Dr Viney Jhanjee

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr VK Jhanjee also known as Lodge Road Surgery on 21 July 2015. Overall the practice is rated as good.

Specifically, we rated the practice as good for providing safe, effective, caring, responsive and well led services for the following population groups:

- 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)

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

- There were systems in place to monitor and reduce safety risks including analysing significant events. Safeguarding concerns were identified and appropriate actions taken to safeguard patients. Infection control measures were in place to protect patients from unnecessary infections. Safe recruitment procedures were in place. Medicines and vaccines were appropriately stored and in date.
- Patients had their needs assessed in line with current guidance and the practice had a proactive approach to patient care. Practice staff promoted health education and screening to empower patients to maintain their health.
- Feedback from patients and observations throughout our inspection showed that staff were professional, kind, caring and helpful. Patient care was met by staff who had received appropriate training. Patients told us they were satisfied with the standards of care they received. Practice staff worked with other healthcare providers to deliver co-ordinated care and regularly reviewed the care needs of patients with complex needs.
- There were systems in place to respond and act upon complaints and feedback from patients. Practice staff had identified carers and entered them on a register. The practice implemented suggestions for improvements and made changes to the way it

Summary of findings

delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG). GPs offered carers advice and signposted them to various support groups.

- The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Effective systems were in place for reporting safety incidents. Untoward incidents were investigated and where possible improvements made to prevent similar occurrences.

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 good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and when to report incidents. There was a robust recruitment procedure in place and senior staff adhered to it when recruiting new staff. Information about safety was recorded, monitored, appropriately reviewed and addressed. Information about safety was highly valued and was used to promote learning and improvement. There were effective safeguarding measures in place to help protect children and vulnerable adults. There were enough staff allocated to ensure patient safety.

Are services effective?

Good

The practice was rated good for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate for their roles. Arrangements were in place to identify, review and monitor patients with long term conditions and those in high risk groups. Staff worked with multidisciplinary teams in providing joined up care. Patients had access to a range of support services to maintain a healthy lifestyle and improve their health.

Are services caring?

Good

The practice was rated good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients told us they were treated with compassion, dignity and respect and were involved with decisions about their care and treatment. Patients were given supporting information and signposted to local services available to them. Staff treated patients with kindness and respect, and maintained their confidentiality.

Are services responsive to people's needs?

Good

The practice was rated good for providing responsive services. Practice staff had reviewed the needs of its local population and efforts had been made to reach out to patients to ensure they received appropriate care and treatment. Staff engaged with the NHS England Area Team and the local Clinical Commissioning Group (CCG) to secure improvements to services where they had been identified. The practice had good facilities and was well equipped to treat patients and meet their needs. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice was rated good for providing well-led services. All staff worked closely together to innovate and promote continuous improvements. We saw evidence that senior staff sought feedback from patients and staff and acts on it where appropriate. High standards were promoted and owned by all practice staff with evidence of team working across all roles. There was strong leadership with a clear vision and purpose. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice had a number of policies and procedures to govern activity and held regular governance meetings that all staff attended.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice was rated good for providing services for older people. Practice staff offered proactive, personalised care to meet the needs of older patients. There was a designated named GP for patients who were aged 75+ years and care plans were in place. All older patients had received annual health checks and where necessary, care, treatment and support arrangements were implemented. Practice staff were responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice was rated good for people with long term conditions. All these patients had structured reviews every three, six or 12 months depending on their needs. We saw evidence of care plans that were in place to help manage and better co-ordinate patients care. Patients were able to see a GP in an emergency if their health was deteriorating. Specialist health professionals regularly visited the practice and worked jointly with practice staff in providing diabetic clinics. The practice nurse maintained weekly contact with some patients who had diabetes to ensure they were able to self-medicate and if necessary provided further training. All patients who had heart failure; hypertension, asthma, cancer, kidney disease, epilepsy, rheumatoid arthritis and cancer had been reviewed.

Families, children and young people

Good

The practice was rated good for care of families, children and young people. A GP partner was the safeguarding lead for the practice. Records showed that senior staff sought advice from health and other social care professionals when necessary. Systems were in place for identifying and following up children who were at risk of harm. Requests for young children's appointments were booked for the same day. Childhood immunisation was provided at the practice. Cervical screening was offered to female patients. Midwives held ante natal clinics at the practice.

