Dr Andrew Thornett

Quality Report

Dr Andrew Thornett also known as Blackwood
Health Centre
Blackwood Rd
Streetly
Sutton Coldfield
B74 3PL
Tel: Tel:0121 353 7558
Website: www.blackwoodhealthcentre.com

Date of inspection visit: 27 October 2014
Date of publication: 26/03/2015

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 as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them. We carried out an announced visit on 27 October 2014. Our overall rating for the practice was good.

We found that the practice was safe, effective, caring, responsive and well-led. We rated the practice overall as good.

Our key findings were as follows:

- There were systems in place to ensure patients received a safe service.
- The practice had effective procedures in place that ensured care and treatment was delivered in line with appropriate standards. We looked at data which showed that the practice was performing similarly to national average for management of long term conditions.
- The practice was caring. 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 was responsive to patients' needs and provided services that reflected the needs of the patients.
- 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.

- All staff acting as chaperones should undergo the DBS checking which the practice told us would be undertaken following our inspection.
- The practice should carry out its own infection control audit as per the practices' own policy.
- The practice should get confirmation from the landlord of that the water system has been tested for legionella.
- All policies should be regularly reviewed and updated.

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 was rated as good for safe. There were effective infection control and medicines management policies and procedures in place. There were clear guidelines and other arrangements in place to deal with any medical emergencies at the practice. Staff had an awareness of procedures to safeguard patients. However, in the absence of a comprehensive training record it was difficult to determine core and mandatory training status, including safeguarding adult training of all staff. The practice ensured continuous learning through significant events reporting which were documented and analysed with an aim to identify any lessons to be learned. Systems were in place for sharing relevant safety information with the staff team.

Are services effective?

Good

The practice was rated as good for effective. Best practice was promoted with staff through availability of current clinical practice information. Patient care was improved by the monitoring of treatment. The practice had a system in place for completing clinical audit cycles to evidence treatment was in line with recognised standards. Patients had access to a range of support to maintain a healthy lifestyle and improve their health. The practice offered specialist clinics for patients with long term conditions where health promotion discussions were part of their treatment plan. Staff files we looked at showed that they received most core and mandatory training and support to undertake their role. They had an annual performance review and personal development plan.

Are services caring?

Good

The service was rated as good for caring. Patients we spoke with and comments cards we received reflected positive experiences of patients at the practice. Patients felt that staff treated them with dignity and respect and spoke to them in a polite and friendly manner. Patients receiving mental health care and treatment received regular reviews. Patients whose first language was not English could ask to have a translator so that they could understand the care and treatment options available to them.

Are services responsive to people's needs?

Good

The practice was rated as good for responsive to people's needs. There was an appointment system that ensured that patients were offered an immediate or same day appointment for urgent cases and for those patients recognised as high risk. There was a clear complaints policy and patients' complaints had been responded to

Summary of findings

and changes made to practice where appropriate. There was an active Patient Participation Group (PPG) who contributed positively to ensure service being delivered was responsive to the needs of patients. The practice worked closely with the PPG and had made changes where appropriate to improve service.

Are services well-led?

Good

The practice was rated as good for well led. Patients were cared for by staff who were aware of their roles and responsibilities. There were governance structures and processes in place to keep staff informed and engaged in practice matters. Staff had received inductions, regular performance reviews and attended staff meetings.There were systems in place to monitor and improve quality and identify risk. The practice was supportive of staff development and of patients' views. Staff and membersof the PPG were supported and listened to by the practice.

Summary of findings

What people who use the service say

We spoke with five patients during the inspection and we also spoke with the chair of the patient participation group (PPG) before the inspection. PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The PPG had a scheduled meeting arranged on the day of our inspection and we also spoke with a further eight members of the PPG on the day of our inspection.

All of the patients who we spoke with were satisfied with the service. All of the patients described the staff at the practice as caring and told us that their privacy and dignity was respected. Patients said that the GPs listened to their concerns and were understanding and said that they felt involved in making decisions about their care and treatment.

