Brierley Hill Health and Social Care Centre

Quality Report

Venture Way,
Brierley Hill,
DY5 1RU
Tel: 01384 481235

Date of inspection visit: 7 December 2016
Date of publication: 25/05/2017

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Overall summary

We carried out an announced comprehensive inspection on 7 December to Brierley Hill additional community services vasectomy clinic to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this service was providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this service was providing effective care in accordance with the relevant regulations

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this service was providing responsive care in accordance with the relevant regulations.

Are services well-led?

Summary of findings

We found that this service was providing well-led care in accordance with the relevant regulations.

Background

We carried out this inspection 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 service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Additional Community Services Ltd provides this service, which comprises a one-stop shop approach for vasectomy for adult men in Brierley Hill. The service is funded through the NHS. This means the service offers a pre-procedure consultation, followed by the procedure on the day and a post-procedure consultation regarding aftercare. Men may wish to defer the procedure to another date if they feel unsure about going ahead on the day. The service offers 35 appointments per month, booked following a GP consultation on the electronic patient appointment booking system (choose and book). Appointments are available every Wednesday and one Saturday per month. A GP who is trained to carry out no scalpel vasectomy procedures runs the service, supported by health care assistants and an administrator.

The doctor carrying out the procedure is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Three people provided feedback about the service at the time of the inspection. They all said that they were happy with the information they had received, and the quality of the service on the day. Patients had not completed any comment cards.

Our key findings were:

- Safe one-stop procedures, including pre-procedure consultation, procedure and post-procedure education.
- Good infection control practices.
- Clear written and verbal information regarding consent and the procedure and outcomes.
- Good evidence of risk management being undertaken for each patient.
- Effective monitoring of patient outcomes.
- Good access with no waiting.
- No complaints and good monitoring of patient satisfaction.
- Well-led with a clear focus on service delivery.
- Good communication channels and governance processes.
- The doctor for the service was a trainer for other no-scalpel vasectomists

There were areas where the provider could make improvements and should:

- Review the recording of lidocaine stock to ensure a permanent record of all deliveries received.

Summary of findings

Our judgements about each of the main services

Service Location	Rating	Summary of each main service

Summary of findings

Contents

Brierley Hill Health and Social Care Centre

Services we looked at
Community health services for adults

Summary of this inspection

Background to Brierley Hill Health and Social Care Centre

We carried out an announced inspection on 7 December 2016. There were two CQC inspectors, who had access to advice from a specialist advisor.

Before the inspection, we gathered information from previous inspections; the latest was 5 March 2014. The service was inspected in 2014 against the essential standards of: care and welfare of people who use services, management of medicines, assessing and monitoring the quality of service provision, and complaints. The service met all of the standards; however, we found during that inspection, the service required some improvement in the auditing of medication stored on the premises.

We reviewed safeguarding alerts and concerns, notifications of never events, deaths, and serious incidents, and deprivation of liberty safeguards (DoLS). There were no instances of any of these occurrences.

We asked the provider for their complaints, referral to treatment times, audits, appraisal information, and patient and staff surveys. We will present this information in the detailed findings section of the report.

We performed the inspection over one day. We carried out observations of care; we talked to three patients and one relative. We interviewed the three members of staff, observed the pre and post-procedure consultations, and reviewed three sets of records.

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?

These questions therefore formed the framework for the areas we looked at during the inspection.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this service was providing safe care in accordance with the relevant regulations.

- We saw that the service had safe one-stop procedures, including pre-procedure consultation, procedure, and post-procedure education.
- The environment was visibly clean and there were good infection control procedures.
- The clinic was staffed fully and there were good processes in place to cover absence.
- Staff undertook a full risk assessment for each patient.

We found areas where the provider should make improvements relating to the safe provision of treatment:

- This was because the provider did not have a permanent record of lidocaine (a local anaesthetic) stock. This meant that the provider did not know if expiry dates had exceeded from a previous delivery.

Are services effective?

We found that this service was providing effective care in accordance with the relevant regulations.