Working age people (including those recently retired and students)

Good

The practice was rated as good for the care of working age people (including those recently retired and students). The practice did not provide extended hours but GP's and the practice nurse offered telephone consultations to provide advice during the practice working hours. On line prescription ordering was available with a 48

Summary of findings

turn around and on line appointment services. Practice staff carried out NHS health checks for patients between the ages of 40 and 74. Health promotion and prevention advice was provided by practice staff. A health trainer visited the practice each week and gave patients information about maintaining their health and well-being.

People whose circumstances may make them vulnerable

Good

The practice was rated good for the care of people whose circumstances may make them vulnerable. Face to face annual health checks were carried out and health plans developed for all patients who had a learning disability. The practice held a register of vulnerable patients. Senior staff held monthly multidisciplinary meetings to monitor the health and well-being of this patient group. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated good for people experiencing poor mental health (including people with dementia). Practice staff regularly worked with multidisciplinary teams in the case management of patients who experienced poor mental health and sign posted patients to the appropriate services. All patients who had depression or dementia had been reviewed which was above the local CCG average. Clinical staff used screening tools to identify those patients who were at risk. All staff worked within the boundaries of the Mental Capacity Act 2005 and had appropriate skills for supporting patients with dementia.

Summary of findings

What people who use the service say

As part of our inspection process, we asked patients to complete comment cards prior to our inspection. We received 21 comment cards and spoke with seven patients. All comments received indicated that patients found the staff helpful, caring and polite and satisfied with the standards of care they received. One patient commented that it was difficult to get through to the practice by telephone. Staff were already aware of this and senior staff were exploring the options for making improvements to the system. Two patients said it was sometimes difficult to get and appointment when they felt they needed one.

The national GP patient survey results for 2014/15 showed that the practice was achieving or was above the national averages:

- 94% of respondents found reception staff were very helpful, the national average was 87%,
- 90% of patients said that the last time they saw or spoke with a GP they were good at giving them enough time, the national average was 87%,
- 73% of respondent said it was easy to get through by telephone, the national average was 73%,
- 74% reported a positive experience of making an appointment, the national average was 73%,
- 58% of respondents waited 15 minutes or less before they were seen, the national average was 53%.

The practice had a Patient Participation Group (PPG). PPGs are a way for patients and practice staff to work together to improve services and promote quality care. During our inspection we spoke with a member of the PPG. They were complimentary about the services provided for patients and made positive comments about the changes that practice staff had put in place. They told us that staff listened and where possible had made changes that patients had requested.

Dr Viney Jhanjee

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr Viney Jhanjee

Dr VK Jhanjee provides primary medical services to approximately 3660 patients within the densely populated and deprived local community of Smethwick. Patients consist of 50% black and ethnic minority groups.

There are two partner GPs and two locum GPs, who between them provide 15 clinical sessions per week. There is a full time practice nurse who is supported by a health care assistant (HCA) who works 15 hours per week. The practice is open from 9am until 6.30pm each day with the exception of Thursday afternoons when the practice is closed from 1pm. Appointments were available between 9am and 12pm and 4pm until 6.30pm. Patients requiring a GP outside of these hours are advised to contact an external out of hour's service or attend to a local walk-in centre. The number of this service is available in the waiting area, in the practice leaflet and on the practice website. The out of hour's service is provided by Primecare.

The practice has a General Medical Service (GMS) contract with NHS England. A GMS contract means that patients are registered with the practice and not an individual GP but the practice will focus on delivery of quality clinical care and well managed services. The practice offers enhanced services such as health checks for all patients who have a learning disability.

Why we carried out this inspection

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people

Detailed findings

- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before our inspection, we reviewed a range of information we hold about the practice and asked other organisations and key stakeholders what they knew about the practice. We reviewed policies, procedures and other information that practice staff had provided. We carried out an announced inspection on 21 July 2015. We spoke with a range of staff including a GP partner, the practice nurse, health care assistant, practice manager, the assistant manager, two reception staff and two administrators. We sought views from the chair of the Patient Participation Group (PPG), spoke with seven patients, looked at comment cards and reviewed survey information.

