Lion Health

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Lion Health has a practice population of approximately 24700 patients within the Dudley area.

We carried out a comprehensive inspection on 14 January 2015.

We have rated each section of our findings for each key area. The practice provided a safe, effective, caring, responsive and well led service for the population it served. The overall rating was good and this was because the practice staff consistently provided good standards of care for patients.

Our key findings were as follows:

- Practice staff worked together as a team to ensure patients received the standards of care they needed.
- There were safe systems in place for ensuring patients received appropriate treatments and prescribed medicines were regularly reviewed to check they were still needed.
- Patients were protected against the unnecessary risks of infections because staff adhered to appropriate hygiene practices and regular checks were carried out.
- The practice was able to demonstrate a good track record for safety. Effective systems were in place for reporting safety incidents. Untoward incidents were investigated and where possible improvements made to prevent similar occurrences.
- Patients were treated with respect and their privacy was maintained. Patients informed us they were very satisfied with the care they received. The feedback we received from patients was without exception positive.

We saw several areas of outstanding practice including:

- The main role of an advanced nurse practitioner is the provision of care for older people including those aged 75+ years. Home visits are also carried out to ensure care for older people meets their needs.
- The main role of a mental health advanced nurse practitioner is the provision of care for patients with

mental health illnesses. Home visits are also carried out. This service helps in provision of effective care and preventing escalation of patient's mental health conditions.

- Practice staff have introduced a system for patients with hypertension where they email their blood pressure recordings to the practice. Recording equipment is supplied by the practice. Staff responds accordingly by email and provide advice so that patients receive appropriate and timely care.
- For patients above a specific weight clinical staff offer them a nutrition and exercise course to promote healthy lifestyles. The practice website gave guidance about various ways of healthy living including diet, exercises and promotion of women's health.
- Clinical staff visited two local schools and provided pupils with advice about sexual health and contraception.

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

Staff understood and fulfilled their responsibilities to raise concerns, report incidents and near misses. Lessons learnt were communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff employed to keep people safe and robust recruitment processes were in place. Patients were protected against the risks associated with infections because appropriate systems were in place and regular audits carried out that ensured hygienic premises, equipment and staff practices.

Are services effective?

Good

Clinicians worked within both the National Institution for Care Excellence (NICE) guidelines and other locally agreed guidelines. People's needs were assessed and care planned and delivered in line with current legislation. Practice staff carried out clinical audits and as a result made changes where necessary to promote effective care for patients. Systems were in place for regular reviews of patients who had long term conditions and housebound patients. Multidisciplinary working was evidenced that promoted streamlined care for housebound patients.

Are services caring?

Good

Patients said they were treated with compassion, dignity and respect and they were involved in their care and treatment decisions. Accessible information was provided and staff provided explanations to help patients understand the care available to them. We also saw that staff ensured patient confidentiality was maintained. We observed that staff interacted with patients in a polite and helpful way and they greeted patients in a friendly manner.

Are services responsive to people's needs?

Good

Practice staff demonstrated how they listened to and responded to their patient group. We saw that efforts had been made to reach out to each population group to ensure they received appropriate care and treatments. Some patients told us the appointments system did not always work well. Staff were monitoring the problem and making changes on an on-going basis. There was a system in place which supported patients to raise a complaint. Complaints received

Summary of findings

were recorded, investigated and responded to in a timely way. The layout of the premises supported access for patients who had restricted mobility. Specialist nurses were employed to assess and provide care for older people and those with mental health illness.

Are services well-led?

There were arrangements to monitor and improve quality, identify risk and to put measures in place to reduce them. Practice staff proactively sought feedback from staff, patients and their relatives and friends and this had been acted upon. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. There was strong leadership with a clear vision for delivering the practice's mission statement.

Good

Summary of findings

The six population groups and what we found

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

Older people

Good

Patients aged over the age of 75 years had been informed of their named and accountable GP. All patients aged 75+ years who had not attended the practice within 12 months were recently reviewed and where necessary care, treatment and support arrangements implemented. GPs provide care to patients registered with the practice who resided in care homes. The practice offered proactive, personalised care to meet the needs of older people and had a range of enhanced services. For example, employment of an advanced nurse practitioner who saw patients in the practice or in their homes. The practice was responsive to the needs of older people, including offering rapid access appointments for those with enhanced needs.