- We saw that the service had effective monitoring of patient outcomes. The doctor carried out surveys that monitored quality of the service.
- The service had competent staff and a good system of training.
- The consent procedure was very clear and included a verbal explanation and written information.
- The procedure and after care were described clearly, supported with written information.
- There were good working arrangements with the patients' GP in case of failure to provide the post-vasectomy semen sample.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

- We saw that staff had a good understanding of the sensitive nature of the service they were providing.
- Staff went out of their way to make the patients as comfortable as possible.

Summary of this inspection

Are services responsive?

We found that this service was providing responsive care in accordance with the relevant regulations.

- We saw that the service had good written information about the procedure and after care.
- There were good arrangements for appointments including a Saturday clinic; patients had no problems with access to the service..
- The service monitored patients not attending (DNA) rates.
- There were no complaints since the service had opened, in 2014, and the doctor monitored the patient surveys and used them to make improvements in patient satisfaction.

Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

- We saw that the service was well- led with a clear focus on service delivery.
- There were good communication channels with the clinical commissioning group and good governance processes.
- The doctor for the service was a trainer for other no-scalpel vasectomists.
- The service used feedback from peer review and patients to improve the service.

Location

Safe	
Effective	
Caring	
Responsive	
Well-led	

Is the location safe?

Reporting, learning and improvement from incidents

- Staff knew to report any serious issues to the doctor who led the service.The doctor was aware of the Serious Incident Framework 2015 (STEIS) and knew how to log incidents through the national reporting system.
- There were no incidents, serious incidents or never events in the period November 2015 to November 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The provider was aware of and described how they would comply with the requirements of duty of candour if an incident occurred. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.

Reliable safety systems and processes (including safeguarding)

- The service offered a one-stop no-scalpel vasectomy to men aged 18 and over. We saw the pre-procedure consultation, preparation for the procedure, and post-procedure education (the GP carried out the procedure, however, we did not observe this due to patient privacy). The GP described the actual procedure in depth. The process was clear, consistent and safe, and was based on the London Faculty of Sexual and Reproductive Healthcare (FSRH): Service Standard for Sexual and Reproductive Health. They ensured that patients understood the post-procedure care requirements before going ahead.
- The provider demonstrated safe systems of practice; they had a clinic protocol clearly on display in the procedure room for staff to follow. They were aware of the policies of the building and gave examples such as the fire procedure. They clearly explained the procedure and told inspectors what action they would take in the event of being mid procedure if the fire alarm sounded.
- The staff had a theatre list clearly on display in the procedure room. The doctor checked the patients' identification at the pre-procedure consultation and the healthcare assistant checked it again just prior to the procedure, against the theatre list. This included checking the name, address and date of birth both times.
- Staff described the process for the clinic from opening up of the department following the clinic process, and then the closing down of the department at the end of the day. This involved opening of only certain doors to prevent unauthorised access, following clinic preparation guidelines and security procedures for the securing of the department after the clinic finished.
- All Staff had undergone safeguarding training adult and children Level 3 and were able to describe recognition of safeguarding issues. They knew who to go to when reporting safeguarding concerns. There had been no safeguarding referrals from this service between 9 November 2015 and 8 November 2016.
- The department was visibly clean and tidy. Staff told us about the equipment cleaning schedule and we saw staff performing these cleaning duties. We were not advised of any cleaning audits, however the building was administered by another provider, who was responsible for the upkeep of the premises.