Good

Are services safe?

Our findings

Safe Track Record

We spoke with seven patients about their experience at the practice. None of the patients we spoke with reported any safety concerns to us.

Practice staff used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients.

Staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, a needle stick injury to a staff member. The risks from this were identified and systems put in place to minimise future occurrence's. As a result all staff commenced annual training in the risks associated with blood and body fluid exposure.

The management team, clinical and non-clinical staff discussed significant events at a range of monthly staff meetings so that all relevant staff learnt from incidents and reduced the likelihood of recurrences. We reviewed safety records, incident reports and minutes of these meetings where incidents had been discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

Staff were encouraged to complete significant event reporting forms and they demonstrated that they knew where to access them. We saw that significant events were recorded, analysed and regularly discussed at practice meetings with an aim to take account of any lessons to be learned. A significant event is any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice.

We saw that the practice had recorded 12 significant events during the last 12 months, which had been reviewed. Clinical staff spoken with confirmed that significant events, incidents and complaints were discussed at their practice meetings and they were able to give some examples.

National patient safety alerts were disseminated by the practice manager to relevant staff to read and sign off. Safety alerts were discussed at practice meetings to ensure all were aware of any relevant to the practice and where action needed to be taken.

Reliable safety systems and processes including safeguarding

There were safeguarding vulnerable adults and children policies in place and staff told us they knew where to access them. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding.

All staff had received safeguarding adults and children training at a level that was appropriate to their roles. GPs attended safeguarding meetings and provided reports when requested. Staff we spoke with demonstrated good knowledge about occasions when they may need to act upon areas of concern. We saw evidence where staff had reported a concern and maintained contact with the investigating authority throughout.

We saw that a chaperone policy was in place. A chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure. We saw chaperone notices were displayed in the waiting area of the practice and within the practice leaflet. Some patients we spoke with were aware that they could have a chaperone if needed. Non-clinical staff we spoke with told us they occasionally carried chaperone duties and we were shown their training records. They were able to demonstrate they carried out this task appropriately. Appropriate risk assessments had been carried in respect of non-clinical staff to consider if a Disclosure and Barring Scheme (DBS) check was required. Disclosure and Barring Service (DBS) criminal record checks had been carried out for all clinical staff.

Medicines Management

Regular medicine audits were carried out with the support of the CCG pharmacy team to ensure GPs were prescribing in line with best practice guidelines. We looked at two medicine audits carried out during January to March 2015. Both audits identified that prescribing was within the CCG targets.

Good

Are services safe?

There was a fridge for the storage of vaccines. The practice nurse took responsibility for stock rotation and control and daily fridge temperatures were recorded. We looked at a sample of vaccines and found they were in date. Recordings were made of all vaccines received into the practice. There was a cold chain policy in place that included the need to place all vaccines received in the fridge at the point of delivery. The recordings included their expiry dates.

Medicines used for emergencies, such as adrenaline for anaphylaxis was available. These were secured stored. There was a 'grab bag' that GPs used for home visits. These contained some emergency medicines. The medicines had been recorded including their expiry dates and these were checked regularly to ensure they were safe for administration.

Cleanliness & Infection Control

All areas of the practice were visibly clean and tidy. Patients commented that they always found the practice to be hygienic.

Consultation rooms had the necessary hand washing facilities and personal protective equipment (PPE) was available. A clinical waste disposal contract was in place.

The practice nurse and the senior GP partner were the leads for infection control. There was an infection control policy and other relevant policies such as, needle stick injury. A cleaning schedule was used by the cleaning staff to confirm all areas of the practice were cleaned. All staff had received training in infection control.

The practice nurse showed us the infection control audit that was dated June 2015. The overall result was 90% achievement and five actions that were required such as obtaining blood spillage kits. We saw evidence that the actions had been addressed.

Equipment

All electrical equipment was regularly checked to ensure it was safe for use.

Clinical equipment in use was checked to ensure it worked properly. For example, blood pressure monitoring equipment was annually calibrated. Clinical staff we spoke with told us there was enough equipment to assist them in assessing patients.