As part of the inspection we sent the practice comment cards so that patients had the opportunity to give us feedback. We received 42 completed cards which were all positive about the practice and all the staff. One card comment on how the surgery had improved with regards to appointment availability and access.

A patient survey was undertaken by the PPG in the last year and the results showed that the majority of patients were satisfied with the care they had experienced. We saw an analysis of the survey with follow up actions so that service could be further improved.

Areas for improvement

Action the service SHOULD take to improve
Action the provider SHOULD take to improve:

- All staff acting as chaperones should undergo the DBS checking which the practice told us would be undertaken following our inspection.
- The practice should carry out its own infection control audit as per the practices' own policy.
- The practice should get confirmation from the landlord of that the water system has been tested for legionella.
- All policies should be regularly reviewed and updated.

Dr Andrew Thornett

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr Andrew Thornett

Blackwood Health Centre is part of Walsall Clinical Commissioning Group (CCG) area. There are 63 member practices serving communities across the borough, covering a population of 274,000.

The practice has two GPs, one male and one female. There was a trainee GP working at the practice. In addition, there is a practice manager, two practice nurses, one health care assistant (HCA) and a team of seven administrative staff.

The practice opening times are from 9:00am until 6.30pm Monday, Wednesday and Friday. The practice had extended hours until 7:30pm on Tuesdays and closed at 1:00pm on Thursdays. However, the practice had recently secured short term funding to stay open until 5:00pm on Thursdays. When the practice was closed out-of-hours primary medical services were delivered by another provider. The practice had opted out of providing out-of-hours services to their own patients. This service was provided by an external out of hours service contracted by the CCG.

The practice register is made up of approximately 3,500 patients. The practice has a higher proportion of patients aged over 65 compared to the national average (England). It also has a lower proportion of patients between the ages of 10 and 40 compared to the national average.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

We conduct our inspections of primary medical services, such as Blackwood Health Centre, by examining a range of information and by visiting the practice to talk with patients and staff.

We carried out an announced visit on 27 October 2014. During our visit we spoke with five patients whilst they were waiting to attend appointments and eight members of the PPG. Before our inspection visit we also spoke with the chair of the PPG on the telephone. We spoke with a range of staff, including a nurse, the lead GP, administration staff, and the practice manager. We looked at the practice's policies and other general documents

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:

Detailed findings

- 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)

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We spoke with a representative of the Patient Participation Group. We also spoke with five care home managers about their experience of using the service.

Are services safe?

Our findings

Safe track record

We saw evidence that the practice had a good track record for maintaining patient safety. We saw that reviews of incidents were available from February 2011. We saw that the GPs completed incident report templates and carried out significant event analysis as part of their on-going professional development. For example, we saw many examples of incident analysis where the GP had reviewed patient notes after a patient was diagnosed with cancer. This was to try and identify any learning and early diagnosis on their part.

There were arrangements for reporting safety incidents and the staff we spoke with were able to describe their role in the reporting process and knew their responsibility in identifying and acting on risks that affected patient care. We saw evidence that feedback was provided during staff meetings of incidents that had occurred.

The practice had a system to ensure guidance received from patient safety alerts were appropriately implemented. Patient safety alerts are issued on important public health messages and other safety critical information and guidance to the NHS and other organisations. A nurse we spoke with described the process to us.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events.

The practice kept records of significant events that had occurred since February 2011and these were made available to us. We saw significant events were a permanent agenda item on the minutes of monthly practice meeting. There was evidence that appropriate learning had taken place where necessary and that the findings were disseminated to relevant staff.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children. All staff had received relevant training on safeguarding children. We did not see evidence that all staff had attended training specific to safeguarding vulnerable adults. The GP informed us that they had attended the training and we saw evidence where the GP had acted appropriately to an adult safeguarding issue. The practice manager had started recently in the role and was unable to locate training certificates to confirm the training. They told us they were currently the process of developing a training matrix to help them identify training needs for all staff.

