Darlaston Family Practice

Quality Report

Darlaston Health Centre
Pinfold Street
Darlaston
Wednesbury
West Midlands
WS10 8SY
Tel: 0121 568 4300
Website: www.darlastonfamilypractice.nhs.uk

Date of inspection visit: 10 October 2014
Date of publication: 19/03/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We undertook a comprehensive inspection of Darlaston Family Practice on 10 October 2014. Our overall rating for the practice was good.

Our key findings were as follows:

- We found the practice to be well-led by dedicated and enthusiastic GPs with the ambition and desire to deliver high quality services and drive forward service improvement. They were supported by an experienced team of staff. It was clear from patient feedback received that there had been noticeable improvements to the service provided since the partnership began.
- Most patients found they were able to make appointments easily and if their needs were urgent they would be seen the same day. However, we did receive some comments from working patients that making appointments convenient to them could sometimes be difficult.
- The premises were purpose built and accessible to patients with mobility difficulties. Patients who were housebound were catered for to ensure they received the care they needed.
- The practice had systems in place to ensure patients who used the service remained safe. Incidents, complaints and comments received from patients were recorded and discussed with staff to ensure learning took place. Staff were aware of safeguarding procedures so that they could take appropriate action if they were concerned someone may be at risk of harm.
- The premises were well maintained and the environment was kept clean and tidy helping to minimise the risk of infection.
- Patients spoke positively about the staff and described them as caring and friendly. They told us they were treated with dignity and respect.
- Patients told us that they were listened to and communicated with in a way they understood so that they could make choices about their own healthcare.

We saw areas of outstanding practice including:

Summary of findings

- The practice provided patient centred co-ordinated care. For example patients with multiple health conditions who were listed on multiple disease registers were identified for reviews and vaccinations so that they could be all undertaken at the same time. This included patients who were identified as housebound. The practice nurse would visit housebound patients to undertake their reviews so that they would not be missed. The practice had also arranged for vaccinations for pregnant mothers to be given at the same time as their appointment with the midwife thus avoiding multiple visits to the surgery.

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

- The practice should ensure incident reports are comprehensively completed to demonstrate the robustness of the investigation of the incident and action taken. This would minimise the risks to patients in the future and prevent reoccurrence.
- The practice should introduce a formal system for managing and recording action taken in response to national patient safety alerts to ensure that those that are relevant to the practice are not missed and acted upon.
- The practice should maintain a copy of cleaning schedules carried out by its cleaning provider so that it is clear what cleaning tasks have they been carried out. Routine checks of the environment should be undertaken to ensure the cleaning is to an appropriate standard consistently and any concerns could be promptly dealt with.
- The practice should review the arrangements for holding telephone conversations of a confidential nature so that they are not overheard by other patients and visitors to the reception desk.
- The practice should develop clearer protocols and support for patients suffering recent bereavement.
- A system should be in place to ensure correspondence is handled appropriately when a patient with no fixed abode registers under their previous addresses.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated among staff to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to individual patients were assessed and well managed. Some of the arrangements to manage risks to the running of the service had not been robust. However, the practice had promptly responded to rectify any inadequacies identified during the inspection. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. NICE provides national research based best practice guidance. People's needs were assessed and care was planned and delivered in line with current legislation. This included an assessment of patients' mental capacity and the promotion of good health. Staff had received regular training appropriate to their roles. The practice could identify appraisals and the personal development plans for staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the treatment available to them. We also saw that staff treated patients with kindness and respect. Confidentiality was understood and respected by staff. We observed that staff were not always aware that conversations could be overheard at reception which compromised patients' right to privacy.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with NHS England's Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Most patients reported good access to the practice with urgent appointments available the same day. The practice had, where

Summary of findings

possible, taken action to improve access for working patients and those who were housebound as some patients had reported difficulties in securing appointments at a convenient time. The practice had good facilities and was well equipped to treat patients and meet their needs. There was evidence demonstrating that the practice responded quickly to issues raised through complaints and learning was shared with staff.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and was working towards delivering this. Staff were aware of their responsibilities in delivering a good service. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meeting had taken place. There were systems in place to monitor and improve quality and following our inspection the practice /GP partners had reviewed processes to identify and manage risk in a more robust way. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The latest nationally reported data available to us showed outcomes for conditions commonly found amongst older people were in line with other practices locally. The practice offered proactive, personalised care to meet the needs of older people in its population. We saw there were care plans in place for older people with complex care needs and that these patients had a named GP to co-ordinate their care. The practice participated in the unplanned admissions enhanced service, a scheme to avoid unplanned hospital admissions to hospital by focusing and coordinating care for the most vulnerable patients. The aim is to effectively support them in their home. An enhanced service is a service that is provided above the standard general medical service contract.

The practice was proactive and could easily identify those who needed additional support to enable them receive the care and treatment they needed. The practice nurse was given protected time to visit housebound patients to review their health conditions and ensure they received their flu vaccinations. We saw evidence that older patients were offered memory testing to detect the onset of dementia.

The practice participated in multi-disciplinary working to ensure patients with complex needs or nearing the end of life received co-ordinated care. We saw evidence of discussions with families and patients at end of their life had taken place to ensure their needs and wishes were respected. We did not however see any clear protocols for the follow up and support of recently bereaved relatives.

