West Bromwich Partnerships for Health

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 24 February 2015 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be rated as good in providing safe, effective, caring, responsive and well-led services. We found the practice provided good care to older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people whose circumstances may make them vulnerable and people experiencing poor mental health.

Our key findings were as follows:

- We found evidence that systems were in place to ensure patients received a safe service. Incidents were being reported and learning shared with staff.
- The practice had effective procedures in place that ensured care and treatment was delivered in line with appropriate standards. The practice was proactive in promoting good health.
- Patients were treated with dignity and respect. Patients spoke very positively of their experiences and of the care and treatment provided by staff.
- The practice provided services that reflected the needs of the patients. The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- We found that the service was well led with well-established leadership roles and responsibilities with clear lines of accountability.

However, there were also areas of practice where the provider should make improvements.

The practice should:

- Ensure Automated External Defibrillator (AED) is in place so that the practice can respond to medical emergencies adequately. An AED used to attempt to restart a person's heart in an emergency.

Summary of findings

- Ensure all staff are aware that the practice was designated as a Place of Safety for vulnerable people and the purpose of this.
- Ensure all sharps bins are labelled appropriately.

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. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice provided opportunities for the staff team to learn from significant events and was committed to providing a safe service. Information about safety was recorded, monitored, appropriately reviewed and addressed. Staff were suitably qualified, trained and competent to carry out their roles and a system was in place to enable sufficient staff numbers to meet service requirements. Most equipment required to manage foreseeable emergencies was available and was regularly serviced and maintained.

Are services effective?

Good

The service is rated good for effective. Treatment was delivered in line with both the National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. Clinical audits were carried out and changes made to ensure patient care was appropriate for their needs. Systems were in place for regular reviews of patients who had long term conditions, those identified as at risk and housebound patients. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could show that appraisals and the personal development plans had been completed for all staff. Staff worked well with multidisciplinary teams.

Are services caring?

Good

The service is rated good for caring. Patients told us that practice staff were caring and helpful. Patients we spoke with told us they were satisfied with their care they had received and had confidence in the decisions made by clinical staff. Staff treated patients with kindness and respect and maintained confidentiality. The comment cards patients had completed prior to our inspection provided positive opinions about staff, their approach and the care provided to them.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice delivered core services to meet the needs of their patient population. Patients had access to screening services to detect and monitor certain long term conditions. There were immunisation clinics for babies and children. The practice was aware of the needs of their local population and engaged with the Clinical Commissioning Group (CCG) to secure service improvements where

Summary of findings

these were identified. There was an accessible complaints system with evidence demonstrating that staff were aware of the process. CCGs are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

Are services well-led?

Good

The service is rated as good for well led. Patients were cared for by staff who were aware of their roles and responsibilities for managing risk and improving quality. Staff had received regular performance reviews and attended staff meetings and events. There were clear governance structures and processes in place to keep staff informed and engaged in practice matters. There was evidence of improvements made as a result of audits and feedback from patients.

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 its population. Patients at risk of an unplanned hospital admission had a care plan in place, which was regularly reviewed and updated. Housebound patients were routinely visited so they could be given information and advice to prevent hospital admissions. The wishes of patients requiring end of life care were met; this included care being provided in the patient's home by the GP and multi-disciplinary team. Telephone consultations were available so patients could call and speak with a GP if they did not wish to or were unable to attend the practice.

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. Longer appointments and home visits were available when needed. Practice staff held a register of patients who had long term conditions and carried out regular reviews. There was a recall system in place when patients failed to attend for their reviews. For patients with the most complex needs, GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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. Practice staff liaised with local health visitors to offer a full health surveillance programme for children. Checks were also made to ensure maximum uptake of childhood immunisations. The practice nurse offered immunisations to children in line with the national immunisation programme.

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 practice offered patients in this group open access or specific appointment times which were accessible, flexible and offered continuity of care. Telephone appointments, online booking of appointments and

Summary of findings

ordering prescriptions were available to meet the needs of those patients who worked. The practice was proactive in offering a full range of health promotion and screening that reflected the needs of this age group. This included health checks for patients aged 40 - 70 years of age.