Staffing & Recruitment

Staff told us there were enough staff to meet patients' needs and they covered for each other during absences. There was a low staff turnover. Senior staff had identified that there was a higher demand for the practice nurse. From 1 April 2015 the practice nurse hours were increased from 28 to 34 hours per week. GPs including the locums covered extra clinical sessions during GP absences and if necessary the practice used a locum from an agency.

There was a recruitment policy that set out the standards to follow when staff were recruited. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS). The DBS check is a criminal records check that helps identify people who are unsuitable to work with children and vulnerable adults. All clinical staff had DBS checks including any non-clinical staff employed since the practice manager commenced 18 months ago.

We saw that relevant checks were completed to ensure clinical staff were up to date with their professional registration, for example nurses were registered with the Nursing and Midwifery Council (NMC). The practice also kept a record to demonstrate that GPs were registered on the performers list. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council (GMC) can the GP continue to practice and remain on the performers list with NHS England.

Monitoring Safety & Responding to Risk

Risk assessments were in place which included areas of health and safety associated with the general environment. Records showed that essential risk assessments had been completed, where risks were highlighted measures had been put in place to minimise the risks.

There was a health and safety policy in place and staff knew where to access it.

There were some arrangements to deal with foreseeable emergencies. We saw that the staff at the practice had received training in medical emergencies such as basic life support. Oxygen was available within the practice for treating patients.

Good

Are services safe?

The practice did not have an automated external defibrillator for treating patients who had heart attacks. An Automated External Defibrillator (AED) is a portable electronic device that analyses life threatening irregularities of the heart and is able to attempt to restore normal heart rhythm. According to current external and national standards, practices should be encouraged to have a defibrillator. However, shortly after the inspection we were sent evidence that a defibrillator had been ordered and received. Practice staff had already received training in use of defibrillators in June 2015.

Arrangements to deal with emergencies and major incidents

We saw the business continuity plan. The document detailed the actions that should be taken in the event of any occurrences which could disrupt the running of the practice and contact details of emergency services that could provide assistance. A copy of the document was held off site by the practice manager. The document covered eventualities such as loss of computer and essential utilities. The plan was clear in providing staff guidance about how they should respond. It included the contact details of services that may be able to help at short notice.

Staff had received regular fire safety training and participated in regular fire drills to maintain their knowledge of how to respond in an emergency. A fire safety risk assessment was in place and had been reviewed annually to ensure it was still relevant. We saw that fire escape routes were kept clear to ensure safe exit for patients in the event of an emergency.

The patient leaflet and a recorded message on the telephone gave information about how to access urgent medical treatment when the practice was closed.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Newly registered patients attended the practice for health checks, which included information about their lifestyles and family history as well as any, medical conditions. This enabled staff to identify the patient's immediate needs.

Clinical staff we spoke with could clearly describe the rationale for their approaches to patients' assessments and treatments. They were familiar with current best practice guidance and those of the national Institute for Health and Care Excellence (NICE) and from local commissioners.

Practice staff used a computer system for coding of patients who had specific needs to inform staff when they accessed patient's records. For example, patients on the 'at risk' register, learning disabilities and palliative care.

As part of the enhanced services practice staff took part in avoidance of unplanned hospital admissions. All of these patients had been reviewed and agreed a health plan. A copy of the health plan was given to each patient and was updated following each review. Reception staff were informed of this patient group were offered priority appointments to further avoid hospital admissions.

Every two months a consultant and diabetic nurse specialist from the local hospital attended the practice to see patients who had diabetes. They worked jointly with a GP and the practice nurse. They saw patients with complex diabetes. These patients were given information and guidance about the importance self-administering their prescribed treatment. A GP and practice nurse had attended a three day specialist training course to further develop their knowledge and skills in this area.

Management, monitoring and improving outcomes for people

Practice staff participated in the Quality and Outcomes Framework (QOF) system. This is a system intended to improve the quality of general practice and reward goof practice. All patients who had heart failure; hypertension, asthma, cancer, kidney disease, epilepsy, rheumatoid arthritis and cancer had been reviewed. These were above the local CCG average. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. The practice had exception reporting of 3.6%, which was 0.5% below the local Clinical Commissioning Group (CCG) average. Exception reporting is the exclusion of patients from the list who meets specific criteria. For example, patients who choose not to engage in screening processes.

