

Grove Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Grove Medical Centre on 25 July 2016. Overall the practice is rated as good.

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

- There was an effective system in place for reporting and recording significant events.
- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses.
- Risks to patients were assessed and well managed. However full recruitment checks were not always completed to ensure the safety of patients at all times.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- 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. Verbal complaints were not monitored.
- 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. Some patients told us that it was not always to get an appointment in a timely way.
- 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 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 areas where the provider should make improvement are:

- Continue to ensure that all relevant employment checks as required by legislation are completed for all staff.
- Review the storage of staff records to ensure confidentiality.

Summary of findings

- Implement a system for receiving, recording, handling and responding to verbal complaints.
- Consider pro-actively identifying carers and establishing what support they need.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

Good



- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, relevant information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed. Recruitment procedures had been reviewed to ensure that full recruitment checks were completed.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were above average compared to the England 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 other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

The practice is rated as good for providing caring services.

Good



- 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 decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.

Summary of findings

- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. The practice worked with the local migrant centre to provide support to patients from East European communities.
- 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. Some patients told us that it was not always to get an appointment in a timely way.
- 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.

Good



Are services well-led?

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 it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- Governance for clinical risks such as medicines, changes in patient care and treatment and acting on information about patient care was well managed.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for 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.

Good



Summary of findings

The six population groups and what we found

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

Older people

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

Good



- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits, same day appointments, longer appointments and urgent appointments for those with enhanced needs.
- The practice maintained a list of housebound patients aged 75 and over together with their carers details.

People with long term conditions

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

Good



- The GPs and practice nurse had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was higher than the local and England average (84% compared to the local average of 75% and England average of 78%). The practice clinical exception reporting rate of 7.3% showed that it was higher than the local average of 6.4% but lower than the England rate of 8.7%. 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.

Families, children and young people

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

Good



- 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.

Summary of findings

- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 77%, which was lower than England average of 82%. The exception reporting rate for the practice of 6% was lower than the local CCG and England average of 6.3%.
- 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, health visitors and school nurses. For example the midwife carried out weekly clinics at the practice.

Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice 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 encouraged patients aged 40 to 74 years to take advantage of the national health screening programme.

Good



People whose circumstances may make them vulnerable

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

- The practice held a register of patients living in vulnerable circumstances including migrants and those with a learning disability.
- The practice worked regularly with the local specialist learning disability nurses to ensure it carried out annual health checks for people with a learning disability. Designated 40 minute clinics were arranged and carried out by the GP and practice nurse.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

Good



Summary of findings

- Staff knew how 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 in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

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

- Data showed that 100% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, was above the England average of 84%.
- Performance for mental health related indicators was higher than the local CCG and England averages. For example, the percentage of patients experiencing mental health disorders who had a comprehensive, agreed care plan documented in their records in the preceding 12 months was 100% compared to the local CCG and England average of 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- 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 had a good understanding of how to support patients with mental health needs and dementia.

Good



Summary of findings

What people who use the service say

The national GP patient survey results published in July 2016 showed the practice was performing above the local and national averages in most areas. A total of 360 surveys (11% of the patient list) were sent out and 78 (22%) responses were received, which is equivalent to 2% of the patient list. The percentage of responses received was lower than the England response rate of 38%. Results indicated the practice performance was higher than other practices in some aspects of care. For example:

- 89% of the patients who responded said they found it easy to get through to this surgery by phone compared to a Clinical Commissioning Group (CCG) average of 70% and a national average of 73%.
- 76% of the patients who responded said they were able to get an appointment to see or speak to someone the last time they tried (CCG average 80%, national average 85%).
- 90% of the patients who responded described the overall experience of their GP surgery as fairly good or very good (CCG average 83%, national average 85%).
- 77% of the patients who responded said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 73%, national average 78%).
- 94% of the patients who responded said they found the receptionists at this practice helpful (CCG average 84%, national average 87%).

