% said they had confidence and trust in the last GP they saw (CCG average 93%, national average 95%).
- 80% said the last GP they spoke to was good at treating them with care and concern (CCG average 80%, national average 85%).
- 91% said the last nurse they spoke to was good at treating them with care and concern (CCG average 83%, national average 85%).
- 94% said they found the receptionists at the practice helpful (CCG average 85%, national average 87%).

Care planning and involvement in decisions about care and treatment

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

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. Results were higher than or similar to the local and national averages. For example:

- 86% 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%.
- 78% said the last GP they saw was good at involving them in decisions about their care (CCG average 76%, national average 82%).
- 91% said the last nurse they saw was good at involving them in decisions about their care (CCG average 89%, national average 91%).

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. There were 85 carers on the practice carers register, which represented 2.8% of the practice population. The practice's computer system alerted GPs if a patient was also a carer. Written information was available for carers to ensure they understood the various avenues of support available to them. Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. The practice

Good

Are services caring?

also had 358 patients who were identified as cared for. These patients lived in care homes or supported housing accommodation. This represented 12% of the practice population.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

- The practice maintained a register of vulnerable patients registered at the practice. The register included asylum seekers, patients with language or literacy requirements.
- The practice had access to translation and interpretation services to ensure patients were involved in decisions about their care.
- Facilities for patients with mobility difficulties included level access to the automatic front doors of the practice, toilets for patients with a physical disability. Access to baby changing facilities were available.
- 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 would benefit from these, which included patients with long term conditions or receiving end of life care.
- Weekly ward rounds were made to patients in two of the four care homes by the advanced nurse practitioner.
- All staff had received dementia friends training to support meeting the needs of older patients.
- Urgent access appointments were available for children and those with serious medical conditions.
- Telephone consultations were available every day after morning and evening clinics.
- Extended opening hours were available two evenings per week and on a Saturday morning for patients who worked. Patients had telephone access to the practice during lunch time.

Access to the service

The practice was open from 8am to 8pm Monday and Wednesday, 8am to 6.30pm Tuesday, Thursday and Friday and 8am to 12pm on Saturday. Extended surgery hours were available from 6.30pm to 8pm on Mondays and Wednesday and Saturday morning. The practice was also open during the lunch period making it accessible to patients who worked. 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, NHS111, Wolverhampton Doctors On Call and the local Walk-in centre.

Results from the national GP patient survey published in January 2016 showed that patients' satisfaction with how they could access care and treatment was higher than or similar to local and national averages.

- 88% of patients were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 75%.
- 91% patients said they could get through easily to the surgery by phone (CCG average 70%, national average 73%).
- 60% patients said they always or almost always see or speak to the GP they prefer (CCG average 58%, national average 59%).

Patients told us on the day of the inspection that they were able to get appointments when they needed them. Patients received a text message immediately to confirm any appointment booked and automatic reminders were sent 24 hours before the appointment time. Patients confirmed this and told us that confirmation of appointments and reminders were helpful to them. Patients who did not attend received a message to let them know that they had missed an appointment.

Listening and learning from concerns and complaints

The practice had an 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. The practice manager was the designated responsible person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system including a summary leaflet available in the reception area. Patients we spoke with were aware of the process to follow if they wished to make a complaint. Records we examined showed that the practice responded formally to both verbal and written complaints.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw records for five complaints received over the past 12 months and found that all had been responded to, satisfactorily handled and dealt with in a timely way. Lessons were learnt from concerns and complaints and action was taken to improve the quality of care.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Staff and patients felt that they were involved in the future plans for the practice. The patient participation group (PPG) told us that changes to improve services at the practice were discussed at the PPG meetings and their input was encouraged. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services.

Governance arrangements

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

- We found that systems were supported by a strong management structure and clear leadership.
- Risk management systems, protocols had been developed and implemented to support continued improvements.
- A programme of clinical and internal audit had been implemented and was used to monitor quality and to make improvements.
- Staff had received training in governance arrangements and monthly meetings were held to discuss clinical governance issues.
- The GPs, nurses and other staff were all supported to address their professional development needs.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- Health and safety risk assessments had been conducted to limit risks from premises and environmental factors.
- There was a clear staffing structure and staff were aware of their own roles and responsibilities
- Practice specific policies and procedures were implemented. Records showed that they were regularly updated and were easily accessible to all staff
- There was a lack of minuted meetings to confirm that information was continuously shared with staff which confirmed learning from significant events and any action taken were appropriate.

Leadership and culture

The directors in 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 directors encouraged a culture of openness and honesty. The practice manager told us that an open door policy was operated for all staff. Staff felt that they worked in a caring and compassionate environment.

There was a clear leadership structure in place and staff felt supported by the management team. 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 team away events.

Regular practice, clinical and team meetings involving 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. There was a practice whistle blowing policy available to all staff to access on the practice's computer system. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. The practice had an active patient participation group (PPG), which consisted of six patients who met face to face and 20 virtual group members. Staff from two of the care homes served by the practice were members of the virtual PPG. The group met three monthly and submitted proposals for improvements to the practice management team. The practice had gathered feedback from patients

Are services well-led?

Good

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

through the PPG and through surveys and complaints received. Feedback from patients and the PPG included introducing a practice newsletter for patients and having photographs of the practice staff in the practice website and on the practice website.

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 shared with relevant staff and demonstrate learning and appropriate improvements were made.

The principal GP was the clinical lead for commissioning at Wolverhampton Clinical Commissioning Group (CCG). The practice was involved in a number of local pilot initiatives which supported improvement in patient care across Wolverhampton. The practice had been successful in being shortlisted and accepted to pilot a model of care. The model of care would involve joint working across primary, community and secondary care to provide a multidisciplinary approach to care and improvements to the care of patients who lived in care homes.

The practice had reviewed the skill mix of staff and new staff employed to ensure the needs of patients could be met in the long term. One of the staff recently employed included a nurse practitioner who was also a qualified independent prescriber and a health care assistant who was also a trained phlebotomist. The practice had established links with other professionals for example, the advanced nurse practitioner worked with a consultant who specialised in the care of older people to support the management of patients in care homes. The practice had achieved recent accreditation to be a training practice for GPs.