Location

- The procedure room was purpose designed for minor procedures.
- Staff were aware of the need to prevent infections. They described the clean down process between patients in the procedure room. We saw staff washing hands before and after each patient. Staff adhered to arms bare below the elbow rules. All rooms were equipped with handwashing facilities with elbow taps, liquid soap, and hand sanitizer. All bins were clearly marked with the appropriate use and bin liners. Staff running the clinic did not carry out hand washing audits.
- The doctor advised patients of the personal cleansing and shaving procedures required prior to attending for the procedure.
- The provider monitored post-procedure infection rates and analysed the results to inform future practice. An infection survey for 12 month period showed that 3% (seven patients)of patients reported possible infections post-procedure.This was slightly higher than the standard, which was 2%. It was felt by the doctor that this was because the results were based on patients saying they had some pain and swelling and therefore maybe an infection, rather than a diagnosis made by a doctor.
- We observed staff using single use sterile equipment for each patient. This was in date and sealed at the time of use. Staff demonstrated safe techniques for the preparation of the procedure trollies for each patient.
- All equipment was clean and was electrically tested. The extraction fan for removal of diathermy odour was due for a maintenance check and the doctor who led the service advised that the manufacturer was going to be doing this during the doctor's annual leave the following week. Staff changed the filter for the extraction fan daily.
- Staff used sharps bins for all sharps, which were located in a safe place in the procedure room. Staff described a safe system for collection of general and clinical waste including sharps. There were no specimen collections going from this service; however, we did see labelling of containers for patients to take away with them for future specimens and instructions given.
- Staff recorded the administration of lidocaine, which was the only drug administered, on patients' records. They recorded drug name, amount, route, batch number, and expiry date. They showed us the system for checking each drug at the point of administration, which was safe.
- The doctor administered the lidocaine by using a fine gauge needle, once he checked the drug name, dose and expiry date with the health care assistant. This was an additional safety check that the doctor implemented. It is not a requirement of the General Medical Council good practice in prescribing and managing medicines and devices March 2013.
- Recording of the stock of lidocaine was on a white board. Stock was recorded when a delivery was received. Staff recorded the name, amount, batch number, and expiry date on the board. Each time a drug was used this was recorded on the white board. When the provider received a new delivery, staff added the remaining amount to the new delivery total. Staff rubbed out the previous record and wrote the new total, batch number and expiry date in its place. Therefore, there was no permanent recording of new stock over time. The provider did not know if expiry dates had exceeded from a previous delivery. We discussed this at the time of the inspection with the service lead. We noted that, because of the checks at the point of administration, there was no risk of staff giving out of date lidocaine to patients. We sought advice after the inspection from a CQC pharmacy specialist. In addition to the recognised risks during the inspection, the pharmacy specialist noted that if an alert was generated about the drugs, the provider would not be able to easily find records of any lidocaine received other than the latest batch.
- The provider kept a record of the procedure undertaken on a standard template, which the GP tailored for each patient. The healthcare assistant completed this during the procedure, which was checked by the doctor on completion of the procedure
- Following the procedure, the doctor took the completed form to their GP practice where secretarial staff scanned the procedure form onto the patient's electronic record. They then shredded the forms following the GP practice protocol for disposal of confidential waste. The forms remained in the procedure room at all times until the end of the clinic. During transportation, the provider kept the forms in a folder, which was in the doctor's presence at all times, and taken immediately to the GP practice.
- The Doctor was registered with the Information Commissioners office and reports were forwarded to the clinical commissioning group each quarter.

- We saw old patient identifiable documentation in the drawers in the clean utility room. The provider advised that they did not know they were there and were from when a different provider ran the clinic. They removed and disposed of the documents using the disposal of confidential waste system within the building immediately after we raised this with them.

Medical emergencies

- All staff knew how to summon help if a cardiac arrest occurred. There were emergency call buttons in each clinical room. Staff described the process clearly. All staff were trained to deal with cardiac arrest, including the two health care assistants supporting the doctor. They had attended basic life support training.
- The provider had emergency medication available in the procedure room in case of anaphylaxis occurring. This is when someone has a severe reaction to something. All staff knew where the provider kept the medication. It was in date on the day of the inspection. We saw that the staff carried out monthly checks for expiry dates and stock levels.

Staffing

- The service was staffed by one doctor who leads the service. The doctor carries out pre and post-consultations and performs the procedure. There were two health care assistants to support the process. We saw that there were enough staff to carry out the clinic safely. There was one administrator who dealt with patient letters and transfer of written paper records on to the patient's' electronic record, who was based at the GP surgery.
- The doctor told inspectors that one health care assistant had been on long-term absence and he had covered the service effectively with another healthcare assistant. They told us there were three other nurses or assistants they could call if sickness occurred. The provider had not cancelled any clinics because of health care assistant sickness. If the doctor was sick, the provider would cancel and re-arrange the clinic. There were alternative services available for patients that they could access via their GP if they did not wish to wait.
- There was one doctor and they described the revalidation process. The provider supplied inspectors with the revalidation confirmation for the doctor and the medical indemnity certificate, which were both up to date.
- The two health care assistants carried out chaperoning duties and they told us and we saw that they had chaperoning training.