Staff members spoken with were aware of signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours.

There was a system to highlight vulnerable patients on the practice's electronic records. Lists of codes corresponding to patients with safeguarding concerns were available on a dedicated safeguarding folder. This ensured that staff were aware of any relevant issues when patients attended appointments.

The practice had a dedicated GP lead for safeguarding. There was a training list for safeguarding which identified that four GPs had received Level 3 safeguarding children training which was appropriate for their role. All staff we spoken with were aware the lead in the event they needed further advice or raise concerns. A safeguarding children's self-assessment tool for GP practice had been completed. The self-assessment score was 100%. The Toolkit is a series of practical workbooks for GPs and the primary healthcare team to recognise when a child, under the age of 18, may be at risk of abuse. This toolkit was downloadable from the Royal College of General Practitioners (RCGP) website.

There was a vulnerable adults policy which was not dated, however the policy did include the new practice manager details so had been subject to a recent review. However, there was a safeguarding policy and procedure for safeguarding children which had not been reviewed since February 2013.

A chaperone policy was in place and visible on the waiting room noticeboard. Chaperone training had been undertaken which was delivered by a practice GP. If nursing staff were not available to act as a chaperone receptionists had also undertaken training and understood the responsibilities of the role including where to stand to be able to observe the examination. However, not all staff acting as a chaperone had a DBS check in place, the lead GP told us that this would be done.

Medicines management

Are services safe?

There were systems in place to ensure emergency medicine and equipment's were safe and effective to use in the event of a medical emergency. We observed medicines were stored, checked and records maintained in line with legal and safety requirements. A cold storage vaccine policy was in place to further guide staff. A cold chain policy details the protocol in relation to the transport, safe handling and disposal of medicines requiring cold storage, by staff working in the practice.

As part of stock control staff routinely checked and recorded the expiry dates of medicines held in the practice. Medicine refrigerators were secure and their temperatures were recorded daily to ensure medicines were stored under conditions which ensured their quality was maintained.

A system was in place for repeat prescribing so that patients were reviewed appropriately to ensure their medications remained relevant to their health needs. The practice had a safe procedure for issuing repeat prescriptions. We saw that certain medication was prescribed only after following appropriate guidance such as ensuring regular blood tests for full blood counts, renal and liver function tests and to monitor the patient ongoing treatment with the medication.

A specialist pharmacist from the CCG attended the surgery each week to provide a hypertension clinic and as part of that process provided an additional review of patient's medications. If there were any concerns about potential issues with medication that were raised by the patients the pharmacist would bring this to the attention of GP for further follow-up and discussion.

Cleanliness and infection control

There was an infection control policy with a named lead for enduring infection control procedures were maintained. The infection control policy contained supporting information so that staff were able to refer to them if required. This enabled staff to plan and implement measures related to infection control. For example, notification of infectious diseases and processes following a needle stick injury. The purpose of the notification system is to detect possible outbreaks of disease, and to trigger investigation. Following needle stick injury policy enables appropriate management of infectious agents.

We found that suitable arrangements were in place for the storage and the disposal of clinical waste and sharps. Sharps boxes were dated and signed with the date of use to enable staff to monitor how long they had been in place.

We saw that Walsall Healthcare NHS Trust had carried out an audit in July 2013 and that improvements identified for action were completed. Although the nursing team had a check list in place to monitor their area of practice there had been no overall audit of infection control since then. This did not follow the practice infection control procedure which stated, "annual audit monitoring involving regular assessments by supervisors to ensure standards are being implemented and management controls work". The external contractor responsible for cleaning of the premises visited monthly to complete their own audit. However, they did not provide any copies to the practice. Also, we saw there were cleaning specifications in place but records were not completed to confirm specification had been followed by the cleaners.