GPs were involved in regular clinical audits. The medicine audits carried out between January and March 2015 in conjunction with the CCG pharmacy indicated that GPs were adhering to best practice guidelines when they prescribed medicines. These audits were due to be repeated to monitor if the improvements made had been sustained.

Other audits included laxatives and supplementary sip feeds. These led to changes in the prescribing and improved patient care. We were given information about the audits that had been carried out during 2014 and a list of those for 2015. We were shown details of a medicine audit and the results at three and six months. We were told that the audit was not yet completed.

The GP partners and practice manager attended the CCG meetings. This involvement supported the exchange of best practice and positive information sharing between practices and secondary care services in the local area. The practice was a member of the newly formed federation, Sandwell Health Care Partnership. The federation was developing initiatives for the further improvement and continuity of patient care.

Effective staffing

The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and confidentiality.

Staff had received training appropriate to their roles that included safeguarding vulnerable adults and children, basic life support, infection and information governance awareness. Practice staff had dedicated time for training when the practice was closed.

The practice nurse had attended specialist training courses such as diabetes and chronic obstructive pulmonary disease (COPD). They also worked with a learning disability nurse specialist when the reviewed these patients to enhance their knowledge and skills for future reviews. The health care assistant (HCA) was attending training courses that were relevant with the role. For example, health checks.

Good

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

The practice had a policy outlining the responsibilities of all staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for any action required. All staff spoken with understood their roles and felt the system worked well.

Patients were referred to hospital using the 'Choose and Book' system and used the two week rule for urgent referral where cancer was suspected. The practice had monitoring systems in place to track progress of referrals.

Practice staff liaised with other healthcare professionals such as specialist services, community services, the community mental health team, district nurses, end of life care teams and health visitors.

The practice did not provide out of hours (OOH) services. This was provided by Primecare. This ensured that patients had access to care and treatment when the practice was closed.

Information Sharing

Systems were in place to ensure information regarding patients was shared with appropriate members of staff. Individual clinical cases were analysed during informal daily clinical meetings. The practice in conjunction with community healthcare professionals held monthly meetings for patients who were receiving palliative care and those who were at risk.

The practice used summary care records to ensure that important information about patients could be shared between healthcare settings. The practice planned and liaised with the out of hour's provider regarding any special needs of a patient. For example, end of life care.

The practice operated a system of alerts on patient's records to ensure staff were aware of any issues. For example, if a patient was a carer.

Consent to care and treatment

The patients we spoke with told us they had been involved with decisions about their care and treatments. They told us they had been provided with sufficient information to make choices and were able to ask questions when they were unsure.

Clinicians were aware of the requirements within the Mental Capacity Act 2005. This was used for adults who lacked ability to make informed decisions. Staff gave examples of how a patient's best interests were taken into account when a patient did not have capacity to make decisions about their treatment.

GPs knew how to assess the competency of children and young people about their capability to make decisions about their own treatments. They understood the key parts of legislation of the Children's and Families Act 2014 and were able to describe how they implemented it in their practice. GPs demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 years of age who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention

An anxiety and depression counsellor worked at the practice three times each week and GPs could refer patients to this service.

A health trainer worked at the practice once a week to provide health education for patients to promote their well-being. The practice nurse proved health advice to patients about balanced diets, keeping fit and coping with long term conditions (LTC).

The diabetes consultant and specialist nurse who regularly held clinical sessions at the practice in conjunction with practice gave patients advice and guidance about healthy lifestyles and how to appropriately manage their diabetes.

We saw that all new patients were offered a health check. New patients who had received prescribed medicines from previous clinicians were given an appointment with a GP to review the medicine dosage to ensure it was appropriate.

Patients who were due for health reviews were sent a reminder to make an appointment. Patients were asked about their social factors, such as occupation and lifestyles. These ensured doctors were aware of the wider context of their health needs.