People with long term conditions

Good

Practice staff held a register of patients who had long term conditions and carried out regular reviews. GP's worked with relevant health and care professionals to deliver a multidisciplinary package of care. Clinical staff had good working relationships with a wide range of community staff and held regular meetings with them to ensure patients received seamless care. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. Structured annual reviews were undertaken to check health and care needs were being met.

Families, children and young people

Good

Appointments were available outside of school hours and the premises were suitable for children and babies. Practice staff held meetings with and liaised with local health visitors to offer a full health surveillance programme for children. Checks were also made to ensure maximum uptake of childhood immunisations. Alerts and protection plans were in place to identify and protect vulnerable children. Clinical staff visited local schools and provided sexual health and contraceptive advice to pupils.

Working age people (including those recently retired and students)

Good

The practice offered extended opening hours to assist this patient group in accessing the practice. Appointments were available from 8am and until 6:30pm every weekday and up to 7:20pm three evenings a week. For those patients who were unable to get an appointment on the day they could arrive late morning any weekday and wait to be seen without an appointment. Patients were also

Summary of findings

able to request telephone consultations. The practice was proactive in offering on-line services for making appointments and ordering repeat prescriptions. Patients over the age of 40 years were encouraged to have health checks.

People whose circumstances may make them vulnerable

Good

The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities. Patients were encouraged to participate in health promotion activities, such as breast screening, cancer testing and smoking cessation. A GP in conjunction with a community health professional held regular clinics to support people who had substance misuse or alcohol related problems. When necessary there was the opportunity for prompt referrals to this clinic.

People experiencing poor mental health (including people with dementia)

Good

Care was proactive and tailored to patients' individual needs and circumstances including their physical health needs. Annual health checks were offered to patients with significant mental health illnesses. Doctors had the necessary skills to treat or refer patients with poor mental health. The practice also employed a mental health nurse practitioner who saw patients at short notice and when necessary visited them in their homes to prevent escalation of their mental health condition. A professional from the Mental Health Trust held clinics at Lion Health. Practice GPs were able to make a referral and the patient would be seen within two to three weeks by the Mental Health Trust. All staff worked within the boundaries of the Mental Capacity Act 2005 and had appropriate skills for dealing with patients with dementia.

Summary of findings

What people who use the service say

We spoke with 18 patients during our inspection who varied in age and clinical needs. Some had been registered with the practice for many years. They informed us that staff were polite, helpful and knowledgeable about their needs. Patients told us they were given enough explanations so they understood about their health status and felt they were encouraged to make decisions about their care and treatment. They all gave us positive feedback about the standards of care they received.

We were told it was easy to obtain repeat prescriptions. Some patients told us it was difficult to get through by telephone and to make an appointment when they needed them. Other patients said they did not have a problem in obtaining an appointment.

We collected 18 Care Quality Commission comment cards left in the surgery prior to the inspection. All comments made about care and staff attitudes were very positive. The comments included staff efficiency and how professional they were and the good standards of care provided. Other comments concerned one patient and their inability to see a particular GP and another who had difficulty in obtaining an appointment

The Patient Participation Group (PPG) had carried out an annual survey. PPG's are an effective way for patients and surgeries to work together to improve services and promote quality care. The outcomes in the report dated 2013 to 2014 were positive. The report included recommended improvements that could be made and a suggested action plan For example, to improve the telephone access for patients and appointments to enable patients to book them at appropriate times.

Outstanding practice

We saw several areas of outstanding practice including:

- The main role of an advanced nurse practitioner is the provision of care for older people including those aged 75+ years. Home visits are also carried out to ensure care for older people meets their needs.
- The main role of a mental health advanced nurse practitioner is the provision of care for patients with mental health illnesses. Home visits are also carried out. This service helps in provision of effective care and preventing escalation of patient's mental health conditions.
- Practice staff have introduced a system for patients with hypertension where they email their blood pressure recordings to the practice. Recording equipment is supplied by the practice. Staff responds accordingly by email and provide advice so that patients receive appropriate and timely care.
- For patients above a specific weight clinical staff offer them a nutrition and exercise course to promote healthy lifestyles. The practice website gave guidance about various ways of healthy living including diet, exercises and promotion of women's health.
- Clinical staff visited two local schools and provided pupils with advice about sexual health and contraception.

Lion Health

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a specialist advisor who had experience in practice management and an expert by experience who had personal experience of using primary medical services.

Background to Lion Health

Lion Health serves approximately 24700 patients.