As part of our inspection we also asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received 39 comment cards 37 of these were positive about the standard of care. Patients said that the service was very good and

that staff were professional, attentive to patients' needs, helpful, polite and understanding. Comments in the two remaining cards included concerns about access to appointments and that consultations were at times not long enough. We spoke with nine patients as a group on the day of our inspection. All nine patients were members 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. The PPG members told us that as patients they were satisfied with the care provided by the practice, felt that they received good treatment were listened to and treated with respect. The group said that they were also encouraged to make suggestions to support improvement of the services provided.

The practice monitored the results of the friends and family test monthly. The results for January 2015 to June 2016 showed that 105 responses had been completed and of these, 60 (57%) patients were extremely likely to recommend the practice to friends and family if they needed similar care or treatment, 37 (35%) patients were likely to recommend the practice and four (4%) patients neither likely nor unlikely to recommend the practice. The remaining results showed that two (2%) patients were unlikely to recommend the practice, one (1%) patient was extremely unlikely to recommend the practice and one (1%) patient stated that they did not know if they would recommend the practice. Comments made by patients in the family and friends tests were in line with comments we received. Patients raised mixed comments about the availability of appointments.

Areas for improvement

Action the service SHOULD take to improve

- Continue to ensure that all relevant employment checks as required by legislation are completed for all staff.
- Review the storage of staff records to ensure confidentiality.

- Implement a system for receiving, recording, handling and responding to verbal complaints.
- Consider pro-actively identifying carers and establishing what support they need.

Grove Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Grove Medical Centre

Grove Medical Centre is registered with the CQC as a partnership. The practice is located in Wolverhampton and has good transport links for patients travelling by public transport. Parking is available for patients travelling by car plus off road parking. The practice is a single story building and all areas are easily accessible by patients with mobility difficulties, patients who use a wheelchair and families with pushchairs or prams.

The practice team consists of two GP partners who are both male. One of the partners is part time and works five to six sessions per week and the senior partner is full time and works nine to ten sessions per week. The GPs are currently supported by a practice nurse and a healthcare assistant. The practice had recently recruited a second practice nurse to replace the health care assistant who was due to leave. Clinical staff are supported by a practice manager, and four administration / receptionist staff. In total there are nine staff employed either full or part time hours to meet the needs of patients. The practice also use GP locums at times of absence to support the clinicians and meet the needs of patients at the practice.

The practice is open between 8.30am and 6.30pm Monday, Tuesday, Friday, 8.30am to 8pm on Thursday and 8.30am to 2.30pm on Wednesday. Appointments times for patients

vary for the doctors, practice nurse and healthcare assistant and include both morning and afternoon clinic sessions. This 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 by Vocare via the NHS service.

The practice has a General Medical Services contract with NHS England to provide medical services to approximately 3,315 patients. It provides Directed Enhanced Services, such as childhood vaccinations and immunisations and the care of patients with a learning disability. The practice has a higher proportion of children (girls) aged below nine and patients aged between 25 and 39 years. The practice is located in one of the most deprived areas of Wolverhampton. People living in more deprived areas tend to have a greater need for health services. There is a higher practice value for income deprivation affecting children and older people in comparison to the practice average across England. The level of income deprivation affecting children of 34% is higher than the national average of 20%. The level of income deprivation affecting older people is higher than the national average (32% compared to 16%).

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

Before our inspection, 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 25 July 2016.

During our inspection we:

- Spoke with a range of staff including a GP, practice manager, practice nurse, administration staff and 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.

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. 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 practice carried out a thorough analysis of the significant events. We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. 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). We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again. The practice manager was responsible for disseminating safety alerts and there were appropriate systems in place to ensure they were acted on.

Records we looked at showed that eight significant events, both clinical and operational had occurred between July 2015 and June 2016. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, one of the events reported that the medicine fridge temperature was reading 15°C (temperature should be maintained between 2°C and 8°C to maintain the stability of medicines). The fridge was reset but the temperature was not monitored or temperature recorded for four days. There had also been a power cut on one of the days over the previous weekend. The practice could not guarantee that the medicines were safe to use as the cold chain had not been maintained. Appropriate procedures were followed for the safe destruction of the vaccines where this was advised and a list of the vaccines destroyed completed. The procedures for checking and resetting the fridge were reviewed and staff reminded of the importance of following the procedure.