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 living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for patients with a learning disability and most of these patients had received a follow-up where issues were identified. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. GPs carried out regular home visits to patients who were housebound and to other patients on the day they had been requested.

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 practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. The practice had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Annual health checks were offered to patients with long term mental health conditions. GPs had the necessary skills and information to assess and treat or refer patients with poor mental health.

Summary of findings

What people who use the service say

We reviewed the 30 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. Patients who had completed these comment cards had written very positive comments. These included that the staff were lovely and caring and that the GPs listened to them. Whilst all the comments cards were positive about the service and treatment received at the practice three also stated that access to appointments could be improved.

We looked at results of the latest national GP patient survey which was published January 2015. Out of the 450 surveys, 76 were completed and returned. Representing a completion rate of 17%. Findings of the survey were based in comparison to the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is a group of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

The results of the national survey showed the practice was above average for seeing patients for their appointments within 15 minutes or less from their appointment times. This was because 70% of respondents stated that they waited 15 minutes or less after their appointment time to be seen compared to 54% locally. We saw that the practice performed less well compared to the local CCG average in some areas. For example, 69% of respondents to the survey stated that they were able to get an appointment to see or speak to someone the last time they tried compared to 77% local average. We saw that the practice had identified this as an issue and had made changes to the appointment system and also reduced the number of people who did not attend their appointment (DNA).

We spoke with four patients, including the chair of the Patient Participation Group (PPG), during the inspection and they confirmed that they were treated well, with dignity and respect by all staff at the practice. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. Patients provided positive feedback regarding the staff and the service. The chair of the PPG confirmed that the practice listened to the group and made changes where appropriate to improve service.

Areas for improvement

Action the service SHOULD take to improve

- Ensure Automated External Defibrillator (AED) is in place so that the practice can respond to medical emergencies adequately. An AED used to attempt to restart a person's heart in an emergency.
- Ensure all staff are aware that the practice was designated as a Place of Safety for vulnerable people and the purpose of this.
- Ensure all sharps bins are labelled appropriately.

West Bromwich Partnerships for Health

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist advisor.

Background to West Bromwich Partnerships for Health

West Bromwich Partnerships for Health is a registered provider of primary medical services with the Care Quality Commission (CQC). The surgery served a population of approximately 3700 patients. The practice is open Monday to Friday 9am to 6pm except Thursday when it closed at 12.30pm when the service was delivered by another provider. The practice has opted out of providing out-of-hours services to their own patients. This is provided by an external out of hours service contracted by the CCG.

The practice was inspected previously in 26 February 2014 and we found that the provider did not have a robust system in place to identify, assess and manage risks to the health, safety and welfare of patients who used the service and others. A new practice manager had recently started and was aware of the improvements they needed to make. We set compliance actions in these areas and required the provider to send us an action plan setting out the actions they would take to improve and to meet standards. We undertook a follow up inspection in 1 July 2014 to ensure improvements were made. At this visit we found that although some improvements were made, further improvements were required.

There was a full time salaried GP (male) and a regular locum GP (female) who worked two to three sessions a week. There was also a nurse practitioner working one session a week and a practice nurse working four sessions a week. There was also a team of administration staff and a practice manager responsible for the day to day running of the practice.

The practice is in an area with a high ethnic population. Many of the practice population are from South Asia and have health needs that reflect that community, for example, a high rate of diabetes. It is a designated deprived area with a high rate of unemployment. The practice has a higher than the national average patients aged between 25 and 50 years old, particularly male patients. The practice has a population of 50 to 85 year olds which is lower than the national average.

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. This inspection was planned to check whether the provider was 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

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

How we carried out this inspection

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 are provided for specific groups of people and what good care looks 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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 12 March 2015. During our inspection we spoke with a range of staff including a GP, a practice nurse, the practice manager and four administration staff. We also spoke with four patients who used the service and received 30 comment cards from patients. We observed how patients were being cared for and staff interactions with them. Where necessary we looked at personal care and treatment records of patients. Relevant documentation was also checked

Good

Are services safe?