There are 11 GP partners at the practice and eight salaried GPs. Lion Health is a training practice with two registrars and medical students spending time at the practice. The nursing team are supported by health care assistants and a phlebotomist who worked varying hours. There is a practice manager who is assisted by two operations managers. Other non-clinical staff consisted of team leaders and a range of administration/reception staff some of which worked part time.

The practice offers a range of clinics and services including chronic disease management, cervical smears, contraception, minor surgery, injections and vaccinations. Some nurses specialise in conditions such as; mental illness, diabetes, chronic obstructive airways disease, family planning and contraception. Practice staff had been trained and provides advice to patients about healthy living and exercising and smoking cessation.

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
- Working age people (including those recently retired)

Detailed findings

- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 14 January 2015. During our visit we spoke with a range of staff including four GPs, two practice nurses a health care assistant, the practice manager, an operations manager, a team leader, three receptionists and one medicines management officer. We also spoke with 18 patients who used the service and the vice chair and another member of the Patient Participation Group (PPG) who acted as patient advocates in driving up improvements. We observed how people were being cared and how staff interacted with them and reviewed personal care or treatment records of patients. Relevant documentation was also checked.

Good

Are services safe?

Our findings

Safe track record

The practice had named safeguarding and infection control leads to protect patients from unnecessary risks. Practice staff demonstrated that there was a good track record for safety. We saw records to show that performance had been consistent over time and where concerns had been identified these had been addressed in a timely way. The practice manager showed us there were effective arrangements that were in line with national and statutory guidance for reporting safety incidents. Practice staff took incidents into account when assessing the overall safety record.

There were clear accountabilities for incident reporting, and staff were able to describe their role in the reporting process. We saw how the practice manager recorded incidents and ensured they were fully investigated. The GPs held regular meetings to review safety within the practice to ensure all relevant actions had been taken.

Learning and improvement from safety incidents

There was a system in place for reporting, recording and monitoring significant events. Staff made the recordings as soon as possible when concerns were identified.

We saw evidence that learning from incidents was shared with staff in a timely and appropriate way in order to reduce the risk of a similar occurrence. Practice staff also notified the local Clinical Commissioning Group (CCG) of specific events. The CCG is the NHS body responsible for commissioning local NHS services.

We were given some sample significant event audits. These clearly stated the investigations carried out, the resultant actions and which staff the information had been cascaded to. The records we looked at showed they had been completed appropriately.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Training records made available to us showed that all staff had received relevant role specific training on safeguarding. All clinical staff were due to attend level three (highest level) training and non-clinical staff level two training in early February 2015. Staff we spoke with knew how to recognise 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 and those details were easily accessible to them.

The practice had a dedicated GP appointed as the lead in safeguarding vulnerable adults and children. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments.

There was a chaperone policy available to staff, a poster was on display on the reception desk, on the television screens in the waiting areas and information was included in the patient leaflet. When chaperoning took place this was recorded in the patient's records. Clinical staff carried out chaperone duties and if they were not available reception staff would carry out this role. Staff had received training before they were permitted to chaperone patients. We asked a range of staff how they would carry out this duty. They demonstrated appropriate knowledge and understanding of their role.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible by authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. Staff were recording the refrigerator's temperatures twice a day to ensure medicines remained at a safe temperature for administration.

Arrangements were in place to check medicines were within their expiry date and safe for use. All the medicines we checked were within their expiry dates.

Vaccines were stored in line with legal requirements and national guidance. We saw recordings that confirmed daily fridge temperatures were recorded to ensure the vaccines were stored at suitable temperatures according to manufacturer's instructions. There was an effective rotation system in place to prevent the likelihood of vaccines going out of date before administration.

Good

Are services safe?

There was a protocol for repeat prescribing which was in line with national guidance and was followed by practice staff. Patients who had repeat prescriptions received regular reviews to check they were still appropriate and necessary.

The practice kept a 'grab bag' which could be collected when GPs visited patients in their homes. The medicines had been routinely checked to ensure they remained safe and within their expiry date.

Cleanliness and infection control

All areas of the practice were visibly clean, tidy and well organised. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We were shown the cleaning schedule for staff to follow and recordings that had been made where actions needed to be followed by the cleaning staff.

The practice had a lead for infection control who had received further training for this role. All staff had received training in infection control. We were told that single use disposable instruments were used for minor surgery.