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep patients safe and safeguarded from the risk of abuse. The systems reflected relevant legislation and local

requirements. Policies were accessible to all staff. One of the GPs was the lead for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and the practice nurse were trained to child safeguarding level 3. The practice maintained records of children identified as being at risk and those with protection plans and had 15 children currently on the register. Vulnerable adults were also identified. Alerts on the patients records ensured staff were made aware of patients at risk when they visited the practice.

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. We found that the healthcare assistant that carried out this role had not had a Disclosure and Barring Service (DBS) check completed to confirm that they were suitable and safe to undertake this role however a risk assessment had been completed in its absence. (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 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 and 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 and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local clinical commissioning group (CCG) medicine advisory teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. The practice had effective shared care

Are services safe?

systems in place to review and monitor patients prescribed high risk medicines. Patient Group Directions had been adopted by the practice to allow the nurse to administer medicines in line with legislation. We saw that the cupboard used to store medicines was not located in a suitable area of the practice. We discussed this with the practice manager and GP who assured us that this would be reviewed and risk assessed.

We reviewed five staff files and found that most recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body. We saw however that the healthcare assistant, who carried out other care duties on their own, had not had the appropriate checks completed through the Disclosure and Barring Service. We discussed this with the practice manager who told us that the healthcare assistant was leaving and they would ensure that the risk assessment they had in place included that the healthcare assistant would not work unsupervised. The practice had recently recruited a second practice nurse to replace the health care assistant. We saw records to confirm that appropriate recruitment checks were being carried out before their employment. We noted that staff records were all stored together in one folder, which did ensure confidentiality of personal information.

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. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was

working properly. 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, 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.

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. 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. Copies of the plan were kept off site by the senior partner and practice manager. The practice manager carried out impromptu emergency scenarios to ensure staff maintained their skills and could take appropriate action in the event of an emergency such as the sudden collapse of a patient or dealing with an aggressive patient.

All staff received annual basic life support training. Emergency medicines were available at the practice, easily accessible to staff and all staff knew of their location. All the medicines we checked were in date and stored securely. The practice had a defibrillator available on the premises and oxygen with adult and children's masks.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed patients' needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. The lead GP could clearly outline the rationale for their approach to treatment. The practice used electronic care plan templates to plan and monitor the care of patients with long term conditions such as diabetes and Chronic Obstructive Pulmonary Disease (COPD). COPD is the name for a collection of lung diseases. They were familiar with current best practice guidance. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice 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 were 98% of the total number of points available. This was higher than the local Clinical Commissioning Group (CCG) average of 92% and the England average of 95%. The practice clinical exception rate of 7.6% was similar to the local CCG average of 7.5% and lower than the England 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.

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

- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was higher than the local and England average (84% compared to the local average of 75% and

England average of 78%). The practice clinical exception reporting rate of 7.3% showed that it was higher than the local average of 6.4% but lower than the England rate of 8.7%.

- Performance for the percentage of patients with who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale (the degree of breathlessness related to five specific activities) in the preceding 12 months was 93%. This was higher than the local CCG average of 91% and England average of 90%. COPD is the a collection of lung diseases. The practice clinical exception reporting rate of 14.3% showed that it was higher than the local average of 6.8% and England average of 11.1%.
- Performance for mental health related indicators was higher than the local CCG and England averages. For example, the percentage of patients experiencing mental health disorders who had a comprehensive, agreed care plan documented in their records in the preceding 12 months was 100% compared to the local CCG and England average of 88%. The practice clinical exception rate of 3.7% for this clinical area was lower than the local CCG average of 8.7% and England average of 12.6%.
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was higher than the local CCG and England average (100% compared to the local CCG average of 82% and England average of 84%). The practice clinical exception rate of 20% for this clinical area was higher than the CCG average of 7.7% and the England average of 8.3%.

The practice had performed well overall when compared to the local CCG and England averages. The practice had a high clinical exception reporting rate in some areas as indicated above in the clinical areas related to dementia and COPD. The practice monitored its exception reporting rates. It had a call and recall system in place to ensure that patients who failed to attend appointments were followed up. The GP attended peer review meetings with other local GP practices where clinical issues, treatments and performance were discussed.