We observed the premises to be clean and tidy. We spoke with five patients on the day of our inspection and all the patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

There was a hand washing techniques policy available. Hand hygiene techniques signage was displayed in staff and patient toilets and in the treatment rooms viewed. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The building was not owned by the practice and the practice manager assured us that legionella testing was done by the landlords. We were unable to see a copy of the risk assessment as the practice was not given a copy. However, we saw records showing regular water quality checks were being carried out. We were told this was an action from the risk assessment. Legionella is a bacterium which causes legionnaires' disease. It occurs from exposure to legionella growing in purpose-built systems where water is maintained at a temperature high enough to encourage growth, e.g. hot and cold water systems.

Equipment

Are services safe?

Systems were in place to ensure that all equipment used in the practice was regularly maintained to ensure they were good working order and safe to use. The fire alarm system and emergency lighting was serviced and electrical appliances were tested.

Records showed that equipment had been calibrated and serviced at regular intervals such as the blood pressure monitors and the electrocardiogram (ECG).

Staffing and recruitment

There were systems in place to monitor and review staffing levels to ensure any shortages were addressed and did not impact on the delivery of the service. This included the practice being proactive and planning ahead, for example, we saw documentary evidence of a restructuring of the organisation with advanced planning for annual leave. The practice manager told us and we saw evidence that a priority of the service was to ensure all administration staff were trained to carry out different roles to ensure better running of the service. We saw that the job roles of staff had been changed and staff were consulted on this.

The practice manager confirmed that most of the staff had worked at the practice for a number of years which provided stability within staff team that ensured patients received continuity in their care. The practice had no staff vacancies at the time of our inspection and any shortfall in GPs, nursing or administrative staff as a result of sickness or leave was covered by internal staff.

Monitoring safety and responding to risk

Records showed that risk assessments had been completed including the control of substances hazardous to health (COSHH) and information governance.

Both a defibrillator and emergency oxygen were available. A defibrillator is an electrical device that provides a shock to the heart when very rapid erratic beating of the heart is reported. We saw systems were in place to ensure oxygen and the defibrillator was checked regularly to ensure it was in working order. We saw records to confirm routine checks of this equipment were undertaken by designated staff members. Emergency medicines were available and were routinely audited to ensure all items were in date and fit for use.

We saw there was a fire policy and a detailed action plan describing actions to take in the event of a fire. There was also a fire risk assessment though that had not been reviewed since May 2012. We saw documented evidence that weekly fire alarm system checks were carried out along with emergency lighting tests and monthly firefighting equipment checks. This ensured staff, patients and visitors were kept safe through the reduction of risk from fire.

Records showed that other risk assessments had been completed, where risks were highlighted measures had been put in place to minimise the risks. They included health and safety, Display Screen Equipment (DSE) and risk assessment for new and expectant mothers.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records we looked at showed that staff had received training in cardiopulmonary resuscitation (CPR).

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, incapacity of the practice GP and access to the building.

A fire risk assessment had been undertaken that included actions that were required to maintain fire safety. Records we looked at showed staff were up to date with fire training and that regular fire drills were undertaken.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice recognised that it had an above average (England) elderly population and therefore tried to address the needs of this patient group. The practice aimed to provide same day appointments to over 75 year olds and had signed up to the Walsall CCG service for over 75 year olds until March 2016. The practice was also able to for a short time secure extra funding to open on an afternoon where they had been closed previously. The practice also provided an additional phone line to allow these patients improved access to the surgery.

Care and treatment was delivered in line with recognised best practice standards and guidelines. Clinical staff we spoke with were aware of and had applied practice based on evidence. For example, the lead GP described how they had initiated a medication audit following National Institute of Health and Care Excellence (NICE) guidance. NICE provides national guidance and advice to improve health and social care. It develops guidance, standards and information on high quality health and social care. We saw instances where the practice had recorded higher or lower incidences of expected prevalence of diseases. We saw evidence that the GP had recognised the issues and had responded appropriately using guidance.