We were shown a copy of the annual infection control audit of the premises that had been carried out by the infection control lead, a practice nurse. The report was dated 12 August 2014 and informed that the practice was hygienic. We saw there were some actions that staff needed to take as a result of the audit. We discussed these with the infection control lead. They told us two of them had been completed. We evidenced this when we visited consulting rooms.

The practice nurse showed us the results of shorter interim audits they had carried out every three months to check that hygiene standards were maintained. They told us that after each audit they attended the clinical governance meetings and reported the results to relevant staff and the actions that were needed. The GP's we spoke with confirmed their hygiene practices were scrutinised by the practice nurse.

The practice nurse had carried out a hand hygiene audit of clinical staff in April 2014 and shared the results with them. They told us they intended to repeat the audit regularly to check against the standards to show where improvements had been made.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use and staff confirmed there were always good stocks of PPE within the practice. There was also a policy in place for needle stick injury.

Legionella risk assessments had been carried out to protect patients and staff from unnecessary water borne infections.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and appropriate recordings maintained.

Staffing and recruitment

Senior staff based the staffing requirements on its experience of how the practice operated. Consideration had been given to the care and treatments that patients required. We asked how staffing shortages were managed across all grades of staff. The practice manager explained that a large number of staff worked at the practice and they were willing to work extra shifts to cover staff holidays. We were told locums were not used to cover GP absences because cover for these were planned well in advance.

Various grades of staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

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.

The practice had a recruitment policy that set out the standards it followed when recruiting each grade of clinical

Good

Are services safe?

and non-clinical staff. Newly employed staff worked a probationary period of three months and were assessed by senior staff before a permanent contract was offered to them.

Monitoring safety and responding to risk

There was a fire safety risk assessment in place. Staff had received regular fire safety training and participated in regular fire drills to maintain their knowledge of how to respond in an emergency.

The emergency lighting had been tested monthly and actions taken where defects found. Risk assessments of work stations had been carried out. We saw that fire escape routes were kept clear to ensure safe egress for patients in the event of an emergency.

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

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and a defibrillator and all staff knew where to access it.

Emergency equipment was also checked to ensure it was in working order. We were informed by various clinical staff that GP's did not carry any medicines in their visit bags. There was a dedicated emergency medicines bag stored at the practice that GPs could take out with them.

We saw a copy of the business continuity plan. It included the contact details of services that could provide emergency assistance. Senior practice staff kept a copy of the document off site to ensure there was access to it in any eventuality.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice used the National Institute for Care and Excellence (NICE) guidance to ensure the care they provided was based upon latest evidence and was of the best possible quality. We saw that any revised NICE guidelines were identified and shared with all clinicians appropriately.

The clinicians we spoke with confidently described the processes to ensure that informed consent was obtained from patients whenever necessary. They were also aware of the requirements of the Mental Capacity Act (MCA) 2005 used for adults who lacked capacity to make informed decisions.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Practice staff had a system in place for carrying out clinical audits. One audit was about gestational diabetes (diabetes in pregnancy). The audit had been carried out using NICE guidelines. The results indicated that not all patients had received annual tests and checks. In response a letter had been developed and was sent to respective patients to remind them of this need. We were informed that progress against this this would be monitored.

Another audit concerned the number of patients who had attended hospital Accident and Emergency during times when the practice was closed. Clinical staff found that over a period of one year 88 attendances were alcohol related. To reduce the incidence of recurrence these patients were contacted and offered support.

These and other audits we were shown included details of further actions that would be taken such as, repeating them in one year to determine if the actions taken had been effective.

All female patients who were referred to hospitals for assessment and treatment of gynaecology conditions had been routinely triaged by a group of four practice GPs to ensure they received the most appropriate care.

GPs met weekly and analysed all hospital admissions to check if any were avoidable and for identifying learning points.

GPs held regular clinical meetings. The minutes of the meetings that we looked at informed us patient care, significant events, complaints, and standards of patient care had been discussed. The recordings included learning from errors.

Effective staffing

Staff received support and guidance to ensure they were able to undertake their role effectively and safely. There was a comprehensive induction programme for all new staff. This included documentation checks, security, health and safety, policies and procedures, confidentiality, record keeping and supplementary areas according to job roles.

All staff received time for education and learning as the practice closed to periodically facilitate this. Staff had received a training programme that was commensurate with their roles. Staff were encouraged to identify extra training courses they may wish to attend. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses.