Clinical audits were carried out to improve care, treatment and patients' outcomes. Nine audits had been carried out over the past 24 months. One of the audits was started in 2015 to review the treatment of patients with a high blood

Are services effective?

(for example, treatment is effective)

sugar level. The audit identified ten patients with a blood sugar level above a specified level. These patients were monitored to make improvements by reviewing medication, providing patient education and monitoring patient compliance with treatment. The audit was repeated in 2016 and showed improvements in four (40%) of the ten patients. The practice planned to carry out a third cycle of this audit in 2017. The practice was also involved in a local initiative to improve the care of patients with diabetes within the community.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. The practice had an induction programme for all newly appointed staff. The staff induction programme covered topics such as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. The practice could demonstrate how they ensured staff received ongoing training. Staff had access to and made use of e-learning training modules and external and in-house training. Staff had received training updates that included safeguarding, fire safety awareness, basic life support and information governance. All staff had received an appraisal within the last 12 months.

The practice also supported clinical staff to attend role-specific training and updates. The GPs and practice nurses 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 for example the care of patients with diabetes and asthma. Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence.

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. The practice worked closely with the out of hours service to ensure they were aware of patients with complex needs and those whose condition was deteriorating.

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 following up patients who were identified on the practice hospital unplanned admission avoidance scheme register. Care plans had been developed with these patients and their care needs were discussed following discharge from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. Advanced care plans had been written for patients with dementia with the support of their carer or family. A midwife carried out weekly antenatal clinics at the practice. The practice maintained monthly contact with health visitors through emails.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). This guidance was available to staff as a poster for them to refer to. DoLS provides additional protection to people who lack mental capacity to consent to care or treatment, and who need limits put on their liberty to keep them safe. 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 minor surgery procedures, vaccinations and in do not attempt cardio-pulmonary resuscitation (DNACPR). The process for seeking consent was monitored through patient records audits and evidence was seen of this.

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, those requiring

Are services effective?

(for example, treatment is effective)

advice on their diet, smoking and alcohol cessation. We saw that information was displayed in the waiting area and also made available and accessible to patients on the practice website. Patients aged 40 to 74 years were offered health checks. The practice provided a service to patients with a learning disability and maintained a register of 17 patients. Fifteen of the patients had care plans completed and the practice ensured that all patients had access to appropriate health assessments and checks.

The practice had a comprehensive screening programme. Travel vaccines, childhood immunisations and influenza vaccinations were offered in line with current national guidance. Data collected by NHS England for 2014/15 showed that the performance for most childhood immunisations was comparable to the local CCG average. For example, the practice childhood immunisation rates for children:

- under two years of age ranged from 74% to 92%, (CCG average 74% to 96%),

- aged two to five 76% to 100%, (CCG average 84% to 96%)
- aged five year olds from 70% to 96%, (CCG average 77% to 95%)

The practice's uptake for the cervical screening programme was 77%, which was lower than the local CCG average of 78% and England average of 82%. The exception reporting rate for the practice of 6% was lower than the local CCG and England average of 6.3%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The performance rates for the practice in these areas were similar to the local CCG and England averages. Effective arrangements were in place to follow up patients referred through the two week rapid access referral scheme for patients with suspected cancer.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard. The area around the reception desk was kept clear to promote confidentiality. Patients were encouraged to queue away from the desk and not stand directly behind a patient speaking to reception staff at the desk. If patients wanted to discuss something privately or appeared distressed a private area was available where they could not be overheard.

Thirty seven of the 39 Care Quality Commission comment cards we received were positive about the service they experienced. Patients said 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 results published in July 2016 showed that the patient responses to their satisfaction with consultations with GP and nurses were above average. For example:

- 92% of patients said the GP was good at listening to them compared to the local clinical commissioning group (CCG) average of 85% and the England average of 89%.
- 90% of patients said the GP gave them enough time compared to the local CCG average of 83% and the England average of 87%.
- 95% of patients said they had confidence and trust in the last GP they saw compared to the local CCG average of 93% and the England average of 95%.
- 90% of patients said the last GP they spoke to was good at treating them with care and concern compared to the local CCG average of 81% and the England average of 85%.
- 97% of patients said the nurse was good at listening to them compared to the local CCG average of 91% and the England average of 91%.