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. We saw some health and welfare information displayed in the waiting area. For example, breast screening and shingles vaccinations for patients aged 70 years. Letters were sent to patients to encourage them to undergo screening such as, breast screening.

Good

Are services effective?

(for example, treatment is effective)

Cervical screening uptake by female patients was 100%; this was above the local CCG average.

Childhood health checks were encouraged by practice staff. There had been an uptake of 100% for childhood vaccinations.

All patients who were eligible for pneumococcal (pneumonia) vaccination had received it.

There was health information provided on the practice web site and in leaflets and posters within the premises. Practice staff sign posted patients to additional services such as smoking cessation clinics.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We observed throughout our inspection that members of staff were courteous, caring and very helpful to patients.

All seven patients we spoke with and the 21 comment cards we received indicated that all staff were helpful, supportive and caring.

The results dated January 2015 from the national GP survey showed:

- 96% of respondents stated that the last time they saw or spoke with a nurse they were good at listening to them, the local CCG average was 88%,
- 95% of respondents stated that the last time they saw or spoke with a nurse they were good at explaining tests and treatments, the local CCG average was 95%,
- 100% reported that they had confidence in the nurse, the local CCG average was 95%,
- 93% of respondents stated that the last time they saw or spoke with a GP they were good at listening to them, the local CCG average was 84%,
- 88% of respondents stated that the last time they saw or spoke with a GP they were good at explaining tests and treatments, the local CCG average was 82%
- 98% reported that they had confidence in the GP, the local CCG average 92%.

Curtains were provided in consulting rooms and doors remained closed during consultations so that conversation could not be overheard.

Patients confirmed they knew their rights about requesting a chaperone. They told us this service was offered to them by clinical staff.

Care planning and involvement in decisions about care and treatment

We were told that patient care was an absolute priority and was embraced by the whole practice team.

Clinical staff supported patients to understand their care and treatment options including the risks and benefits to enable them to make informed decisions. Patients were given the time they needed and were encouraged to ask questions until they understood about their health status and the range of treatments available to them. They told us they were able to make informed decisions about their care and felt in control.

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

Patients we spoke with confirmed they had been given advice and choices about where they could be referred to assist them in making decisions for secondary assessment and care.

Patient/carer support to cope emotionally with care and treatment

There was a dedicated notice board for carers in the waiting area. It provided information and sign posting to support organisations. The practice website also provided information for carers. The practice kept a list of patients who had carers to help identify patients who may require extra support.

The respective GP contacted bereaved families and offered a range of services they felt to be appropriate for the family to access. There were also bereavement counselling services available that GPs could make referrals to. Staff sent a card of condolence to the next of kin.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had an established Patient Participation Group (PPG). Adverts on the practice web site encouraged patients to join the group. The membership consisted of a wide age range of patients. The PPG met quarterly and the practice manager attended the meetings. We spoke with the chairperson of the PPG who told us that practice staff had been responsive to the four targets that the PPG had set for 2014. They were to improve appointments, ensure continuity of care by patients seeing the same GP, health checks of the over 40s and reduction of the patients who did not attend (DNA) for their appointments. The PPG member told us they had made improvements in all of the targets especially the over 40s health checks.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

The surgery was a member of a federation called Sandwell Health Care Partnership. This consisted of 30 GP practices within the locality covering 150,000 patients. The purpose of the federation was to improve patient care and was in the process of developing proposals.

Tackling inequity and promoting equality

Reception staff organised for a translator to be present during consultations for patients whose first language was not English. We were told that staff also organised for a sign language professional for one patients who could not hear. Physical assistance was provided for a patient who was unable to see.

The building was accessible for disabled patients. All consulting rooms were located on the ground floor. A toilet was available for use by patients who had restricted mobility.

The practice had an equality and diversity policy and staff were aware of it. Patients we spoke with did not express any concerns about how they were treated by staff.

Access to the service

The practice was open between 9am and 6.30pm with the exception of Thursdays when it closed at 1pm. Appointments were from 9am until 12pm and from 4pm until 6.30pm. There were no extended hours available. GPs provided telephone advice for patients each morning.

A number of emergency appointments were available each day to support those patients who needed to be seen urgently. A number of pre-bookable appointments were made available for each clinical session. Staff told us that patients with complex needs and young children were given priority appointments and if the list was full staff would slot in an extra appointment for these population groups.