Vulnerable patients with long term conditions were assessed and patients over 75 years old were started on a care plan to enable increased monitoring and follow up of patients. Patients had annual reviews undertaken by the GPs and there were arrangements to review patients in their own home if they were unable to attend the practice.

The practice was undertaking an enhanced service to reduce unnecessary emergency admissions to secondary care. 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. We looked at two care plans which were detailed and personalised.

Management, monitoring and improving outcomes for people

The practice had a register of patients with conditions such as hypertension, diabetes, peripheral arterial disease, erectile dysfunction, stroke, ischaemic heart disease or other risk factors for coronary artery disease. These patients were asked to have annual blood tests and blood pressure measurement at the surgery. A specialist pharmacist attached to the CCG attended the surgery each week to provide a hypertension clinic. As part of that process the pharmacist conducted an additional review of the patient's medicines[HL1] and any concerns raised by the patient were brought to the attention of the GPs by the pharmacist.

The practice had a system in place for completing clinical audit cycles. We saw that 11 audits had been completed by the practice. Many were around medicines and had input from the CCG pharmacist. We saw one audit which identified a number of patients on a particular medicine that needed to be reviewed and changed if appropriate.

Patients told us they were happy with how the doctors and nurses at the practice managed their conditions and if changes were needed, how they were part of the discussion before any decisions were made. Data we looked at showed that the practice performance in relation to QOF was similar to the national average.

The practice nurse delivered the childhood vaccination programmes. The most recent data available to us showed that the practice was achieving a 100% rate of vaccinations for children. Information leaflets about some of the common children's vaccinations were available in the patient waiting room.

The practice actively contacted patients with abnormal blood and other test results to arrange for them to come into the surgery for a review. A double review process was in place for all letters that came in to the surgery to try and reduce the risk of missing important information. This involved an administrator checking the letter and cross checking that against the records and then a doctor double checking the administrators work and ensuring that nothing had been missed.

Effective staffing

Are services effective?

(for example, treatment is effective)

There were clear policies and procedures in place in regard to staff induction. This ensured that staff working at the practice received appropriate training and support to carry out their work. We saw examples of completed induction checklists in staff files.

An annual appraisal system was in place for all staff with identified development plan. The practice was able to demonstrate how staff had been supported with further development so that it could deliver a robust service to patients. For example, we saw a letter from the lead GP in relevant staff files following their appraisal informing them that there was a need to ensure there was appropriate skill mix. Further training was identified for staff so that they were able to perform multiple tasks.

Clinical staff at the practice ensured they developed their knowledge and skills through continuous professional development. For GPs this included an annual appraisal and revalidation which happened every five years. Revalidation is a process by which the GPs demonstrate that they are meeting the standards set by the General Medical Council. Records we looked at also showed practice nurses renewed their registration to practice annually.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. We spoke with two community midwives who were undertaking clinics. Both were complimentary of the joint working within the practice. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The GP reviewed these documents and took action where appropriate.

Multidisciplinary working was evidenced for example joint working arrangements were in place with the pharmacist, community psychiatric nurse (CPN) and the palliative care team. We saw minutes of meetings held quarterly to discuss those patients with end of life care needs. The staff we spoke with felt this system worked well and remarked on positive feedback they had received from families.

A staff member we spoke with told us that a member of the community learning disabilities team attended surgery to support and train staff to identify any appropriate treatment patients with learning disability.

Information sharing

The practice had an electronic system to receive and send information to other providers such as the out of hours services. Information received was reviewed daily by a GP at the practice so that any management plans could be followed up.

Patients were signposted to relevant services and support networks. We saw that all cancer patients received a hospice review to allow the patient to be known to other appropriate services and to help plan future palliative care should it be needed.

Consent to care and treatment

The practice was registered for surgical procedures and undertook joint injections. We saw evidence that detailed formal consent was sought and appropriate cooling off period was given prior to the procedure.

The patients we spoke with said they had been involved in decisions about their care and treatment. They told us their treatment was fully explained to them and they understood the information. Patients felt they could make an informed decision.