All staff had received training in safeguarding vulnerable adults and had contact information to refer to should they suspect a person may be at risk of harm.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. The practice had a good track record in the management of patients with long term condition. Patients with long term conditions received regular reviews to monitor their health and ensure their medicines were appropriate These were undertaken by clinical staff who maintained their skills, knowledge and received training in these areas. For those patients with the most complex needs the named GP worked with relevant health

care professionals to deliver a multidisciplinary package of care. Where appropriate, the practice would refer patients to specialist health care professionals to help manage the patient's health needs, for example health visitors and district nurses.

The practice participated in the unplanned admissions enhanced service, a scheme to avoid unplanned hospital admissions to hospital by focusing and coordinating care for the most vulnerable patients such as those with multiple conditions. There was a higher incidence of respiratory disease in the local area. Patients could request longer appointments if needed to manage their condition and there was a good range of information about various long term diseases and links to further support on the practice website.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. The practice population was younger than the national average and situated in one of the most deprived areas nationally. Staff had appropriate skills and training to help support this population group. One GP had specialist training in paediatrics including child health and the practice nurse had training to enable them to safely administer childhood immunisations.

There were systems in place for identifying and following-up children living in disadvantaged circumstances and those who were at risk of harm. The practice made use of information received to ensure that children at risk could be identified and followed up. All staff had received training in safeguarding children so that they had the knowledge and understanding to take action if they were concerned a child may be at risk of harm.

Appointments were available outside of school hours and the premises were suitable for children and babies with sufficient space for prams and buggies. We were provided with good examples of co-ordinated working with midwives and health visitors. Child health and immunisations clinics were arranged to coincide with the health visitor clinics. Immunisation rates were in line with the other practices in the Clinical Commissioning Group (CCG). With some childhood vaccines the practice was achieving a 100% uptake. Children who did not attend for their immunisations were followed up.

Flu vaccines for pregnant women were available at the same time as midwife clinics to avoid the need for multiple visits to the practice.

There was arrange of health information and promotion of health screening checks available on the practice website which reflected the needs for this age group.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified. The practice had adjusted the services it offered, where possible, to ensure these were accessible, flexible and offer continuity of care. For example patients could book and cancel appointments and request medication online via the practice website. Telephone consultations were also available for patients who found it difficult to attend the practice and did not need to be seen face to face.

Extended opening hours were not available at the practice and there was some feedback in comment cards from working age patients about the difficulty in accessing appointments. The practice opened until 6.30pm on three days each week.

The practice offered health checks for patients between the ages of 40 to 74 years. Cervical screening to help detect early changes which may need treatment.

The practice was making good progress with targets for blood pressure checks and recording the smoking status for patients in this age group helping to identify patients who may be at increased risk of developing health conditions. We saw that 90% of patients in the working age group had received a blood pressure check in the last year.

There was a range of health information and promotion of health screening checks available on the practice website which reflected the needs of this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held registers of patients living in vulnerable circumstances, for example the practice had a register for patients with learning disabilities and had undertaken annual health checks for 95% of the patients on this register.

The practice offered longer appointments for people who needed them, and there was clear guidance to staff as to the patient groups who should be offered one, for example patients with learning disabilities. This was advertised in the practice so that patients were aware.

Summary of findings

The practice was able to identify patients who were housebound or carers and used this information to ensure these patients received the care and treatment they needed in a patient centred way. For example patients with multiple health conditions had appointments coordinated.

Homeless patients could access healthcare at the practice. Staff gave us an example of when they had registered a patient with no fixed abode under their previous addresses. We did not see that there was a system in place to ensure correspondence was handled appropriately to minimise the risk of post being delivered incorrectly.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Information was regularly shared with other health care professionals and good working relationships were evident to ensure vulnerable patients were identified to receive the treatment, care and support they needed. Staff had access to information and contacts for reporting safeguarding concerns about vulnerable patients to the relevant agencies.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice held a mental health register and was able to demonstrate that patients on this register were receiving comprehensive annual physical health checks. We saw from data available that all patients on the dementia register at the practice had been reviewed in the last 12 months and that dementia screening was in place.

The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health. The practice hosted a weekly clinic with the community psychiatric nurse. This facilitated good links with the mental health services to help signpost patients to other services and discuss those patients who may require a mental health referral. One of the GP's had undertaken additional training in substance misuse. Longer appointments were allocated to patients with poor mental health as it was recognised some patients needed more time to discuss their health needs.

Summary of findings

What people who use the service say

We spoke with nine patients who were registered at the practice; this included two members of the practice's Patient Participation Group (PPG). The PPG is a way in which patients and practices can work together to improve the quality of the service provided. We also reviewed the 48 comment cards we had left for patients to complete.

The feedback and comments we received about the practice were mostly positive. The majority of patients told us that they were happy with the service provided at the practice. Patients spoke highly of all the staff (GPs, nurses and reception staff). They described staff at the practice as caring and friendly. Patients told us that they felt listened to and were treated with dignity and respect.