Our findings

Safe track record

The practice was able to demonstrate it had a good track record for safety. Practice staff used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts, as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. The practice manager showed us there were effective arrangements in place for reporting safety incidents. Regular meetings were held and included a review of the practice's safety record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Training records looked at showed that staff had received training in incident reporting as well as root cause analysis training. Root cause analysis is a method of problem solving used for identifying the root causes of faults or problems. To report incidents there was a pro-forma on the shared computer drive and all staff had access this. We saw records of incidents that were recorded over the last year with actions and learning points documented. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example, we looked at one incident which had been reviewed by the practice. There were three learning actions identified, one of them was that all staff should receive customer care training. Records looked at showed that all staff had received this training.

Significant events were a standing item on the practice meeting agenda and meetings were held regularly to review actions from past significant events. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts were discussed at team meetings. We saw minutes of meetings where a recent alert regarding Ebola in West Africa was discussed. We saw that staff were told to offer the screening service for Ebola to any new patients between the ages of 16 and 35 years and meeting other criteria.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Staff members we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. We saw contact details including an email addresses were available for the relevant child protection and adults' teams and were easily accessible to staff in the practice.

The practice had appointed dedicated GP as the lead in safeguarding vulnerable adults and children. This was displayed in the practice noticeboard in the reception area. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerator and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

At our previous inspection of the service we saw that the process for checking and monitoring medicines was not robust. At this inspection we saw processes in place to check medicines were within their expiry date and suitable for use. The practice nurse was responsible for monitoring medicines and we saw a flow chart of the protocol that was on the wall next to the medicines fridge. This enabled staff to follow the protocol especially when the nurse was away

on leave. All the medicines we checked were within their expiry dates. We saw that an audit of the medicines stored in the fridge was carried out quarterly. Audits looked at showed that the protocol was being followed.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. Up to date copies were shown to us.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. Training records looked at showed that all staff had received training in infection control.

The practice manager was the lead for infection control. We saw evidence a recent infection control audit had been carried out and the outcomes shared with staff. Minutes of meetings we looked at confirmed this.

We observed the premises to be visibly clean and tidy. The practice employed cleaners who cleaned the premises daily. We saw cleaning schedules were displayed for each area. For example, we saw cleaning schedules were displayed on the wall in the reception area detailing what needed to be cleaned in that area. Other areas included in the treatment rooms and toilets. We saw records of checks that were made by the practice manager to ensure cleaning was being done to standard. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

There were arrangements in place for the safe disposal of clinical waste and sharp instruments, such as needles and blades. We saw sharps bins were in place but not all sharps bins were labelled appropriately with the location, name of the individual who assembled the bin, and date of assembly.

We saw evidence that their disposal was arranged through a suitable company. There were guidelines informing staff what to do in the event of a needle stick injury. Staff confirmed to us that they knew what action to take in the event they or a colleague sustained such an injury. We saw clear guidelines displayed in the treatment rooms to guide staff.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. We saw that the actions identified in the risk assessment were being followed.

Equipment

We were told by staff that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw maintenance records which showed equipment at the practice was being serviced. We saw evidence of calibration of relevant equipment; for example we saw a log of all equipment that had been calibrated by an external agency, for example blood pressure monitors and scales.

Staffing and recruitment

The practice had a recruitment checklist that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). DBS checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff we spoke with and the practice manager confirmed that there was always two reception staff on duty in the mornings as it was the busiest period. We saw evidence that the practice had considered weekends and bank holidays and the impact that would have on practice. For example, the day after bank holidays when the demand for the service may be greater.

Good

Are services safe?

Staff told us they worked additional hours to cover sickness and annual leave within the practice. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. For example, we saw there were protocols in place to respond to heart attacks, hypoglycaemic attacks as well as dealing with head injuries, listing all the equipment required.

The practice had a health and safety policy and a risk assessment was in place. A weekly fire alarm test was carried out and we saw that the fire evacuation procedure was displayed in the practice so that staff and patients would know what to do in the event of a fire. We saw records that confirmed that fire drills were carried out every six months. Training records looked at showed that staff had attended fire training.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage medical emergencies. We saw records that showed all staff had received training in basic life support and staff confirmed they knew how to respond to a medical emergency should one occur. Emergency equipment was available that included a resuscitation kit with disposable airways to support patients should they stop breathing as well as access to medical oxygen. Staff we spoke with knew the location of this equipment and records we saw confirmed these were checked regularly.