Health promotion and prevention

The practice offered all new patients registering with the practice a health check with the health care professional. NHS health checks were also offered for patients aged between 40-74. The GP was informed of all health concerns detected and these were followed-up in a timely manner.

The practice had also identified the smoking status of 84% of patients over the age of 15. Patients were offered lifestyle literature and signposting to community services. Similar mechanisms of identifying at risk groups were used for patients who were obese. These groups were offered further support in line with their needs.

The practice offered a full range of immunisations for children, travel vaccines, shingles vaccines and flu vaccinations in line with current national guidance. There was an excellent range of health prevention and promotion information available in the waiting area and on the practice website.

Members of the PPG told us that they had run a health corner in the practice where patients were invited to complete their own monitoring checks, for example height

Are services effective?

(for example, treatment is effective)

and weight. Ten blood pressure monitors were purchased to allow patients to test their blood pressure in the home environment. If necessary this would be followed up with 24 hour monitoring.

The surgery had also signed up to the free condoms scheme which enabled condoms to be given out to young people and we saw leaflets in the surgery advising patients that free condoms were available. The practice informed us that they provide this service for all patients in the local community whether or not they were patients at the surgery.

[HL1]Panel comment: Please check the report and make sure you refer to medicines rather than medication throughout

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed patients arriving at the surgery were treated respectfully. We saw when staff answered the telephone they were courteous and polite. Patients were greeted warmly by the nurse and GP when called into their consultation. Comments card we reviewed and patients we spoke with told us they were treated them with dignity and respect. The national GP patient survey we reviewed showed that 87% of patients would recommend this surgery to someone new n the area. This was higher than the CCG average of 75%.

We saw that all consultations and treatments were carried out in the privacy of a consulting room. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard in the waiting area. Patients had fed back concerns regarding confidentiality in reception, where conversations at reception could be heard. With the support of the PPG a television had been installed to deflect people's attention away from conversations at reception. If patients needed to speak privately a private room was made available.

Some staff members had completed online training on equality and diversity including one of the GPs. Other staff were due to complete this training.

Care planning and involvement in decisions about care and treatment

We saw that personalised care plans were in place for patients with a view to avoiding unnecessary hospital admissions. In addition all patients with long term conditions such as chronic obstructive pulmonary disease (COPD) or asthma were invited to attend an annual review of their condition. Any medication these patients were taking was reviewed so that patients were on the most appropriate medication for their condition. We saw that this was supported by carrying out audits and input from the CCG prescribing pharmacist.

Regular appointments to manage long term conditions along with NHS Health Checks for patients between the ages of 40 to 74 years old meant there were opportunities for patients to discuss any concerns they may have with a medical professional.

For patients on the palliative care register the practice involved the patients and their families to provide supportive care.

We saw information leaflets in the waiting area. The information included details of advocates, groups and agencies to contact should patients require advice and support. Patients told us they felt involved in planning their care and making decisions. Patient told us the GPs took time to explain their treatment and options. This made them feel involved and informed about their care.

Patient/carer support to cope emotionally with care and treatment

We discussed bereavement support with the GPs. We saw that there was a system in place to pick up any bereavement support issues by a GP so that the family members could be contacted for further support and signposted to other organisation where appropriate. To help guide staff, a comprehensive bereavement protocol was in place with an example letter to be sent out to the carer or next of kin of the patient.

The practice supported the carers ID key fob scheme developed by Walsall Local Authority and in partnership with the Walsall Carers Centre. The scheme looks to support carers by providing a simple way of telling people that they have caring responsibilities. For example, a system recognised by the emergency services, so that staff at A&E could recognise the key fob and become aware that there may be someone who needs support if the carer was unable to attend.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had numerous ways of identifying patients who needed additional support, and was pro-active in offering additional help. The practice had a register of patients with long term conditions such as hypertension, diabetes, peripheral arterial disease, erectile dysfunction, stroke, ischaemic heart disease or other risk factors for coronary artery disease. These patients were asked to have annual blood test and blood pressure measurement at the surgery. A specialist pharmacist attached to the CCG came to the surgery each week to provide a hypertension clinic and as part of that process completed an additional review of the patient's medications. Any concerns raised either by the pharmacist or the patient were brought to the attention of the GPs.