Five patients commented on how much the practice had improved since the new GPs had taken over. We received two negative comments where patients felt they had not received the help they needed. Five patients although happy with service received told us that it was sometimes difficult making an appointment. Three of these comments were from patients who worked.

We also looked at feedback from patients and others about this practice that had been recorded on the NHS Choices website. There had been 23 comments from patients dating back to September 2013. The majority of comments received were positive. The overall rating given to the practice on the NHS choices website was four out of a possible five stars based on 25 ratings by patients.

Since the new partnership had commenced at the practice there had been one patient survey. This was carried out in December 2013 and sent to 50 patients. The findings from this survey indicated that patients were generally happy with the care and support they received from the GPs nurses and reception staff.

Areas for improvement

Action the service SHOULD take to improve

- The practice should ensure incident reports are comprehensively completed to demonstrate the robustness of the investigation of the incident and action taken. This would minimise the risks to patients in the future and prevent reoccurrence.
- The practice should introduce a formal system for managing and recording action taken in response to national patient safety alerts to ensure that those that are relevant to the practice are not missed and acted upon.
- The practice should maintain a copy of cleaning schedules carried out by its cleaning provider so that it is clear what cleaning tasks have they been carried out. Routine checks of the environment should be undertaken to ensure the cleaning is to an appropriate standard consistently and any concerns could be promptly dealt with.
- The practice should review the arrangements for holding telephone conversations of a confidential nature so that they are not overheard by other patients and visitors to the reception desk.
- The practice should develop clearer protocols and support for patients suffering recent bereavement.
- A system should be in place to ensure correspondence is handled appropriately when patient with no fixed abode registers under their previous addresses.

Outstanding practice

- The practice provided patient centred co-ordinated care. For example patients with multiple health conditions who were listed on multiple disease registers were identified for reviews and vaccinations so that they could be all undertaken at the same time. This included patients who were identified as housebound. The practice nurse would visit housebound patients to undertake their reviews so

that they would not be missed. The practice had also arranged for vaccinations for pregnant mothers to be given at the same time as their appointment with the midwife thus avoiding multiple visits to the surgery.

Darlaston Family Practice

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 practice manager specialist advisor and a second CQC inspector.

Background to Darlaston Family Practice

Darlaston Family practice was formed by two GP partners in May 2013. The practice provides General Medical Services to a population of approximately 2700 patients. It is located in Darlaston Health Centre which is shared with several other practices. The area served by the practice is ethnically diverse and has high levels of deprivation. The practice population is younger than the national average.

The practice staff includes two male GPs who are both partners and one full time female practice nurse. The practice is also a training practice for final year medical students although there were none at the time of the inspection.

The practice has opted out of providing out of hours services and these are delivered by another provider. Details for contacting the out of hours service are available in the practice leaflet and website and the answer phone message.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit

Detailed findings

on 10 October 2014. During our visit we spoke with a range of staff including both GP partners, the practice nurse and three reception staff. We also looked at a range of documents that were made available to us relating to the practice.

We spoke with patients who visited the practice and observed how staff interacted with them. We reviewed comment cards where patient and members of the public shared their views and experiences of the practice. We spoke with two members of the practice's Patient Participation Group (PPG). The PPG is the way in which practices can work with patients to improve the services provided.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. These included reported incidents, comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns and how to report incidents and near misses.

Both GPs routinely received national patient safety alerts but did not have a formal system for discussing and recording any action that was taken in response to them. Patient safety alerts are issued when potentially harmful situations are identified and need to be acted on. One GP told us that they met with the practice nurse for clinical meetings where they would raise awareness and discuss any relevant safety alerts. The practice nurse confirmed that this was the case.

We reviewed safety records and incident reports and minutes of meetings where such issues were discussed for example, the management of a complaint. Complaints were managed effectively.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred since May 2013 and these were made available to us. We saw that there had been two reported incidents, neither of which had occurred within the last 12 months. Staff told us that any feedback or learning from incidents would take place at the practice meetings, minutes available confirmed this.

Members of staff that we spoke with were aware of the systems in place for reporting incidents and told us that they were encouraged to do so. Incident forms were available to staff on the practice systems. Once completed these were reviewed and any action necessary was taken by one of the GPs. We looked at the two incidents that had been recorded. We found that the incident reports and action taken were not comprehensively completed. However, the GP we spoke with was able to speak in detail about the incidents and action that had taken place as a result. For example where incorrect information had been given to a patient appropriate action had been taken by the practice.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. All staff we spoke with told us that they had received training in safeguarding. We saw certificates for the three clinical members of staff which showed us that they were trained to a level 3 (the highest level) for safeguarding children. Members of staff we spoke with were aware who the safeguarding lead was at the practice and said they could speak to them if they had any concerns that someone may be at risk of harm. There were detailed safeguarding policies in place for children and vulnerable adults to support staff to identify and report abuse. We saw that staff had easy access to contact details for the relevant agencies who investigate safeguarding concerns. Contact details were also included in the information pack for locum doctors.