- 95% of patients said the nurse gave them enough time compared to the CCG average of 91% and the England average of 92%.
- 99% of patients said they had confidence and trust in the last nurse they saw compared to the local CCG average of 96% and the England average of 97%.
- 98% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the local CCG average of 88% England average of 91%.
- 94% of patients said they found the receptionists at the practice helpful compared to the local CCG average of 84% and the England average of 87%.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey published in July 2016 showed that patient satisfaction was above average to the local CCG and England averages for how GPs and nurses involved them in planning and making decisions about their care and treatment. For example:

- 87% of the patients who responded said the last GP they saw was good at explaining tests and treatments which was the same as the local CCG average of 83% and lower than the England average of 86%.
- 89% of the patients who responded said the last GP they saw was good at involving them in decisions about their care (CCG average 78%, England average 82%).
- 96% of the patients who responded said the last nurse they saw or spoke to was at explaining tests and treatments (CCG average 89%, England average 90%).
- 92% of the patients who responded said the last nurse they saw was good at involving them in decisions about their care (CCG average 84%, England average 85%).

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. Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and a carers' pack were available for carers in the patient waiting area which told patients' how to access a number of support groups and organisations. There were 28 carers on the practice carers

Are services caring?

register, which represented 0.8% of the practice population. The practice's computer system alerted the GPs if a patient was also a carer. Patients who were identified as carers were offered a flu vaccination and health checks. Written information was available to direct carers to the various local community support services available to them. Carers were asked to complete a consent form so that they could receive information such as test results or make appointments on behalf of patients they cared for.

The practice had a bereavement policy in place. This detailed the action to be taken when a patient registered

with the practice died. Staff told us that if families had suffered bereavement, the GP contacted them and a sympathy card was sent to the family from all the staff at the practice. Staff said that patients were offered a consultation at a flexible time and location, which could be a visit to the family home if appropriate. Leaflets and other written information on bereavement were available for patients in the waiting area and on the practice website. Families and carers were signposted to support services such as bereavement counselling.

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:

- Fast track access was provided for patients experiencing poor mental health with same day access to the mental health crisis team when needed.
- The practice worked closely with the local refugee migrant centre to support the needs of patients from the Eastern European communities.
- The practice worked with the 'Safer Wolverhampton Partnership Safe Place Scheme' to provide a safe haven for patients in crisis, such as domestic abuse. The practice had a direct alarm and telephone link to the local police station.
- There were longer appointments available for patients with a learning disability, older patients and patients with long-term conditions.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that required same day consultation.
- The practice offered online access to make appointments and ordering repeat prescriptions.
- Telephone consultations were available every day after morning and evening clinics.
- Translation and interpreter services were available to patients whose first language was not English.
- Facilities for patients with mobility difficulties included level access and adapted toilets for patients with a physical disability.

Access to the service

The practice was open between 8.30am and 6.30pm Monday, Tuesday and Friday, 8.30am to 8pm on Thursday and 8.30am to 2.30pm on Wednesday. Appointments times for patients vary for the doctors, practice nurse and healthcare assistant and included both morning and afternoon clinic sessions. This 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 by Vocare via the NHS service.

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

- 80% of patients were satisfied with the practice's opening hours compared to the local CCG average of 77% and England average of 76%.
- 89% patients said they could get through easily to the practice by phone (local CCG average 70%, England average 73%).

Information we received showed that most patients were happy with the access to the practice. Three of the comments cards commented on lack of access to appointments at times. We saw that the practice continuously reviewed the appointment system and made improvements to improve patients' experience. Improvements made included increasing the number of clinical staff and the number of clinical sessions available.

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. The practice operated a telephone triage system and patients were contacted following the morning and evening clinics. Non-clinical staff would refer any calls which caused concern or they were unsure of to a clinician for advice. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits. Information in the patient leaflet and on the practice website informed patients to contact the practice after 11am if they required a home visit. The priority of the visit was based on the severity of their condition. The GP made a decision on the urgency of the patients' need for care and treatment and the most suitable place for this to be received.