Patients with learning disabilities and all were offered an annual physical health check. Practice records showed 100% had received a check up in the last 12 months. A staff member we spoke with told us that a member of the community learning disabilities team attended surgery to support and train staff to identify any appropriate treatment.

Patients with dementia and memory loss were offered a short computer based memory assessment. This test helped to detect cognitive impairment and allowed arrangement of relevant memory investigations such as CT and ECG tests. Patients who did not fit the criteria for dementia were also referred patients to social services if they were finding it increasingly difficult to manage their own care.

Patients with complex needs were treated as urgent cases, same day appointments were available and the practice ran extended opening hours. The practice also provided home visits where it was appropriate, along with annual reviews for significant mental health disorders.

The nurse we spoke with told us that a large number of patients with chronic obstructive pulmonary disease (COPD), dementia and memory loss amongst other conditions were registered at the practice. The nurse was aware of their training needs and gave example of completing a recent spirometry portfolio training (spirometry is used to diagnose asthma, COPD and other conditions that affect breathing) to meet the needs of the population group. The nurse felt supported with training and we were told that a CCG Practice Nurse advisor/ facilitator also provided regular updates, guidance and advice.

Tackling inequity and promoting equality

The practice offered telephone appointments each day to patients as an alternative to coming to the surgery. Patients were able to leave their preferred telephone number for the GP to call back avoiding them having to wait for an appointment or to have to leave work to come and see their GP. This had been popular with patients who were unable to attend the surgery during normal working hours.

The practice was accessible to patients who had difficulties with their mobility and hearing. The practice also had access to an interpreting service for patients whose first language was not English.

The practice also offered online services for appointments, repeat prescription as well as a full range of health promotion and screening.

The practice made use of other services available in the area for vulnerable patients such the community drug and alcohol team and the learning disability team. The practice also invited all patients on their learning disabilities register to the surgery for an annual health check and for flu and pneumonia vaccination if appropriate.

Access to the service

The practice was situated in a single level building. Touch pad doors were available to support patients with pushchairs and mobility difficulties. 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.

There was a flexible appointment system through extended evening clinic once weekly and access to information and services via the practice website. Urgent appointments were available for the same day of contacting the practice. Telephone appointments were also available each day where patients were called back by a GP.

The practice recognised that it had an above average (England) elderly population and therefore tried to address the needs of this patient group. The practice aimed to provide same day appointments to over 75 year olds and had signed up to the Walsall CCG service for over 75 year

Are services responsive to people's needs?

(for example, to feedback?)

olds until March 2016. The practiced was able to secure funding for a short time to open on an afternoon where they had been closed previously. As part of this funding the practice also provided an additional phone line to allow these patients to access the surgery better.

There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients on the practice website and on the telephone answerphone message.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there were designated responsible persons (GP and practice manager) who handled all complaints in the practice. We saw that the complaints policy was due for review in November 2013 but had not been updated. The policy named the Primary Care Trust (PCT) in relation to the handling of complaints. However, PCTs were replaced by CCGs in April 2013.

We saw that a review of complaints had been carried out and changes made to practice where appropriate. For example, we saw that a female GP had been recruited after the complaint by a patient. In another example, we saw that learning had been identified and shared with staff regarding sending out letters to patients' home address for routine tests. Staff were advised to check patients records to ensure they did not send out letters requesting the patient to attend the surgery for tests if they had already had.

We also saw some thank you cards sent in by patients who were very happy with the treatment and service they had received. We also looked at NHS choices website where patients were able to leave views of their experience and we saw these were mostly. The practice always responded to all comments and where a negative comment was left the practice invited the patient for further discussion so that so that they could use it to improve their services further.