The practice did not have an automated external defibrillator (AED, used to attempt to restart a person's heart in an emergency). The practice manger told us that they will look to purchase an AED.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The practice was part of a group and staff we spoke with told us that the business continuity plan was on the shared drive which could be accessed from other locations that were part of the group. There was also a 'disaster box' with documents such as radiology request forms and prescription pads so that consultations could take place in the event there was no access to practice facilities.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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 accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

The GP showed us data which showed that the practice had a lower rate of antibiotic prescribing than the local Clinical Commissioning Group (CCG) average. The GP demonstrated to us how they used computerised tools to identify patients with complex needs and who had multidisciplinary care plans documented in their case notes. The GP also showed us the process for reviewing patients recently discharged from hospital.

The GP told us that their referral rates to secondary care were lower than local and national average due to the younger patient population. Data we looked at showed that the practice was below national and local referral rates to secondary and other community care services for all conditions. The practice also carried out routine checks such as hypertension, diabetes, dementia screening which were above the CCG and national average.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. All the patients we spoke with spoke positively about the GP and other staff.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. For example, the GP had expertise in diabetes, the practice manager was the information and IT lead, and the nurse was the lead for Quality of Outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually. The information staff collected was then collated by the practice manager in quarterly clinical governance meetings. We saw 26 standing items were discussed such as referrals, summary notes and significant events. Minutes of meetings we looked at confirmed this. This enabled the practice to monitor and improve outcomes for patients.

There was a system in place for carrying out clinical audits. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through systematic review of care and the implementation of change. It includes an assessment of clinical practice against best practice such as clinical guidance to measure whether agreed standards are being achieved. The process requires that recommendations and actions are taken where it is found that standards are not being met. The GP was supported by a CCG pharmacist who visited the practice each week. This resulted in a number of clinical audits regarding prescribed medicines. We saw that the practice was one of the lowest antibiotics prescriber within the locality.

Performance information on patient outcomes was available to staff and the public, which included monitoring of QOF. The practice assigned different areas of QOF to different staff members depending on clinical lead roles. For example, administration staff were made responsible for ensuring patients with specific conditions were invited to attend regular reviews of their health. QOF targets were reviewed regularly in practice meetings and data we looked at showed that the practice had achieved higher QOF results than the local and national average.

The practice was undertaking an enhanced service to reduce unnecessary emergency admissions to hospital. GP practices can opt to provide additional services known as enhanced services that are not part of the normal GP contract. By providing these services, GPs can help to reduce the impact on secondary care and expand the range of services to meet local need and improve convenience and choice for patients. The focus of this enhanced service was to optimise coordinated care for the most vulnerable patients to best manage them at home.

The practice had a palliative (end of life) care register and had regular contact with multidisciplinary teams and attended relevant meetings to discuss the care and support needs of patients and their families.

Good

Are services effective?

(for example, treatment is effective)

The GP in the practice undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept their skills up to date. There was a consent policy and forms for consent for specific procedures.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff had attended training courses that were relevant to their roles. Staff interviews confirmed that the practice was supportive and proactive in providing training.

All staff had annual appraisals that identified any learning needs from which action plans were documented. For example, we saw that a staff member had requested training on making referrals to secondary care through the IT system. We saw that this training had been arranged by the practice manager. There was also a six monthly review of the appraisal to ensure actions were being implemented.

The practice manager showed us examples of how they reviewed and monitored the performance of staff. For example, we saw evidence where referrals to secondary care were requested by the GP. Appropriate administration staff members were then responsible for ensuring referrals were made appropriately and on time. We saw how the manager had monitored these to ensure referral requests were being processed appropriately. The practice manager also monitored progress against QOF outcomes. Staff were given responsibilities for specific parts of QOF and were monitored for progress in meetings. Random checks were also made by the practice manager and any poor performance issues were addressed during staff appraisals.