All GPs had completed their yearly continuing professional development (CPD) requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

Most staff had annual appraisals which identified learning needs from which action plans were developed. Senior managers were aware of those staff whose annual appraisal was overdue and arrangements were in place to address this gap. All staff had individually attended an interim appraisal meeting with a senior manager to check whether they had any concerns after moving into the new premises in April 2014.

Working with colleagues and other services

Good

Are services effective?

(for example, treatment is effective)

There was evidence of appropriate multidisciplinary team working and it was evident there were strong relationships in place. A multidisciplinary meeting was held every week to discuss patients receiving end of life care, those considered to be at risk and housebound patients. Community staff attendance included Macmillan nurses, the community matron, district nurses and dementia nurses. The purpose of these meetings was to ensure prevention of staff going to see patients at varying times and promote joined up care. There was engagement with other health and social care providers to co-ordinate care and meet patient's needs.

Practice staff held monthly meetings with health visitors to discuss workload issues that related to child welfare to ensure information was shared across teams. Practice staff told us they had good working relationships and communications with health visitors.

The practice worked with other service providers to meet people's needs and manage complex cases. Patients were given hospital discharge summaries for them to deliver to the practice but practice staff told us this did not always happen. Senior practice staff were holding discussions with the hospital staff and an alternative method was being considered.

There was a physiotherapy unit located within the practice. GPs made referrals to the service where patients received an average of six physiotherapy consultations before being referred to the hospital physiotherapy department for further assessment and treatment.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patient care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The system included a facility to flag up patients who required closer monitoring such as children at risk.

For patients who had attended an out of hours service or following discharge from hospital we were told that the respective GP (or the duty GP if the designated GP was not available) reviewed the information provided to them on a daily basis. A GP told us that if patient's required follow up they would send a request to the patient for them to make an appointment. If necessary a referral would be made to a hospital or physiotherapist.

Consent to care and treatment

We spoke with 18 patients and they all confirmed they felt in control of their care because they had been well informed about their illnesses and treatment options. We were told that consent forms were signed only after full explanations had been given to patients. We saw evidence that patients who had minor surgery at the practice had been properly informed of the risks and benefits of the procedure.

GPs were aware of the requirements within the Mental Capacity Act (MCA) 2005. This was used for adults who lacked capacity to make informed decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity.

They also knew how to assess the competency of children and young people about their ability to make decisions about their own treatments. Clinical staff 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. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged less than 16 years of age who have the legal capacity to consent to medical examination and treatment).

Health promotion and prevention

The practice manager told us all new patients were offered a health check, tests and a review of any illness and medicines they were taking. 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. Patients above a specific weight were offered nutrition guidance an exercise course to promote healthy lifestyles.

The practice website gave guidance about various ways of healthy living including diet, exercises and promotion of women's health.

Good

Are services effective?

(for example, treatment is effective)

Patients with learning disabilities or mental health conditions were offered an annual health review. Free health checks were available to patients between the ages of 40 and 74. Patients aged 75 and over were also offered annual health checks.

Clinical staff visited two local schools and provided pupils with advice about sexual health and contraception. The practice supports the chlamydia (thrush) screening programme for people aged between 16 and 25 years.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that reception staff greeted patients in a polite and courteous manner. When patients made appointments by telephone we overheard receptionists giving patients choices and respected when patients were not available to attend on some days.

A receptionist told us they could ask a patient to speak with them privately in an unoccupied room to protect their confidentiality. We were shown the quiet room where such discussions could be held.

We observed patients were treated with dignity and respect throughout the time we spent at the practice. We saw that clinical staff displayed a positive and friendly attitude towards patients. Patients we spoke with told us they had developed positive relationships with clinical staff.

Some patients we spoke with confirmed they knew their rights about requesting a chaperone. They told us this service was offered to them by clinical staff. Some patients had used the chaperone service and reported to us they felt quite comfortable during the procedure. The practice had a chaperone policy in place and staff knew where to access it.

There was a privacy and dignity policy in place and all staff had access to this. We saw that all clinical rooms had window blinds and privacy screening across the doorway entry into them. We observed staff knocking on doors and waiting to be called into the room before entering.

Care planning and involvement in decisions about care and treatment

Patients told us they 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. Patients we spoke with told us they were able to make informed decisions about their care and felt in control. 18 patients completed CQC comment cards to provide us with feedback on the practice. Patients said they felt the practice offered a good service and were professional and helpful.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice well in these areas. For example, respondents said the GP involved them in care decisions and they felt the GP was good at explaining treatment and results.