Monitoring health & safety and responding to risks

- The provider told us the only risk to the service was sickness of the doctor as this was a single doctor service. The clinical commissioning group (CCG) had contracts with other providers if this service was unavailable. These alternative providers were available through the patients' GP.
- The service provided patients with an emergency contact number post-procedure in case of any urgent or serious problems. This was a dedicated number. Patients had used this only twice since the service began, for reassurance purposes only**.**
- The doctor performed a risk assessment on each patient regarding illness, allergies, and the patient's decision to go ahead with an irreversible method of contraception. The doctor documented this on the consent form. The form was standardised to ensure staff carried out the same risk assessment for all patients. This was in line with the London Faculty of Sexual and Reproductive Healthcare (FSRH): Service Standard for Sexual and Reproductive Health. Appendix 7 – Risk management.
- The doctor advised patients on the risk of failure at the pre-procedure consultation and advised additional contraception until they had confirmed the procedure was a success. They also advised patients that there was still a small chance of pregnancy after they had confirmed success of the procedure. The advice given was in accordance with the London Faculty of Sexual and Reproductive Healthcare (FSRH): Service Standard for Sexual and Reproductive Health.
- The service received referrals based on a risk assessment carried out by the patients' GP. The patient's GP referred any patients with additional needs to secondary care for the procedure. This included conditions such as learning difficulties.
- The building administrator was responsible for risks associated with the premises. The provider only used the rooms where it delivered the services. The staff had a clear understanding of the process to inform the building administrator if there were any issues with the premises or equipment.
- We found areas where the provider should make improvements relating to the safe provision of treatment. This was because the provider did not have a

permanent record of lidocaine stock. This meant that the provider did not know if expiry dates had exceeded from a previous delivery. In addition, if there was an alert raised about the drugs, the provider would not be able to easily find records of any lidocaine received other than the latest batch.

Is the location effective?
(for example, treatment is effective)

Assessment and treatment

- The provider used a less invasive method of performing vasectomy, called no-scalpel vasectomy. This included the formation of one small opening, no requirement for suturing and less impact upon the patient, during the procedure and afterwards. It also meant that the risk of wound infection was significantly reduced. Using this method meant the procedure could be performed in a community clinic, enabling more effective use of secondary care services.
- The doctor who led the service was a member of the British Association of No Scalpel Vasectomists (BANSV), which supports practitioners with peer review and guidance on this new type of vasectomy.
- The provider told us about the immediate and four month patient surveys which they used to monitor quality of care. The immediate patient survey involved monitoring of the pre-procedure consultation including cooling off opportunities, suitability of the premises, communication of the staff, and whether counselling was needed. The four month survey involved asking about time off work and overall quality.
- The results of the 2015 immediate survey showed that seventeen people said the communication during the procedure was excellent and one said it was very good. Sixteen people said they did not feel they needed a counselling session before the consultation and 13 people did not feel an additional cooling off period was required. The doctor explained that patients could defer the procedure on the day and we saw that take place. Overall people rated their one-stop clinic appointment as excellent (12), very good (three) or good (three).
- The results of the July 2015 to July 2016 four month survey showed that out of 23 respondents 18 took the amount of time off work they expected to after the procedure. Of the other five there did not seem to be any correlation with pain or infection. The overall quality was broken down into three sections: quality of the work of the doctor, healthcare assistants and administration. About the doctor, 19 people said the quality was excellent, three said it was very good and one said it was good. About the healthcare assistants, 17 people said the quality was excellent, four said it was very good and two said it was fair. About the administration process, 11 said it was excellent, five said very good, five said good, one said fair and one did not answer.
- The doctor leading the service monitored levels of pain during and after the procedure. They asked about pain in the immediate and four month patient surveys. In the immediate survey a five point scale was used to ask about pain during the procedure. Two people said they had no pain, 14 said they had some discomfort, none had slight pain, two said it was painful and none said it was very painful. On discussion with the doctor they said that the results were in line with what was expected for the type of procedure. In the four month survey, pain was split into two time frames. They asked about pain in the first few days then about pain after the first week. They used a pain score tool of 1-10 with 10 being the worst pain when they asked about pain in the first few days. They analysed the results, which showed them that most people scored five or less for pain in the first few days (19 out of 23). For pain after a week, the provider used a yes no scoring system. This showed 10 out of 23 people experienced some pain after one week.
- The provider carried out post-vasectomy semen analysis (PVSA) to identify early failure. This is in line with the London Faculty of Sexual and Reproductive Healthcare (FSRH): Service Standard for Sexual and Reproductive Health. Appendix 7 – Risk management.
- The provider carried out audit on response to semen analysis reminders. They described the process of recording due diary entries and performing an audit three monthly against any patients who had not provided the sample. There was a system of three reminders and a letter to the patients' GP. The doctor supplied inspectors with the audit results from the 2015-2016 audit, which showed 81% of those who had the procedure responded to the sample request. This was significantly above the standard for this service which was 60% based on current evidence.
- The doctor who led the service told us that they monitored upcoming clinics to ensure they had a good