There was a system to highlight vulnerable patients on the practice's electronic records. We saw examples where children were subject to child protection plans. We found that the GPs were appropriately using the required codes on the electronic patient record system to ensure patients at risk could be identified. For example we saw systems for recording domestic abuse and children who were considered below the threshold for a safeguarding referral but where the GP had some concerns about their welfare. This enabled staff to be vigilant when patients attended for appointments. We were given an example by one member of staff of concerns about a patient being followed up which demonstrated to us that the systems in place to safeguard those who were vulnerable to harm or abuse were robust.

A chaperone policy was in place which provided guidance as to the role and use of chaperones in the primary care setting. Patients were alerted to the chaperone policy via notices displayed in the waiting area. Both the nurse and reception staff acted as a chaperone and understood their responsibilities when acting as a chaperone. Training records confirmed that reception staff who undertook chaperone duties had received training for this.

Good

Are services safe?

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines that needed to be stored at specific temperatures were stored in line with the manufacturer's instructions. This was being followed by the practice staff.

Processes for checking emergency medicines (including oxygen) were in date and suitable for use were not robust. The practice nurse told us that they checked the emergency medicines, and we found that they were in date and fit for use. However, there was no formal records to confirm they were checked regularly to ensure that the medicines were present and in date. We alerted the practice to this and within two working days they advised us of the systems that they had put in place for checking the oxygen and emergency medicines. We have not been able to independently verify these systems are in place.

We saw that there had been reviews of prescribing at the practice. For example we saw that there had been a review of antibiotic prescribing with the aim of reducing unnecessary prescribing. The findings from this review showed there had been a reduction over the last 12 months and that the practice compared well with other practices in the Clinical Commissioning Group (CCG) area.

Vaccines were administered by the practice nurse. We saw from their training records that they had received appropriate training to do so.

Repeat prescriptions were authorised by the GPs. There were disease specific protocols for patients on high risk medication. We saw from examples shown that patients on high risk medications who required monitoring through regular blood tests were appropriately managed.

There were appropriate arrangements in place for the storage of prescription pads. Prescription pads are controlled stationary because they could be used to unlawfully obtain medicines. We saw that prescription pads were kept locked away and logs maintained so that those used could be easily accounted for.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. The practice was well maintained making it easier to keep clean. Cleaning was carried out by an external provider for the whole of the health centre. No specific cleaning logs were maintained by the practice as to what cleaning was carried out by this provider or any spot checks to ensure the standard of cleaning was maintained. The nurse told us that they were responsible for cleaning their own room and maintained records of equipment cleaned including the cleaning of the privacy curtains around the examination couches. The practice told us that the cleaning provider did their own monthly audit but did not have a copy of this. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Appropriate hand washing sinks with hand soap and hand towel dispensers were available in treatment rooms to help minimise the risk of cross infection.

The practice nurse was the lead for infection control at the practice and had undertaken training in this area enabling them to provide advice to other members of staff. Infection control training had also be undertaken by all the administrative staff within the last year. We saw evidence that an infection control audit had been carried out by the local Clinical Commissioning Group (CCG) in June 2013 and the practice had scored 96% in this. There were four actions identified through the audit. We saw evidence that all the actions had been implemented.

An infection control policy and supporting procedures were available for staff to refer to, which supported staff to implement infection control measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. There was also a policy for the management of clinical waste and needle stick injury. We saw appropriate arrangements were in place for the storage and removal of clinical waste.

During the inspection we had found records of staff immunisation and their Hepatitis B status had not been kept up to date. There were no risk assessments for practice staff that had not received a Hepatitis B vaccination. We informed the practice of this who immediately rectified the situation. Within two working days we had received evidence that one member of staff had received their booster vaccination and risk assessments had been put in place for members of staff whose duties were identified as low risk. This ensured records were up to date so that any risks to patients or members of staff could be minimised.

Legionella testing (a germ found in the environment which can contaminate water systems in buildings) had been carried out. This was carried out by an external provider for the whole health centre. We saw evidence that the checks had been done to reduce the risk of infection to staff and patients.

Equipment

We saw records to show that equipment used at the practice for the purposes of diagnostic examinations, assessments and treatments were regularly maintained. We saw records that confirmed equipment had been serviced and calibrated and undergone electrical safety testing within the last 12 months. Stickers displayed on equipment indicated the last testing date enabling staff to keep a note of when re-testing was due.

The practice kept copies of the manufacturer's instruction manuals for equipment so that staff could refer to them if needed.

Staffing and recruitment

There had been one new member of staff recruited since the new partnership had started. Records for this person contained evidence that appropriate recruitment checks had been undertaken prior to their employment. For example, proof of identification, references, qualifications, 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 clinical and non-clinical staff.

We saw from a sample of staff records that criminal records checks had been undertaken to ensure staff were suitable to work with vulnerable people. For relevant staff, checks were also undertaken to ensure that they were registered with their appropriate professional bodies and had professional indemnity. The practice had a signed agreement with a locum agency to provide locum GPs when needed. They told us that the agreement did not specifically set out what checks the agency made however, we saw that they kept their own records such as DBS certificates, professional indemnity and relevant training for the locum staff they had used.

There were no current vacancies at the practice. The GPs told us that the current staffing levels were appropriate to the list size as the practice was establishing itself but may need to be reviewed in the future. The GPs advised us that when they first took over the practice they had looked at the data available on patient access to determine the GP cover required.