The Mental Capacity Act 2005 governs decision making on behalf of adults and applies when patients did not have mental capacity to make informed decisions. Where necessary patients had been assessed to determine their ability prior to best interest decisions being made. Staff we spoke with had an awareness of the Mental Capacity Act and had received training.

A practice nurse told us they explained tests and treatments to patients before carrying them out and on-going information was provided during the procedures so that patients knew what to expect.

Patient/carer support to cope emotionally with care and treatment

Following bereavement the respective GP contacted the family by phone to offer them information about the various bereavement counselling services available to them. Counselling services were provided at the practice by external professionals. One GP we spoke with told us they were still providing support to a patient whose relative had died two years previously. One of the patients we spoke with commented about the good support they had received after their relative had died.

The practice held a register of those people who cared for other persons. The practice website, television screens in waiting areas and the patient information leaflet asked carers to identify themselves to practice staff so that they could be added onto the register. The website and television screens provided information about carers support groups such as, Care Co-ordinators at Dudley Metropolitan Borough Council and included contact details.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The NHS Local Area Team (LAT) 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.

Practice staff recognised the long term condition needs of its practice population and had adopted a proactive approach to their care. For example, arrangements were in place for patients who suffered with hypertension (high blood pressure) to email their blood pressure recordings to the practice and practice staff would provide health advice by return emails. Recording equipment (24 hour recording) was supplied by the practice.

The practice employed an advanced nurse practitioner whose main role was assessment and care of older patients including those aged 75+ years. The nurse saw patients at the practice and in their own homes if they were not able to travel to the practice. They also carried patient's annual health reviews.

A mental health advanced nurse practitioner was employed whose main role was assessment and care of patients with mental health illness. The nurse saw patients at the practice at short notice and in their own homes if they were not able to travel to the practice to prevent escalation of their mental health illness. They also carried out patient's annual mental and physical health reviews. A professional from the Mental Health Trust held clinics at Lion Health. Practice GPs were able to make a referral and the patient would be seen within two to three weeks by the Mental Health Trust whilst being supported by the mental health advanced nurse practitioner and a GP.

Patients who were housebound and those with dementia had recently been reviewed to ensure they received appropriate care, treatment and support from community professionals.

All female patients who were referred to hospitals for assessment and treatment of gynaecology conditions were routinely triaged by a group of four practice GPs to ensure they received the most appropriate care.

GPs met weekly and analysed all hospital admissions to check if any were avoidable and for identifying learning points. All patients who had recently been diagnosed with cancer were clinically reviewed to ensure all systems had been put in place for their support, care, treatment and for monitoring their condition.

A practice GP who had a specialist interest in substance misuse joined external health professional and held regular clinics at the practice for patients with substance misuse or alcohol related problems. This initiative provided these patients with support, guidance and treatment of their conditions.

Patients requiring specialist investigation or treatment were referred to hospitals. Patients could choose where they wished to be referred. Patients told us their referrals had been carried out effectively and promptly. There was a 'choose and book' system so that patients could review the waiting times at various hospitals before making their decisions about where they wanted to be seen. We asked administration staff how long it took to send out the referral letters. We were told they were completed within 24 to 48 hours and urgent ones on the day they were requested.

We saw the Patient Participation Group (PPG) report for 20134 to 2014. PPG's act as a representative for patients and work with practice staff in an effective way to improve services and promote quality care. The report informed us that patients were satisfied with the service they had received. The PPG held meetings every three months with a GP and senior management staff in attendance. Discussions included information received from patients and the results of the survey and where improvements could be made. The main point that needed addressing was that some patients had commented about the length of time they waited to be responded to by telephone. Also that sometimes it was difficult in obtaining appointments. The practice manager told us they were monitoring both problems and they intended to make changes to the appointments system and were considering options for improving the telephone system.

Tackling inequity and promoting equality

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had recognised the needs of different groups in the planning of its services. We were told that people visiting the area would be seen as temporary patients. A GP informed us they had very few travellers in the area but a large amount of university students were seen.

Staff told us that translation services were available for patients who did not have English as a first language. When the translation service was used reception staff booked a double appointment for these patients so they were given sufficient time for effective communications and to enable them in understanding their health status and care needs.

The premises were accessible by patients who had restricted mobility. There was a toilet for disabled people on the ground and first floors. The corridors and doorways to consulting rooms were wide enough to accommodate wheelchairs. All consulting rooms were located on the ground and first floors and there was a shaft lift for access that accommodated a mobility scooter.