The practice nursed offered advice by telephone and had extended the appointments to 15 minutes each to ensure patients received a full assessment and care needs were met.

GPs carried out home visits for patients who were unable to travel to the practice. Requests for home visits were actioned the same day.

The patient survey indicated that 72% of patients were satisfied with the practice's opening hours, which was 3% below the national average. The practice manager and a GP told us they were reviewing the opening hours to look at ways of increasing them.

Listening and learning from concerns & complaints

There was a system in place for handling complaints and concerns. The complaints procedure was in line with recognised guidance and contractual obligations for GPs in England. The procedure clearly outlined a time framework for when the complaint would be acknowledged and responded to.

Information about how to make a complaint was available in the waiting area and at the reception desk.

The practice manager kept a complaints log. The practice had received four complaints during the last 12 months. One complaint concerned a patient who was unable to book a same day appointment. The complaint was resolved when the patient was seen on the day as an emergency. Reception staff were told by senior staff to book emergency appointments if necessary, offer telephone consultations and to promote the on line booking service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Complaints received were discussed at the monthly practice meetings and where possible lessons learnt were identified.

Are services well-led?

Good

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

Our findings

Vision and Strategy

Senior staff had developed a five year plan. They had successfully secured funding to extend the practice and improve the access for patients. For example, automated entrance doors and a low level reception desk for the assistance of children and infirm patients. The work was due to be completed by April 2016. Opinions had been sought from the PPG about the plans. This will result in more GP and practice nurse appointments for the steady increase of registered patients.

Staff we spoke with were aware of the culture and values of the practice and told us that patients were at the centre of everything they did. They felt that patients could be involved in all decisions about their care and patient safety was paramount. Comments we received from patients were complimentary and they confirmed that they were consulted and given choices.

Senior practice staff engaged with the local Clinical Commissioning Group (CCG) to ensure the services met the local population needs.

Governance Arrangements

There were policies and procedures in place to support staff governance arrangements which were available to all staff.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with or above the national standards.

The practice staff held monthly practice meetings and all staff were invited to attend. Staff told us they could make suggestions for improvements and that they would be listened to by senior staff. For example, an administrator had suggested that more concise information was needed for some referrals. This was put into practice and led to improved referrals.

Leadership, openness and transparency

There were specific identified lead roles for areas such as safeguarding and infection control and management was shared amongst the GPs and the practice manager.

The practice had a protocol for whistle blowing and staff we spoke with were aware of what to do if they had to raise any concerns.

We saw evidence of staff appraisals that were regularly undertaken. Staff members we spoke with told us that they aimed to provide a good quality and caring service.

Staff told us that they felt supported and also supported each other as necessary. We were told that staff worked well as a team and also that they felt appreciated for the work that they did.

Practice seeks and acts on feedback from users, public and staff

There was an established Patient Participated Group (PPG) and we spoke with the chairperson of the group. They told us that staff responded positively to their suggestions and targets and if a suggestion was not possible to implement staff would explain why. They told us that staff were very patient centred and had involved them in any proposed changes to the service.

The web site invited patients to join the PPG, the meeting minutes and the patient survey reports were available for patients to access.

The patient survey dated June 2015 was mostly positive. It included an action plan consisting of five actions for improvements. Senior staff told us they had already identified some to of the actions and were considering ways to implement them. For example, additional female GP clinical sessions.

The practice was participating in the 'Friends and Family' survey where patients were asked to record if they would recommend the practice to others. The survey commenced December 2014 and the practice manager submitted monthly reports to the local CCG. We looked at the results for June 2015. There were 27 responses and all said they would recommend the practice to others.

Management lead through learning & improvement

Practice staff told us they worked well together as a team and there was evidence that staff were supported to attend training appropriate to their roles.

There was evidence that staff had learnt from incidents and significant events. For example, during a home visits a GP had concerns about a patient's safety and took appropriate

Are services well-led?

Good

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

action. The issue was treated as a safeguarding event and senior staff maintained regular contact with the investigating authority. This was a good example of providing safe care and all staff had learnt from it.