There was an agreement among administrative staff that only one person went on leave at any one time to ensure there were sufficient staff available.

Monitoring safety and responding to risk

The practice had arrangements through systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The building in which the practice operated was not owned by them. Maintenance of the building and environment was carried out by the owners as part of the contract. We found the practice premises were well maintained.

The practice did not keep any specific risk logs but would discuss concerns and issues as they arose. Regular staff meetings were used to discuss issues which affected the practice. The practice also had a health and safety policy which staff were able to access.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage medical emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment. Records were kept confirming that the automated external defibrillator was checked weekly to ensure it was in working order. We found the emergency medicines, oxygen and equipment were in date and fit for use.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of anaphylaxis and asthma. Although there is currently no prescriptive list as to what emergency medicines a GP practice should hold we noticed that the practice did not routinely hold stocks for hypoglycaemia, chest pain or suspected meningitis these are medicines commonly required in medical emergencies.

The practice had a service continuity plan for dealing with emergencies that may impact on the daily running of the

Good

Are services safe?

practice such as power failure to the building. We noticed that the plan contained very little detail to support staff in managing such situations. We informed the practice of this and within two working days they provided us with an update of their business continuity plan. This included more comprehensive detail as to the action staff should take in different situations to ensure potential disruption to the service was minimised.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance and accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. NICE provides national guidance and advice to improve health and social care. We saw evidence that when new guidelines were disseminated, the implications for the practice's performance and patients were discussed. Evidence we reviewed confirmed that actions taken in response to the guidance were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

Evidence seen from a sample of 10 patient records confirmed that patients with long term conditions were appropriately supported and their care and treatment followed appropriate guidance. There was recognition that the prevalence of respiratory diseases was high in the practice population and training of clinical staff reflected this need. We saw personalised care plans in place for patients over the age of 75 years. A system had recently been introduced for the follow up of patients with personalised care plans to be contacted within 72 hours of discharge from hospital and we saw evidence of this.

The practice used comparative data available to see how it was performing and used this to identify areas for action. The GPs told us that they were aware that their gynaecology referral rates were slightly higher than average, this was because some female patients did not want to be examined by the male GPs. We were also shown some comparative data of the practice's performance for antibiotic prescribing which compared well to similar practices in the CCG locality and nationally.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs collaborated this. There was an understanding of patients cultural and faith and staff were able to give examples as to how these could be met.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patient care and outcomes. It participated in the Quality Outcomes Framework (QOF), a national performance measurement tool which rewards practices for how well they care for patients. We reviewed some of the QOF data and found that the practice's performance was in line with other practices nationally.

The GPs at the practice were very aware of their performance against QOF. They had achieved all QOF targets for the previous year and were able to show us how they were progressing well against some of the targets for this year. For example, 100% of females on the mental health register had already received their cervical smear in the last five years which was better than the national average. The GPs told us how they were proactively working to achieve targets in advance of the year end and had systems in place to recall patients on the chronic disease registers for a review of their health condition.

The practice was aware of their performance and had put in place measures to try and improve performance where needed. For example the percentage of pregnant women who had received their flu vaccination. They had introduced systems so that when patients came to see the community midwife they could receive the flu vaccination on the same day.

The practice had a system in place for completing clinical audit cycles. Examples from three clinical audits undertaken included reviews of diabetes checks and hypertension reviews. The practice was able to demonstrate changes resulting since initial audits. For example improvements in the care of patients with poor mental health.

Effective staffing

Practice staffing included medical, nursing, and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support. One GP had a diploma in paediatric and child health, and both GPs had the required hospital paediatric training. As a training practice the GPs provided support for final year medical students. The GPs were up to date with their yearly continuing professional development requirements. GPs are required to be appraised annually and every five years undertake a fuller

Good

Are services effective?

(for example, treatment is effective)

assessment called revalidation. This is the mechanism by which doctors demonstrate their fitness to practice. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England. We saw evidence to confirm that both GPs had undergone annual appraisals and had dates for their revalidation.

All staff undertook annual appraisals which provided staff with the opportunity to discuss their performance and learning needs. Staff interviews confirmed that the practice was proactive in providing training and support for relevant courses, for example we saw that mental health training had been discussed and completed by the practice nurse. Minutes at practice meetings confirmed administrative staff had received refresher training from the nurse in using the automated external defibrillator after this had been requested. As the practice was a training practice, the medical students had access to the GP partners for support and were supervised throughout the day.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, the practice nurse had received training in the administration of vaccines, cervical cytology and wound management. They had also received updates for seeing patients with long-term conditions such as asthma or chronic obstructive pulmonary disease.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries from the out of hours' providers and the 111 service were received both electronically and by post. The practice had processes in place for receiving, reviewing and taking action in response to the information received. The GPs told us that they reviewed information received within 24 hours and we saw from the patient record system that the practice was up to date with this. We looked at a sample of patient information that had been recently received and saw that they had been acted on appropriately and without delay.

