Dr David Mackenzie Bush

Quality Report

2a Coalway
Penn
Wolverhampton
West Midlands
WV3 7LR
Tel: 01902 333408
Website: www.pennsurgery.co.uk

Date of inspection visit: 28 January 2016
Date of publication: 21/03/2016

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr David Mackenzie Bush practice on Thursday 28 January 2016. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. There was an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by the management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the Duty of Candour.

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 providing safe services. There was an effective system in place for reporting and recording significant events. Lessons were shared to make sure action was taken to improve safety in the practice. Patients affected by significant events received an apology and were told about actions taken to improve care. The practice had systems, processes and practices in place to keep patients safe and safeguarded from the risk of abuse. Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services. Data from the Quality and Outcomes Framework showed patient outcomes were at or above average for the locality and compared to the national average. Staff assessed patients' needs and delivered care in line with current evidence based guidance. Clinical audits demonstrated quality improvement. Staff had the skills, knowledge and experience to deliver effective care and treatment. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services. Data from the National GP Patient Survey showed patients rated the practice higher than others for aspects of care. For example:

- 98% said the GP was good at listening to them compared to the local Clinical Commissioning Group (CCG) average of 84.5% and national average of 88.6%.
- 95% said the last GP they spoke to was good at treating them with care and concern (CCG average 80.3%, national average 85.1%).
- 90.5% said the last GP they saw was good at involving them in decisions about their care (CCG average 76.8%, national average 81.4%).

Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. For example, the development of a service that would be responsive to supporting care homes with nursing. A review of the service demonstrated improvements in care, reductions in hospital admissions and safer prescribing for this group of patients.

The practice had good facilities and was well equipped to treat patients and meet their needs.

Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Urgent appointments were available the same day. Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by the management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. The practice was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active. There was a strong focus on continuous learning and improvement at all levels.

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 practice offered proactive, personalised care to meet the needs of the older people in its population. The practice offered home visits and urgent appointments for those older patients with enhanced needs. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice had a proactive working relationship with nursing care homes. There was effective communication between the practice and care home staff and visits to the homes were made when requested.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Performance for diabetes assessment and care was slightly above the national average (93% as compared to the national average of 89.2%). Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Data showed that 75.22% of patients on the practice register had had an asthma review in the last 12 months. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw positive examples of joint working with midwives and health visitors. The practice's uptake for the cervical screening programme was 80.56%, which was comparable to the national average of 81.83%.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services, extended hours as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients with a learning disability and carried out annual health checks for these patients with the support of the community learning disability nursing team.

The practice provided a service to patients who suffered domestic abuse. Staff were aware of their responsibilities regarding confidentiality, information sharing, documentation of safeguarding concerns and how to contact relevant agencies. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff had been trained to recognise signs of abuse in vulnerable adults and children.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The data showed that 91.67% of patients on the practice register who experienced poor mental health had a comprehensive agreed care plan in the preceding 12 months. This was comparable to the national average of 88.47%. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. The practice regularly worked with multi-disciplinary teams in the case management of people who experienced poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 85%, which was comparable to the national average of 84.01%. Staff had a good understanding of how to support people with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results published on 2 July 2015 showed the practice was performing above the local and national averages in most areas. A total of 313 surveys (6.3% of patient list) were sent out and 102 (32.6%) responses, which is equivalent to 2% of the patient list, were returned. Results indicated the practice performance was comparable to other practices in most aspects of care, which included for example:

- 82.6% found it easy to get through to this surgery by phone compared to the local Clinical Commissioning Group (CCG) average of 72.8% and a national average of 73.3%.
- 82.5% were able to get an appointment to see or speak to someone the last time they tried (CCG average 82.1%, national average 85.2%).
- 94.6% described the overall experience of their GP surgery as fairly good or very good (CCG average 82.1%, national average 84.94%).
- 85.02% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 70.5%, national average 79.11%).

As part of our inspection we also asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received 37 comment cards which were overall positive. Patients said that this was a good practice, staff and GPs spoke nicely, were very caring, respectful and they listened. Patients said that they could not recall a negative experience and they received good after care following referral for treatment. The main concerns raised by patients were about the waiting time at the appointment to see the GP.