understanding of demand for the service. They advised that they planned the spacing of appointments themselves to ensure there was enough time to deliver the consultations effectively.
- The doctor advised patients during the pre-procedure consultation of the effectiveness of vasectomy in comparison to the short, long-term and permanent forms of female contraception in accordance with the London Faculty of Sexual and Reproductive Healthcare (FSRH): Service Standard for Sexual and Reproductive Health.
- The doctor advised patients clearly about the importance of providing the post-vasectomy semen analysis sample, and the instructions on when and how to provide it. The doctor wrote to the patients with the results following analysis of the sample.

Staff training and experience

- The doctor was also a GP and told us about their general appraisal, which was carried out as part of their role as a GP. They submitted evidence of development and competency to carry out no-scalpel vasectomy as part of that. They told us that they attended an annual conference, carried out clinical audit and saw 35 patients per month. There were links between a mentor and the doctor when the service was new and there were ongoing links with consultant urologists at the acute hospital in Brierley Hill for peer support.
- The health care assistants had training using a system called bluestream. The GP practice where the doctor worked used this system, and the provider linked into their system for monitoring this training. Bluestream academy, which ran the training, developed a suite of interactive training modules that were easy to use, and encompassed competencies for primary care services.
- The bluestream training covered mandatory and competency based training. The provider showed us the mandatory training modules and how often staff repeated them. This included topics such as, basic life support, infection control, conflict resolution, information governance, health and safety, anaphylaxis, equality and diversity, and safeguarding. The provider also showed inspectors the competency-based modules, examples of these were chaperoning, consent, learning disabilities, mental health, and mental capacity training.
- Staff showed us certificates of training modules they completed and the monitoring forms that showed completed and non-completed training. The practice manager monitored when training was due and informed the doctor. The doctor then advised the health care assistants. Mandatory training for all staff was up to date, at 100%.

Working with other services

- The provider received its referrals from GPs via the electronic patient appointment booking (choose and book) system. They reported to the patients' GP by letter. The provider posted the letter after the procedure to inform the GP the procedure had taken place. Staff showed us the letter for patients in the clinic that day.
- There were arrangements with the urology department at the local acute hospital in Brierley Hill for referral of patients who were not suitable for the community clinic or required further follow up for failure of the procedure.
- The doctor monitored patients who had not provided the PVSA sample and liaised with the patient's GP to alert them so that the GP could also follow this up with the patient.

Consent to care and treatment

- The provider obtained written consent at the pre-procedure consultation. We saw the consent form, which had the patient's details, and information about the procedure. The consent form was signed by the patient, kept in the clinic until the end of the day and then the secretary scanned it into the patient's electronic record after the procedure.
- We observed staff gaining consent on the day of the inspection. The doctor explained the procedure, side effects, failure rates and post-procedure care. The doctor took time to explain clearly giving time for questions before the patient signed the form. This was in line with the London Faculty of Sexual and Reproductive Healthcare (FSRH): Service Standard for Sexual and Reproductive Health standard on obtaining valid consent.

Is the location caring?

Respect, dignity, compassion & empathy

- Staff were respectful to patients at all times. We observed interactions with three patients and staff said that they understood the sensitive nature of the procedure the patient had come for.