Working with colleagues and other services

Discussions with staff and records showed that the practice worked in partnership with other health and social care providers such as social services, end of life care teams and district nursing services to meet patients' needs.

The practice participated in multidisciplinary team meetings as required to discuss patients with complex needs, for example those with end of life care needs or children who were considered to be at risk of harm. These meetings included health visitors and palliative care nurses. Decisions about care planning were documented in each patient's record.

Staff told us and records confirmed that the practice manager or the GP attended quarterly Sandwell Health Alliance locality steering group meeting which was attended by a CCG board member. This was one of five locality groups, comprising of 32 GP practices within Sandwell and West Birmingham CCG. The purpose of this group was to better identify and meet the health needs of the local population. We saw that the last meeting was held in December 2015 and the five year forward plan was discussed.

The practice manager also attended monthly practice managers meeting. This was a federation of practices within the local region and the practice manager told us that these meetings took place at this surgery and they usually chaired them. The aim of this was to cascade and share learning between different practices.

Patients who had accessed the out of hours service were reviewed and followed up where necessary by the GP at the practice. Correspondence received from other services was dealt with by GP on the day.

Patients were invited to contact the practice to receive their test results. However, if a test result was abnormal, patients would be contacted and informed by the GP either face to face or by telephone consultation. Where necessary referrals would be made to hospitals and other services such as physiotherapy.

Information sharing

We saw evidence where emergency patients were provided a printed copy of a summary record and a letter to take with them to A&E. The practice was in the process of implementing the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The GP and practice nurse we spoke with told us they had good working relationships with community services, such as district nurses. There was good evidence of joint working relationships and their ability to make contact with each other at short notice when a patient's condition changed to enable the provision of appropriate care.

Consent to care and treatment

Good

Are services effective?

(for example, treatment is effective)

Patients told us they had been involved in decisions about their healthcare and treatments. They had been provided with sufficient information that enabled them to make choices and felt they had been able to ask questions when they had been unsure about anything.

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. The clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice, in relation to consent to treatment.

The GP demonstrated a clear understanding of the Gillick competencies. The Gillick competencies help clinicians to identify children under 16 years of age who have the legal capacity to consent to medical examination and treatment.

Health promotion and prevention

Latest data we looked at showed that the practice performance in relation to health promotion activities such as e.g. cervical screening, diabetes checks, cardiovascular disease prevention as well as child health surveillance was in line with local and national rates.

The practice manager told us all new patients were offered a health check. New patients were asked to attend the practice to undergo a health check and review any illnesses they had and medicines they received. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice offered screening for Ebola for new patients registering at the practice if they were considered to be from a high risk area. Similarly in accordance with the local initiative, new patients registering at the practice was screened for tuberculosis (TB) if they were identified as coming from a high risk area.

Patients who were due for health reviews were sent a reminder letter and if they failed to attend a further reminder letters would be sent to them. Patients were asked about their social factors, such as occupation and lifestyles. These ensured GPs were aware of the wider context of their health needs. The GP told us that they engaged with the local community particularly the hard to reach groups by attending churches, mosques and temples to encourage people to attend the surgery and have regular reviews.

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. We saw some health and welfare information displayed in the waiting area. For example, information on childhood immunisation was displayed in the notice board in the waiting area.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. The practice offered flu vaccinations to patients over the age of 65 and to patients with chronic diseases such as asthma, diabetes, heart disease, and kidney disease.

The practice was also designated as a Place of Safety for vulnerable people. However, staff we spoke with were not aware of the purpose of this. A place of safety is a community place where people could go to get help if they felt unsafe, at risk or vulnerable when they were out in the community.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with four patients including the chair of the PPG during our inspection. We received 30 completed cards where patients shared their views and experiences of the service. Patients we spoke with told us they felt that all of their health matters were assessed and they were cared for by staff who were considerate of their needs. Patients told us that staff displayed empathy and were respectful when they were in contact with practice staff. All the comments cards received showed that patients were very positive about the staff and told us they were helpful and polite.