We also spoke with three patients on the day of our inspection, which included two members of the patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. Their comments were in line with the comments made in the cards we received. The practice monitored the results of the friends and family test monthly. Information presented by the practice showed that 80 responses had been received for the period March 2015 to December 2015. The results showed that of the 80 responses, 52 (65%) patients were extremely likely to recommend the practice to friends and family if they needed similar care or treatment and two (2.5%) patients were unlikely to recommend the practice.

Dr David Mackenzie Bush

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector**.**The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Dr David Mackenzie Bush

Dr David Mackenzie Bush practice (also known as Penn Surgery) is located in one of the less deprived areas of Wolverhampton. The practice provides medical services to approximately 4,954 patients. The practice has a higher proportion of patients between the ages of 40 to 85+ years compared with the practice average across England. There is a lower practice value for income deprivation affecting children and older people in comparison to the practice average across England. The practice has a higher percentage of patients with a long standing health condition and also a higher percentage of nursing home patients than the practice average across England.

The practice staff team consists of a principle GP and three salaried GPs, (two male and two female). The clinical practice team includes a practice nurse and two healthcare assistants. Practice staff also include a practice manager and nine administration/ receptionists support staff. In total there are 16 staff employed either full or part time hours to meet the needs of patients. The practice is a training practice for GP registrars and medical students to gain experience and higher qualifications in general practice and family medicine.

The practice is open Monday to Friday. Opening times are 8.30am to 6pm Monday to Wednesday, Thursday 8.30 to 1pm and Friday from 7am to 6pm. Appointments are from 8.30am to 11.30am and 3.30pm to 5.30pm Monday to Wednesday, 8.30am to 11.30am on Thursdays and from 7am to 8am, 8.30am to 11am and 3.30pm to 5.30pm on Fridays. Extended surgery hours are from 7am to 8am on Friday mornings. The practice does not provide an out-of-hours service to its patients but has alternative arrangements for patients to be seen when the practice is closed. Patients are directed to the out of hours service Primecare, the NHS 111 service and the local Walk-in Centres. This information was available on the practice answerphone, patient leaflet and practice website.

The practice has a contract to provide General Medical Services (GMS) for patients. This is a contract for the practice to deliver primary medical services to the local community. They provide Directed Enhanced Services, such as the childhood vaccination and immunisation scheme and minor surgery. The practice provides a number of clinics for example long-term condition management including asthma, diabetes and high blood pressure.

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. The 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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 28 January 2016.

During our visit we:

- Spoke with a range of staff, GPs, practice nurses, and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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 were provided for specific groups of people and what good care looked 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)

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach to learning and a system was in place for reporting and recording significant events. Staff told us they would inform the practice manager of any incidents to ensure appropriate action was taken. The practice carried out a thorough analysis of the significant events.

We reviewed safety records, national patient safety alerts and incident reports where these were reported and discussed. Lessons were shared to make sure action was taken to improve safety in the practice. The practice had recorded five significant events, both clinical and operational over the past 12 months. One of the events was due to a delay in updating patient records in a timely way and had resulted in incorrect information being shared with the coroner. Appropriate action was taken to ensure that GPs had the resources to update patients' records immediately following a visit outside of the practice.

We found that significant event records were maintained and systems put in place to prevent further occurrence. We found that the significant audit form/adverse incident meeting report forms showed that events were discussed with staff, areas of learning identified and suggestions to prevent reoccurrence were discussed. Minutes of meetings showed that these events were also discussed at practice meetings; however they did not show that ongoing monitoring of events had taken place to ensure that systems put in place were appropriate. We found that when there were unintended or unexpected safety incidents, patients received reasonable support, information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

Arrangements were in place to safeguard vulnerable adults and children from the risk of abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The principle GP was the lead for safeguarding. Staff we spoke with demonstrated that they understood their responsibilities and told us they had received training relevant to their role. Certificates of safeguard training at the appropriate level were seen for all staff. The practice shared examples of occasions when suspected safeguarding concerns were reported to the local authority safeguarding team. This involved where necessary providing reports and meetings with external agencies, such as social workers and the community mental health team. Our review of records showed appropriate follow-up action was taken where alleged abuse occurred to ensure children and adults were safeguarded.

The practice had an infection control policy in place and supporting procedures were available for staff to refer to. There were cleaning schedules in place and cleaning records were kept. Treatment and consulting rooms in use had the necessary hand washing facilities and personal protective equipment which included disposable gloves and aprons. Hand gels for patients and staff were available. Clinical waste disposal contracts were in place. The practice nurse was the clinical lead for infection control.