Are services well-led?

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

Our findings

Vision and strategy

The practice vision was to ensure a good skill mix of staff to allow it to deliver a consistent service by ensuring staff had appropriate training to perform various roles. We saw records of discussions regarding this with staff members which had taken place during their appraisals.

There was a clear leadership structure and staff felt supported by management. Photographs of all staff were displayed in the practice waiting area and on the website introducing staff, their roles and any other responsibilities. Staff we spoke with were aware of their roles and of the roles of other staff members when their duties overlapped.

The practice had a number of policies and procedures to govern activity and there were systems in place to monitor and improve quality and identify risk.

Governance arrangements

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

The practice had a number of policies and procedures in place to govern activity. We looked at a selection of these policies and procedures. Most of the policies and procedures we looked at had been reviewed annually and were up to date.

The practice manager used the Quality and Outcomes Framework (QOF) to measure the practice's performance. The QOF data for this practice showed it was performing in line with local and national averages. The practice manager was new to the role and said that their priority was to ensure an appropriate skill mix of staff. The practice manager was trying to understand what governance arrangements were in place before starting to implement their own

Leadership, openness and transparency

The practice had a staff handbook which included policies and procedures covering grievance and equal opportunities. The purpose of the handbook was to give clear advice to staff and create a culture where issues were dealt with fairly and consistently.

The practice had a whistle blowing policy which was reviewed in September 2014 and staff told us that they felt confident to raise any concerns about poor care. Whistleblowing is when staff are able to report suspected wrong doing at work, this is officially referred to as 'making a disclosure in the public interest'.

The details of the PPG group were on the practice notice board and patients were also encouraged to raise any issues or concerns with the PPG. The PPG group also helped to raise funds to buy new treatment couches and other equipment. The balance of PPG funds was declared in the minutes of meetings in the practice website and this also recorded how the money was to be spent.

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

The practice PPG provided feedback on service delivery to the management which was responded to where appropriate. On the day of our inspection the PPG had also scheduled a meeting for to group to meet. We spoke with many of the PPG members during their meeting and received positive feedback about the practice. The PPG members told us that the layout of the reception area meant that conversations could be overheard by other patients waiting to be seen. The PPG had communicated this to the practice management and as a result the layout of the waiting area was changed and a TV was purchased. The change in layout ensured patients were facing away from the reception desk and facing the TV which added background noise. The PPG also asked for the practice to organised name badges for staff members so that patients knew which staff member they were speaking with. We saw that all staff members had name badges with their job roles

The practice also carried out patient surveys. We saw a patient survey was carried out in October 2013. The surveys were independently analysed by Healthwatch Walsall and showed that patients were overall happy with the service. However, the practice recognised other opportunities for improvement and had taken action. For example, 20% of patients taking part in the survey commented on the

Are services well-led?

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

potential improvements regarding the opening hours. The practice already offered telephone consultations and evening appointments and made efforts to inform patents as some patients were not aware.

The practice was taking part in the Friends and Family and Test (FFT). The FFT is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. We saw 35 completed forms, 33 said they were either likely or extremely likely to recommend the practice.

Management lead through learning and improvement

The practice is a training practice for GP Registrars (fully qualified doctors who wish to become general practitioners). We saw evidence of feedback taken from a trainee GP on aspects of the training they had found particularly useful. We also saw feedback on aspects of the training that could be changed or improved.

All staff received training that was relevant to their role. Staff were able to develop professionally through ongoing appraisal in the form of personal development plans. There was a template to manage staff performance but the manager confirmed that there were no performance issues they had identified and so have not had to use the template.

We saw examples of reviews of patient notes after any patient that had been diagnosed with cancer. This was to try and identify any learning on the part of the GP that could help early diagnosis.

We saw examples of many clinical audits including medication audits. Where appropriate actions were taken to improve patient care.