We reviewed the most recent data available for the practice on patient satisfaction from the national GP Patient Survey dated January 2015. The evidence showed that patients were satisfied with the consultations and felt they were treated with compassion, dignity and respect. Data showed that 95% of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care. This was higher than the local average of 83%. Data also showed that 70% of patients waited 15 minutes or less to be seen. This was above the local average of 54%.

We saw that staff treated patients with kindness and respect ensuring their confidentiality was maintained. Reception staff told us that a consultation room was always available if a patient requested private discussions. We saw a notice in the waiting area informing patients of this.

Staff told us they offered a chaperone service if patients preferred. Staff we spoke with confirmed they had received chaperone training. We saw records to confirm that training had been completed by staff in May 2013. We saw information displayed in the reception area and consultation rooms informing patients that they could have a chaperone. Non clinical staff carried out chaperone training when clinical staff were not available. We saw that all staff had had a criminal records check carried out through the Disclosure and Barring Service.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. For example, the practice had a policy in place to put an alert on their records for younger patients who were concerned about confidentiality after getting the morning after pill. This ensured extra measure was in place so that the patient's family members would not informed. The practice manager showed us how they conducted spot checks to ensure staff were following confidentiality procedures.

Care planning and involvement in decisions about care and treatment

Patients told us on the comment cards and in person that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also commented that they felt supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. This was supported by the findings of the national GP patient survey published in January 2015

Clinical staff demonstrated their understanding of best interest decisions for patients who lacked capacity. They told us that patients were always encouraged to be involved in the decision making process. They told us that they always spoke with the patient and obtained their agreement for any treatment or intervention even if a patient had attended with a carer or relative.

Patient/carer support to cope emotionally with care and treatment

We saw that regular multi-agency meetings were held and recorded. End of life care and bereavement information was available to patients and their relatives. The GP contacted bereaved families and offered a range of services they felt to be appropriate for the family to access. This ensured that emotional support was available for patients when needed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice delivered core services to meet the needs of the main patient population they treated. For example, screening services were in place to detect and monitor the symptoms of long term conditions such as asthma and diabetes. Clinical staff told us they carried out regular and routine blood tests for patients with diabetes. They explained they also used these sessions to give dietary advice and support to patients on how to manage their conditions. Longer appointments were available for patients who needed them such as patients with mental health needs, patients with learning disabilities and those with long term conditions.

The practice had register of patients who had mental health needs and we saw that annual health checks had been carried out. The practice had a palliative care register and regular multidisciplinary meetings were held to discuss patient and their families care and support needs.

The practice had an active patient participation group (PPG). We spoke with the chair of the PPG who told us that the practice manager had listened and responded to their concerns and suggestions. They told us that it was difficult to get an appointment and the practice manager had made changes to bring down the number of people that did not attend for the appointment (DNA) from 198 to less than 40. This helped to improve access to appointments. The PPG chair also told us there was only once reception staff previously which did not enable prompt service such as quick answering of telephone calls. We were told that another reception staff had been employed in the mornings in response to their suggestions. The practice manager also told us that they had recognised there was a need for an additional reception staff member.

Tackling inequity and promoting equality

Practice staff had recognised the needs of different groups in the planning of its services. For example, arrangements were in place for temporary residents to register at the practice to ensure vulnerable patient groups had access to a GP when necessary.

There were arrangements in place to ensure that care and treatment was provided to patients with regard to their disability. For example, all the consultation rooms were on the ground level and there were no steps to negotiate. Doors were wide enough for patients in wheelchairs to gain access. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

Some staff could speak other languages spoken by the patient population including the GP. Staff told us that translation services were available for patients who did not have English as a first language. We saw that patients were also informed of this in the practice website in English and other common languages including Polish, Bengali and Punjabi.

Access to the service

The practice was open from 9am to 6pm Mondays to Fridays except Thursdays when it closed at 12.30pm when the out-of-hours service was available. Home visits were available for patients who were too ill to attend the practice for appointments and if they rang the surgery before 11am. A telephone consultation service was also available at the end of surgery time.

Patients we spoke with and the comments cards we received showed that most were satisfied with the appointments system. They confirmed that they could see a doctor on the same day if urgent.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

The practice notice board had information available to patients about how to make a complaint if they needed to and a complaints and comments leaflet was available in the reception. This explained the process for complaining

Good

Are services responsive to people's needs?