The practice was commissioned for the new unplanned admissions avoidance enhanced service. This is a scheme to avoid unplanned hospital admissions to hospital by focusing and coordinating care for the most vulnerable patients. The aim of this scheme is to effectively support these patients in their home. An enhanced service is a service that is provided above the standard general medical service contract. We saw that patients at high risk of unplanned admissions had been identified by the practice and examples of personalised care plans that had been put in place for them.

The practice held multidisciplinary team meetings every three months to discuss the needs of patients with complex needs and those with end of life care needs. The meetings were attended by both GPs, practice nurse, practice secretary, palliative care nurses, community matron and district nurses.. We saw minutes from these meetings.

Information sharing

The practice told us that it used the Choose and Book system for making the majority of patient referrals. The Choose and Book system enables patients to choose which hospital they would prefer to be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

The practice had systems in place to provide staff with the information they needed. The practice used the EMIS electronic patient record system to coordinate, document and manage patients' care. Staff were competent in its use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

We also saw evidence that staff shared information with other services for example special patient notes. These were notes for patients who had complex health needs or were vulnerable and may need to contact the out of hours service provider. We saw evidence of reports for case reviews where the GPs shared important information with relevant professionals.

Consent to care and treatment

There was a practice policy for documenting consent for specific interventions. The practice did not undertake any minor surgery however, we saw appropriate consent had been recorded for vaccinations.

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. Although we did not see any formal training records for this clinical staff advised us that they had received training in this area and understood the key

Good

Are services effective?

(for example, treatment is effective)

parts of the legislation. The practice did not have any specific examples to demonstrate how best interest decisions were made for a person who lacked capacity to consent.

Health promotion and prevention

The practice met regularly with the local Clinical Commissioning Group (CCG) to discuss the implications and share information about the needs of the practice population.

The practice offered all new patients registering with the practice a health check with the practice nurse. The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. This helped to identify any early stage disease. Practice data showed that 48.5% of patients in this age group had taken up the offer of the health check in the last 12 months. If there were any concerns arising from the health check the practice nurse told us that they would notify the GP. The GP would either see the patient straight away or ask the patient to make an appointment to see them.

We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by co-ordinating care with other health professionals with whom they could discuss patient needs such as the health visitor clinics.

The practice had systems for identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities. There were 14 patients on the learning disabilities register and all had received an annual physical health check in the last 12 months. The practice had also identified the smoking status of 95% of patients over the age of 16. The practice nurse offered basic smoking cessation support to patients but would usually referred patients to another provider for this service.

At the time of our inspection the practice had reached 87% uptake for cervical screening and was already achieving its performance target for 2014/2015. There was a process in place for following up patients who did not attend for cervical smear tests by letter.

The practice offered a range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for childhood immunisations was similar to other practices in the CCG area and in some cases higher. The practice nurse explained how they had followed up a patient who had not turned up for their immunisation. The practice had worked flexibly to try and encourage a high uptake of the flu vaccinations such as making them available at the same time as other clinics. Although the practice did not administer the yellow fever travel vaccine they held lists of places that did and could advise patients where to go.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, an in house practice survey of 50 patients undertaken in conjunction with the practice's Patient Participation Group (PPG) and comments received on the NHS choices website. The evidence from all these sources showed patients were satisfied with how they were treated and that practice staff treated them with compassion, dignity and respect. The national patient survey 2013 showed that the practice was similar to other practices nationally in terms of overall patient experience and with the GP treating them with care and concern. The practices own patient survey found all but one patient had found the standards of care as good or excellent. We found comments from patients on the NHS choices website were mostly positive and had become increasingly so over time. The practice was rated four out of five stars on the NHS choices website based on comments received.

Patients completed Care Quality Commission (CQC) comment cards to provide us with feedback on the practice. We received 48 completed cards. The majority of these were positive about the service patients received. Patients spoke very highly of all the staff (GPs, nurses and reception staff). They described staff at the practice as caring and friendly. Patients told us that they felt listened to and were treated with dignity and respect. Five patients commented on how much the practice had improved since the new GPs had taken over. We also spoke with nine patients, this included on the day of the inspection and by telephone prior to the inspection. All told us that they were happy with the care received at the practices and would be happy to recommend it to others.

We also received from the comment cards two that were less positive where patients felt they had not received the help they needed. Five patients although happy with service received told us that it was sometimes difficult making an appointment. Three of these comments were from patients who worked.

We saw that consultations and treatments were carried out in the privacy of a consulting room and conversations taking place within them could not be overheard by others. We observed staff knocking on consultation room doors and waiting before entering. Privacy curtains were available around examination couches so that patient's privacy and dignity could be maintained during examinations, investigations and treatments. Feedback from patients confirmed that they were treated with dignity and respect.

None of the patients we spoke with or feedback received indicated that they had any concerns about patient confidentiality. Staff demonstrated an awareness of protecting patient confidentiality and we saw that confidentiality agreements had been signed when new members of staff had started work at the practice. Reception staff told us that if patients wanted to speak in private they would offer a room away from the waiting area. However, there were no notices available to make patients aware that they could speak in private if they wished. We also noticed that telephone conversations where confidential information was discussed with patients could be overheard at the reception desk.