Location

- We saw that staff offered patients a separate room to change ready for the procedure and they only removed clothing that was a necessity for the procedure. Patients had privacy to change alone and to go through to the procedure room when they were ready.
- Staff used distraction techniques to help the patient be at ease during the procedure.
- Staff kept the procedure room door closed and secure at all times during the procedures.
- Staff warmed the skin cleansing solution prior to using it and offered the patients a warm water bottle to hold against their groin to make the procedure easier to perform.
- The provider used an extractor fan to remove the odour created by diathermy of flesh to make the procedure more comfortable. Diathermy is a method of sealing off the seminal tubes in the scrotum by cauterising them.
- The doctor used a small gauge needle to administer lidocaine to minimise pain from the needle in line with the recommendations of the London Faculty of Sexual and Reproductive Healthcare (FSRH): Service Standard for Sexual and Reproductive Health. Appendix 7 – Risk management.
- We saw the results of the friends and family test for 2015, 15 people said they were extremely likely to recommend the service to friends and family and three said they were likely to. There were no negative responses.

Involvement in decisions about care and treatment

- During the pre-procedure consultation, we observed the doctor providing full information on the procedure and asked the patients if they understood. They asked all patients if they had any questions. The doctor gave all patients the opportunity to have a cooling off period and return on another date for the procedure if they wished. They informed patients of the post-procedure care including exercise, rest, sexual activity and work so they could modify their lifestyle accordingly.

Is the location responsive to people's needs?

(for example, to feedback?)

Responding to and meeting patients' needs

- The provider had worked with the local clinical commissioning group (CCG) to plan the community vasectomy service. They told us that the CCG commissioned the service to offer 35 appointments per month.
- The provider delivered the service against an initial service specification with quarterly reports to the CCG The reports related to the immediate and four month patient surveys and the semen analysis audits. The doctor described a positive relationship with the CCG and the outcomes from the quarterly review were always positive.
- The provider always made sure that they delivered 35 appointments per month. They described that they amended the appointment schedule if they knew they were not going to be able to deliver appointments during times of absence such as annual leave.
- The provider sent out written information about the procedure to patients prior to the appointment. We saw patients attend the clinic with the information sheet they had been sent.
- Staff told us that they had accessed the interpreter service in the past for people whose first language was not English. The initial letter sent out to patients for their appointment advised that it was available in other languages.
- Staff gave an example of how they had dealt with an issue where a patient expressed concern about female healthcare assistants being present during the procedure because of religious beliefs. Staff described how they ensured as little direct observation and eye contact as possible. They asked the patient if they were happy with the arrangements and they confirmed that they were.
- We saw written information for the procedure, after care and the post-vasectomy semen analysis. There were diagrams of the procedure to help patients understand what they were having done. We saw staff giving the aftercare leaflet to patients on the day of the inspection.
- There was a range of written information in the pre-procedure consultation room about alternative methods of contraception, in case the patients wished to defer the procedure and consider alternatives. We saw this given out to a patient.
- We observed the doctor responding to patients regarding work arrangements. They advised about the

Location

best day to have the procedure done if the patient could not take time off from work to rest after. They advised on a compromise regarding work activities for manual work.

- The immediate patient survey involved monitoring of the effectiveness of the booking procedure, and usefulness of the patient information leaflet. The results of the 2015 immediate survey showed that 17 out of 18 respondents said the booking system was good, 12 out of 18 people said the patient information leaflet was very good, four said it was "okay" and two said it was poor. The poor responses were in relation to non-receipt of the information before attending the clinic. Of the 18 respondents 15 said the pre-procedure consultation was very good and three said it was fairly good. All respondents were happy with the premises too with 11 saying they were excellent and seven saying they were very good.

Tackling inequity and promoting equality

- The provider offered appointments once monthly on a Saturday for those unable to attend during weekdays.
- The premise was a new purpose built facility for delivering community services and was fully compliant with disability access rights.
- Appointments were available for any man aged over 18-years living in Brierley Hill, that wished to have a vasectomy and whose GP deemed appropriate for community services.