(for example, to feedback?)

and also other external organisations patients could complain to if they were unhappy. Reception staff we spoke with told us that if a patient wanted to complain they would also hand out the complaints leaflet and explain the process to them. The practice had not received any complaints in the last year. The patients we spoke with told us that they did not have a reason to complain but that they would not hesitate to discuss this with the practice manager or other staff.

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 considered that to be able to deliver this service they needed to embrace clinical innovation whilst supporting a knowledgeable, skilled medical and administrative team. The practice aimed to provide high quality patient centered care in a safe clean environment. The practice also aimed to treat patients as individuals by respecting their privacy, dignity, culture and religious beliefs. We spoke with two members of reception staff and they all demonstrated that they understood the vision and values for the practice. They knew what their responsibilities were in relation to these. They told us they felt all staff worked as a team and were encouraged to make suggestions that led to improved systems and patient care.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in hard copies and on the computer within the practice. We looked at a selection of these policies and procedures. We saw plans were in place to ensure these were reviewed annually or sooner if required.

The practice used the quality and outcomes framework (QOF) to measure their performance. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually. Reviews of the minutes of meetings and discussion with practice staff confirmed that QOF data was regularly reviewed and discussed. The practice manger showed us records which confirmed that staff were assigned specific QOF tasks such as contacting patients for review and that performance in this area was monitored. The latest data we looked at showed that the practice QOF achievement was better than the local and national average.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead for infection control and the GP was the lead for safeguarding. We spoke with four members of the practice staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice was part of a group of practices and the organisational and clinical governance structure with named leads was available and displayed for the benefit of staff.

Leadership, openness and transparency

The organisational structure was made clear in the form of flow diagram which ensured there was a clear and visible leadership and management structure in place. Staff told us that there was a positive culture and focus on quality at the practice. We saw examples where staff had been supported and encouraged to develop their skills through individual appraisals. We spoke with four staff members who confirmed that there was an open and transparent culture of leadership and encouragement of team working.

We saw that practice staff held a range of regular meetings. They included practice meetings, meetings with external stakeholders as well as with multidisciplinary teams. The minutes of some of the meetings we looked at showed that all aspects of the running of the practice were discussed as well as ways of taking corrective actions to meet patient's needs.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had an established Patient Participation Group (PPG) in place. PPGs are group of patients registered with a practice who work with the practice to improve services and the quality of care. We spoke with the chair of the PPG and looked at minutes of previous PPG meetings. We saw evidence of how the PPG was involved to help improve the practice. For example, an extra member of reception staff was employed to ensure patients received a prompt service.

The practice asked patients who used the service for their views on their care and treatment and they were acted on. This included the use of surveys to gather views of patients. We saw that a survey had been conducted in 2014; this had been analysed to identify any issues. We saw that these were discussed with the PPG and an action plan had been put in place to address the issues.

Are services well-led?

Good

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

For example, patients felt that access to appointments was an issue and so the practice had introduced changes to the appointment system including telephone triage. During our discussion with the chair of the PPG we were told that there was only one reception staff which did not ensure patients queries and telephone calls were being dealt with promptly. We saw that this was also identified though the patient survey. Additionally patients identified that there was a language barrier for many of South Asian patients who did not speak English as a first language. To address this we saw that the practice had employed an additional reception staff who was multilingual and could speak languages spoken by some of the patients.

Management lead through learning and improvement

The practice held regular meetings that ensured continued learning and improvements for all staff. All staff we spoke with confirmed that meetings had taken place on a range of topics. This included significant events, complaints and palliative care for patients, with discussions on actions to be completed where appropriate.

We looked at a selection of staff files and saw that regular appraisals had taken place which included a personal development plan. Staff told us that the practice was very supportive of training.

The results of significant event analysis, spot checks of staff targets and clinical audit cycles were used to monitor performance and contribute to staff learning.

Clinical staff held regular meetings to discuss each patient who had been admitted to hospital to monitor their progress and to determine if there were any lessons to be learnt.