The practice was sensitive to the needs of patients whose circumstances may make them vulnerable and supported them to access the service. For example the practice offered extended appointment times for patients who needed them. The information for this was displayed in the waiting area. We also saw the practice protocol which showed which patient groups should be given longer appointments. This included patients with learning difficulties, dementia and mental health issues. Members of staff we spoke with were aware of these protocols. The practice told us that they did accept patients with no fixed abode and had in the past used their previous address to register.

The GPs told us that they were aware that they had a higher referral rates for gynaecology. They were aware and sensitive to the fact that as two male GPs some female patients did not want to be examined by them and so they referred patients to ensure their health needs were met.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed responses from patients to questions about their involvement in planning and making decisions about their care and treatment were similar to other practices. For

Good

Are services caring?

example, data from the national patient survey showed 77% of practice respondents said the GP involved them in care decisions and 80% felt the GP was good at explaining treatment and results to them.

Patients we spoke with as part of our inspection told us that their health issues were discussed with them and they felt involved in decision making about the care and treatment they received. Patient feedback from comment cards received reiterated these views. Patients also told us they felt listened to and that information was explained to them in a way they could understand to help them make decisions about their own health care. Feedback regarding the practice nurse was particularly positive.

Staff told us that translation services were available for patients who did not have English as a first language so that they could understand and be involved in decisions about their care. We saw notices in the reception areas informing patients this service was available. Staff told us and we saw from the practice leaflet that one GP spoke a second language and some patients preferred to see them.

We were shown examples of anonymised care plans that for patients over 75 years which demonstrated that the patients had been involved in plans about their care. Discussions with patients regarding end of life had been recorded so that staff were aware of their needs and wishes.

Patient/carer support to cope emotionally with care and treatment

We spoke with one GP about how they supported patients emotionally with their care and treatment. They showed us a range of up to date information available to help patients to access support services to help the patient manage their health conditions. The practice's website contained information and links for patients in relation to various long term conditions. Patients with complex health needs were seen as part of the multi-disciplinary team meetings which enabled a more co-ordinated approach to the patients wider health needs.

Patients who were housebound and also carers were identified on their notes. This enabled staff to ensure their care needs were supported. For example the practice nurse was given protected time to undertake home visits to administer the flu vaccination for patients who could not get into the practice.

Although the GPs told us that they contacted families following the death of a patient we did not see any specific support for signposting those bereaved to support services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice understood the population it served and was responsive to their patients needs. The practice made good use of information available to identify areas for improvement and take action where needed. For example, the GPs told us how they were working with pregnant women to try and improve the uptake of the flu vaccine. The practice had arranged that pregnant women could receive the flu vaccine on the same day they came to see the community midwife.

The practice was participating in the unplanned admissions enhanced service, a scheme to avoid unplanned hospital admissions to hospital by focusing and coordinating care for the most vulnerable patients. The aim is to effectively support them in their home. An enhanced service is a service that is provided above the standard general medical service contract. We saw that the practice had used a risk stratification tool to identify patients who would most benefit from this.

The practice worked collaboratively with other services and shared information to ensure patients received co-ordinated care. The practice had implemented the gold standards framework for end of life care. We saw evidence of multi-disciplinary meetings with community services to discuss the patient and their families care and support needs and care plans were in place to help deliver this. We also saw information shared about vulnerable/complex patients with out-of-hours services should the patient need to contact them when the surgery was closed.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of services. We saw that the practice had a register for patients with learning disabilities. There were 14 patients on the register and all had received a physical health check in the last 12 months. Longer appointments were available to patients where needed such as those with learning disabilities, dementia or mental health issues.

We spoke with staff about how they supported patients with no fixed abode to receive the health care they needed. Staff told us that they had used a previous address to register someone in these circumstances but may need to consider systems to prevent post being sent to this address.

Staff had access to information about translation services and one of the GPs spoke a second language which was recorded on the practice leaflet. We saw an example where a patient's need for an interpreter had been recorded on their records. This enabled patients whose first language was not English to receive care and support at the practice. Information available on the practice website could be translated into a range of languages.

The practice was located in purpose built shared health centre and was accessible to patients with physical or mobility difficulties. There were designated parking spaces for people with limited mobility and accessible toilet facilities. The entrance to the health centre was via a ramp and automatic doors. Consulting rooms were situated on the ground floor. There was a low area at the reception desk which enabled patients who used wheelchairs to speak to reception staff more easily.

The practice supported patients on long term sick leave to return to work. We saw an example of a medical certificate which advised the patients what they needed to do to recover.

Access to the service

Appointments were available between 9am and 1pm and between 4pm and 6.30pm Monday, Tuesday and Friday, 9am to 5pm on Wednesday and 9am to 1pm on a Thursday. Routine appointments could be booked ahead with some appointments reserved as urgent same day appointments. Telephone consultations were also available where appropriate. There was a number available on the practice answerphone informing patients where they could seem medical assistance when the practice was closed.

Comprehensive information was available to patients about appointments in the practice leaflet and website. This included information about home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Information to access the out-of-hours service was provided to patients as an answerphone message when telephoning the practice number and in the practice leaflet.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients were generally satisfied with the appointment system. Results from the national patient survey 2013 showed that satisfaction with the appointment system was similar to that seen nationally. However, we did receive comments from five patients during our inspection who told us that it was sometimes difficult making an appointment. Three of these comments were from patients who worked.