Listening and learning from concerns and complaints

The practice had a policy and procedure in place for handling complaints and concerns. These were in line with recognised guidance and contractual obligations for GPs in England. Patients we spoke with were knew how to make a complaint if they needed to. Leaflets and notices in the waiting area ensured patients were aware of how to raise a complaint. Patients had details of how to progress their

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

concerns if they were not happy with the response they received from the practice. The practice manager who was

also the designated person for handling complaints told us that they had not received any complaints in the last 12 months. The practice did not maintain a log of any verbal complaints received.

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 general health care to its local population. The vision made reference to staff putting patients first and always accommodating their needs to ensure good outcomes for patients. The practice vision, aims and objectives were included in the statement of purpose, on the practice website and were displayed in the practice. Staff were aware of the practice vision statement and showed support for it. The GP partners had plans for the future development of the practice which considered the needs of the local population and local initiatives planned for the Wolverhampton area. The practice was working on a two year development strategy. These plans included re-locating into new premises with another local practice. Discussions were also taking place as to whether a merger should be considered.

Governance arrangements

The practice had a governance framework which supported the operation of the practice and promoted 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. The GP partners and nurses had designated clinical lead roles.
- Practice specific policies and procedures were implemented and were available to all staff.
- 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 arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However recruitment procedures were not always completed to ensure all risks to patients were minimised.

Leadership and culture

On the day of inspection the partners at 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 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 that affected people received reasonable support, relevant information and a verbal and written apology.

There was a clear leadership structure in place and staff felt supported by the management. Staff we spoke with were positive about working at the practice. They told us they felt comfortable enough to raise any concerns when required and were confident these would be dealt with appropriately. Regular practice, clinical and team meetings which involved all staff were held and staff felt confident to raise any issues or concerns at these meetings. Topics on the agenda included day to day operation of the practice, health and safety, audits, complaints, significant events and other governance arrangements. All staff were involved in discussions about how to run and develop the practice, and the GPs encouraged all members of staff to identify opportunities to improve the service delivered by the practice. Practice meetings were held every two to three months to discuss the governance and operation of the practice. We saw that minutes of meetings were maintained to evidence this.

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. Comments we received from patients told us that they felt listened to. The practice had an active patient participation group (PPG), which consisted of 11 patients who met face to face approximately every three months. The PPG held formal meetings on a date and time to suit the group. The practice had gathered feedback from patients through PPG and through surveys received.

Are services well-led?

Good 

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

Members of the PPG told us that the practice supported the group to be involved in the implementation of changes at the practice. They told us that they were kept up to date with changes to the appointment system, shared challenges the practice faced and arranged talks such as advice on diabetes and pain control to promote self-care and healthy lifestyle. The PPG was also looking at initiatives to support the practice to be more involved in the local community. One of these initiatives included working with the local church in planned local events.

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. Staff told us that they were involved in making improvements to the appointment system and were actively encouraged to improve their skills and knowledge to ensure that patient's needs were met.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice had completed reviews of significant events and other incidents and had ensured that lessons learned from these

were used to make improvements and prevent further reoccurrence. The learning needs of staff were identified through appraisals, meetings and when reviewing the future development needs of the practice. The practice had acknowledged concerns raised by patients about the difficulty they experienced with getting an appointment. To address this, the practice had recruited additional clinical staff which allowed the practice to increase the number of clinical sessions available to meet patient's needs.

The practice was involved in a number of local pilot initiatives which supported improvement in patient care across Wolverhampton. For example, the practice was involved in joint projects with consultants who worked in secondary care and community professionals in the treatment of patients with long term conditions such as diabetes and chronic obstructive pulmonary disease (COPD is the name for a collection of lung diseases). The practice had also agreed to take part in a national initiative to improve the care of patients with asthma.

One of the GP partners was the lead in a Wolverhampton CCG initiative looking at a primary care home model of care. This model enables primary care, community health and social care professionals to work in partnership with specialists to provide care to patients outside of hospital.