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

Access to the service

Appointments were available weekdays from 8am until 6:30pm. Patients could make appointments up to four or more weeks in advance or on the day. There were three evenings when appointments could be made up to 7:20pm. Appointments could be made by telephone or on-line via a computer. For those who could not get an on the day appointment but felt they needed to be seen they could arrive late morning and wait to be seen. The practice manager told us that when GPs finished their morning clinics they would see patients who had arrived without an appointment. Reception staff told us children and frail older patients would always be seen on the day an appointment was requested.

Comprehensive information was available to patients about appointments on the practice website and in the practice leaflet that included information about how to access care and urgent attention. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were generally satisfied with the appointments system but some patients we spoke with told us it was difficult to obtain appointments. Other comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day they contacted the practice.

Home visits were made on the same day they had been requested. Regular home visits were made by GPs and advance nurse practitioners to patients who were housebound.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy is in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handled all complaints in the practice. The practice leaflet informed patients about how to make a complaint if they needed to.

The practice staff had a system in place for handling concerns and complaints. We were shown a summary of the complaints received during the last 12 months. We saw they had been investigated, responded to and there were instances where changes had been made to prevent recurrences. Practice staff told us that the outcome and any lessons learnt following a complaint were disseminated to relevant staff and discussed during meetings. We saw that complaints were discussed during clinical meetings.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice manager told us that there was a two year written business plan but that it needed updating following the move to new premises. We were told by the practice manager staff had concentrated on the move and sorting out any resultant problems from it. We were told the practice had a vision to provide quality healthcare. It was evident that senior staff had continued to search for further areas of improvement on an on-going basis. Senior staff had developed a positive relationship with the Patient Participation Group (PPG). The members of the PPG we spoke with told us that they had communicated with patients well throughout about the recent changes.

We spoke with 14 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. They told us they were encouraged to make suggestions that led to improved systems and patient care.

Governance arrangements

Clinical governance meetings were held every six weeks, all practice staff were encouraged to attend. One of the routine agenda items was case reviews. GPs would present a varied range of health conditions, how they were dealt with and explore if there were any areas where care could be improved.

There was a clear governance structure designed to provide assurance to patients and the local clinical Commissioning Group (CCG) that the service was operating safely and effectively. Senior staff regularly attended the CCG meetings to gain further insight for potential performance improvements. There were specific identified lead roles for areas such as infection control and safeguarding. Responsibilities were shared among GPs, nurses, the practice manager and other senior staff.

The practice staff held regular governance meetings. We looked at the minutes from the last two meetings and found that performance, quality and risks had been discussed and actions identified.

Leadership, openness and transparency

There was a clear leadership structure which had named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP leads for safeguarding. We spoke with 14 members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

Records demonstrated that a range of team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at meetings. For example, the practice nurse who was the lead for infection control regularly spoke about the subject and any actions clinical staff needed to take to make improvements. Staff we spoke with knew where to find policies if required to assist them in carrying out their role effectively.

The practice had a whistle blowing policy which was available to all staff.

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

The practice had an active Patient Participation Group (PPG). The PPG had carried out annual surveys and met every quarter. PPG's act as representative for patients and work with practice staff in an effective way to improve services and promote quality care. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG. The results and actions agreed from these surveys and the recordings from each meeting were available on the practice website.

We spoke with two members of the PPG. They told us practice staff worked as a team and the PPG had positive working relationships with staff. They informed us that staff made ongoing efforts to improve the quality of the service and constantly searched for ways to improve staff practices.

Management lead through learning and improvement

Staff told us that senior staff supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files including the latest recruit and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and any requests they made.

The practice manager told us they regularly checked the appointments system to ensure there were enough to meet patient demands. Most patients we spoke with and the

Are services well-led?

Good

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

comment cards we received informed us they could get appointments when they needed them but some felt availability of appointments needed to improve. Senior staff told us they were considering the options before implementing changes.

The practice had completed reviews of significant events and other incidents and shared them with staff via meetings to ensure the practice improved outcomes for patients. For example, an urgent test result had not been seen by the respective GP. A system was implemented whereby a 'buddy' GP would take on this role when the GP was absent from the practice. Another incident concerned a relatively new member of staff was not aware of the need to transfer delivered vaccines to a fridge promptly. This problem was sorted through induction and training.