The practice did not provide extended opening hours. Earlier in the year they had provided additional opening hours on a Sunday, which was an enhanced service different to the extended opening hours, but had to stop when funding for this ceased. There had been patient feedback from the PPG requesting this service.

Listening and learning from concerns and complaints

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

Patients were alerted to the complaints system through a notice displayed in the waiting area. However, the notice signposted the patient to the reception where the complaints leaflet was held behind the desk and had to be requested. This could prevent some patients from raising their concern or complaint.

The complaints leaflet set out the process for patients to follow including where to go if they are not satisfied with the response received from the practice. None of the patients we spoke with during our inspection had ever made a complaint about the practice or had needed to.

We looked at the two complaints that had been received in the last 12 months. Only one was a formal written complaint. We saw that the complaints had been investigated and responded to appropriately and in a timely manner. As there had been only two complaints received there were no themes or trends identified but lessons learnt from the individual complaints had been acted upon.

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 was a newly established partnership. The two GPs in the partnership were clear about their vision for the practice and told us about their future plans although had not formally documented this. They wanted to be recognised as a strong practice and had already established themselves as an undergraduate teaching practice for final year medical students from the University of Birmingham, and had applied to Health Education West Midlands to become a postgraduate training practice for doctors. The GPs demonstrated throughout the inspection that they were proactive in their approach to delivering services and improvements in the quality of service provided. They were flexible and willing to try out new approaches to meet the needs of the practice population. Patient satisfaction in the practice was showing an upward trend.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to all staff on the computer. The policies and procedures were kept up to date and staff had signed a document to acknowledge their presence.

The practice used the Quality and Outcomes Framework (QOF) to measure performance. The practice performed well against QOF targets and had scored close to maximum points last year. The practice was making good progress towards achieving the QOF targets again this year and was aiming to meet them early.

The practice undertook and completed audits in areas such as care plans for patients on the mental health register and checks of patients with diabetes. Some of these were still in progress but this was consistent with the age of the partnership.

Performance and quality issues were discussed as part of the practice meetings. We saw minutes from these meetings and saw that performance and quality issues were discussed with staff. However, we found that arrangements for managing risks to the service were not robust. The GPs told us that risks were discussed at the partners meeting but this was not formally documented.

Following our inspection the practice had taken action to review risks to service continuity such as staffing or damage to the premises and we saw that copies of these risk assessments were now in place.

Leadership, openness and transparency

There was clear leadership at the practice through the two GP partners. At the time of our inspection the practice did not have a practice manager and we were told this was a conscious decision given the stage of the practice's development. We did not find the absence of a practice manager to have an adverse impact on the running of the service but this may need to be reviewed as the practice list size increases. The practice had inherited from its predecessor an experienced administrative team and practice nurse. Staff told us that they were well supported. There was a healthy respect between all team members and staff spoke positively about each other.

We saw that practice meetings were held regularly and all staff were invited to attend. From agenda items discussed we saw that staff were made aware of what was going on in the practice. For example discussions about the new enhanced services and flu campaigns took place which helped with the smooth running of the service. Staff told us that the GPs were very approachable and that they could raise issues if needed with them.

We saw examples of policies and procedures to support staff in their work and improve services provided. For example there was a blame free culture policy and whistle blowing policy to support staff to raise concerns they may have. We saw evidence to show that processes were appropriately followed in the management of poor staff performance, including increased supervision.

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

The practice had gathered feedback from patients through patient surveys. A comments box was also available in the waiting area but the box was empty and staff told us that there had been no comments left recently. We looked at the results of the latest national patient survey, only 67.3% of patients were satisfied with the opening hours, which was worse than the national average. As a result of feedback received we saw the practice had taken action to improve access to appointments. For example the number of appointments available had increased from 130 to 180 each week, online booking and telephone consultations

Are services well-led?

Good

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

were made available and text messaging to remind patients to attend their appointment was used. The practice had also opened for a short period on a Sunday until funding for this had ceased.

We saw that the practice had acknowledged and responded to feedback from patients which had been left on the NHS choices website. These were sometimes detailed responses which showed that the feedback raised had been considered and reflected upon.

The practice had an active patient participation group (PPG) with approximately 10 members. Patient representation on the group included patients from various population groups in terms of age, ethnicity and disability. The group met approximately every six months and had been involved in the development and analysis of the last patient survey. We spoke with two members of the PPG who told us that both clinical and administrative practice staff attended these meeting and were always willing to listen. The practice advertised for new members on the practice website and by notices in the waiting area. Information about issues discussed and the patient survey results were shared with patients through the practice website.

The practice gathered feedback from the staff generally through meetings, appraisals and informal discussions. Staff that we spoke with told us that they felt listened to and gave examples such as requests for specific training which had been provided.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and support given. We looked at training records and saw that staff had received regular training to keep their skills and knowledge up to date. We looked at two staff files and saw that appraisals provided an opportunity for staff to discuss their training needs and achievements over the previous year.

Practice meetings provided opportunities for learning and discussion. Significant incidents and complaints were shared with staff to ensure the practice improved outcomes for patients.