Access to the service

- Patients accessed the service following an appointment with their GP. They used the electronic patient appointment booking system (choose and book). They chose the date and time most suitable to them.
- Patients could access the service two weeks after booking to enable the staff to send out pre-procedure information and the appointment details in writing before they attended.
- The provider told us there was no waiting list for appointments and showed us the upcoming appointment schedule.
- There had never been any clinics cancelled.
- The provider monitored people who did not attend for their appointment (DNA) and told us they switched to the 'choose and book' system. The provider used to use a system where the service gave the patients a date and time of appointment. This had reduced DNAs.

Concerns & complaints

- All of the staff had undergone complaints training. The doctor for the service was the lead for complaints at their GP practice. They described the complaints procedure.
- There had been no formal complaints made against the service. Staff told us that if a patient said they were not happy with any aspect of their care they would deal with it immediately.
- The doctor reviewed the results of the immediate and four month patient surveys and reviewed any areas for concern from that. They informed staff on any areas needed for improvement.
- We saw NHS complaints leaflets in the department waiting room.

Is the location well-led?

Leadership, openness and transparency

- We saw that the doctor provided strong leadership. They oversaw the preparation of the department for the clinic to commence.
- Staff told us that they had open dialogue with the lead doctor and this was in both directions. They felt they could discuss any issues they had.
- The doctor gave us an example of when he had to discuss staff performance and spoke with the staff about an issue that he had observed.
- All staff described a good working relationship with frequent communication. Formal team meetings were not required as the staff worked together all day and were only a team of three.
- The doctor gave the healthcare assistants feedback about the immediate and four month patient survey results and they confirmed this.
- The doctor took responsibility for duty of candour and advised that they used the duty of candour policy of the practice where they worked as a GP. The other staff confirmed this.
- The healthcare assistants spoke highly of the doctor and felt this was a good place to work.
- The doctor was a trainer for other no-scalpel vasectomists undergoing specialist training for this role.

Governance arrangements

Location

- There was no written risk register; which did not present any problems because the doctor was the only senior manager for the service, and they were fully aware of the risks and actions. The two risks were absence of the doctor or healthcare assistants. Should the doctor be absent the clinic administrator would cancel and reschedule the clinic, this had never had to be done as previously mentioned. There were two healthcare assistants, which mitigated against cancellation of the clinic and the doctor had a list of staff to call if absence occurred.
- The doctor who led the service had developed the initial service specification. He was responsible for monitoring performance against the specification and met with the clinical commissioning group (CCG) regularly to review the performance. They had a clear understanding of the goals of the service.
- There were peer support arrangements in place with the urology consultants at the local acute hospital.
- The doctor took responsibility for the clinical audit plan, which involved the setting up and reviewing the immediate and four month patient surveys, and the post-vasectomy semen analysis audit. The details regarding the audits have been discussed in previous domains.
- There were logistics arrangements with the building administrator. The provider was clear about what the responsibilities of the service were, for example, maintenance of specialist equipment was the services responsibility, whereas maintenance of general fixtures and fittings were the responsibility of the building administrator.
- Staff were clear that they reported any issues to the doctor for the service.
- The doctor for the service was responsible for informing staff about any issues that affected the service and the staff confirmed this was the case.
- The doctor advised that they had a clear path of communication to the CCG to discuss any governance issues. For example, if the doctor was absent long–term, their responsibility was to inform the CCG who would then liaise with the local GPs regarding availability of other services.

Learning and improvement

- The doctor carried out appraisals for staff and reviewed their training plans with them. We saw the training plan documentation that the doctor had for the staff. 100% of staff had received their appraisal as of October 2016.
- The doctor actively sought feedback from the urologists at the local hospital. The provider told us they had a nominated link consultant and were able to tell us who this was. The doctor advised that they sent any patients with vasectomy failures to the nominated link consultant who reviewed the cases for any learning points.
- The doctor undertook peer review by videoing an actual procedure and requesting feedback from consultant urologists. The feedback was very positive.

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

- The doctor used the results from the immediate and four month patient surveys to review the service and make improvements. Examples of this were ensuring patients were not booked into an appointment for two weeks after the initial contact, to ensure written information had time to reach them before their appointment. Another example was using the patient electronic appointment booking system to reduce DNA rates.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- Review the recording of lidocaine stock to ensure a permanent record of all deliveries received
- Develop and maintain a service risk register