A notice was displayed in the waiting room, advising patients they could access a chaperone, if required. All staff who acted as chaperones were trained for the role. Staff files showed that criminal records checks had been carried out through the Disclosure and Barring Service (DBS) for staff who carried out chaperone duties. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The arrangements for managing medicines, including emergency medicines and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of the local prescribing advisor to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. This included a review of the medicines for patients living at care homes. Appropriate actions were taken to review patients' medicines where necessary.

Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. The practice had a system for the production of Patient Specific Directions (PSDs) to enable health care assistants to administer vaccinations after the completion of specific training and when a doctor or nurse were on the premises. Robust systems were in place to

ensure that PGDs and PSDs were signed and up to date. The practice had appropriate systems in place to ensure the safe storage and security of both hand written and computerised prescription pads.

We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

The practice had assessed risks to those using or working at the practice. We saw that where risks were identified action plans had been put in place to address these issues. A building maintenance policy and schedules for maintenance were identified by the practice. The practice had completed a risk assessment log where specific risks related to the practice were documented. We saw that each risk was rated and mitigating actions recorded to reduce and manage the risk.

Fire risk assessments of the building had been completed and staff told us that regular fire drills were carried out. Records we saw confirmed this. Electrical equipment had been checked to ensure the equipment was safe to use and clinical equipment was regularly maintained to ensure it was working properly. The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal) and a legionella risk assessment had been carried out. An infection control audit was undertaken by the local Clinical Commissioning Group (CCG) infection control team. We saw that the practice had scored highly and evidence showed that action was planned to address recommendations made. The practice had completed in-house legionella checks, records showed that the cleaner flushed taps and checked water temperatures weekly.

There were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made. Staff we spoke with told us that children were always provided with an on the day appointment if required. Patients with a change in their condition were reviewed appropriately. Patients with an emergency or sudden deterioration in their condition were referred to a duty GP for quick assessment.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice had made changes to staffing following the outcome of a patient survey where concerns were raised about the use of locum GPs. To address this the practice had employed an additional salaried GP. There was a rota system in place for all the different staffing groups to ensure that enough staff and staff with appropriate skills were on duty.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff had received cardio pulmonary resuscitation training. Robust systems were in place to ensure emergency equipment and medicines were regularly checked. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date.

The practice had a business continuity plan in place for major incidents such as power failure or loss of access to medical records. The plan also included emergency contact numbers for staff and mitigating actions to reduce and manage the identified risks.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed patients' needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and systems were in place to keep all clinical staff up to date. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and reviewed their performance against the national screening programmes to monitor outcomes for patients. The practice achieved 97% of the total number points available for 2014-2015 which was above the practice average across England of 94.2%. Further practice QOF data from 2014-2015 showed:

- Performance for diabetes assessment and care was comparable to the national average (93% as compared to the national average of 89.2%).
- The percentage of patients with hypertension having regular blood pressure tests was comparable to the national average (86.79% as compared to the national average of 83.65%).
- Performance for mental health assessment and care was comparable to the national average (97.37% as compared to the national average of 88.47%).
- The dementia diagnosis rate was comparable to the national average (77.42% as compared to the national average of 84.01%).

The practice was performing well when compared to the local average across England. The practice had no indicators that required further enquiry. Regular meetings were held to monitor performance and an action plan was developed at each meeting to identify the areas of patient's care that needed to be reviewed. The practice felt that this helped identify any areas for improvement and ensured that appropriate action was taken in a timely way.

Clinical audits were carried out to facilitate quality improvement and all relevant staff were involved in the practice aim to improve care and treatment and patient outcomes. We saw four clinical audits carried out over the last 12 months. A second cycle had been completed for one of the audits. The audit looked at whether the information recorded in the care records of patients who had an internal contraceptive device fitted followed the recommended guidance protocol. The first audit showed that the practice was performing below standard in four of the ten identified protocol areas. The second cycle of the audit showed that improvements had been made in all areas; however the practice remained below the target standard for obtaining signed consent prior to the procedure. To ensure continued improvements the practice had written a protocol for GPs trained in this procedure to follow.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. All staff had annual appraisals that identified their learning needs from which personal development plans were identified. All the staff had had an appraisal within the last 12 months. Our interviews with staff confirmed that the practice provided training opportunities. Staff had also received training that included safeguarding, fire procedures, basic life support, mental capacity awareness and information governance awareness. Staff had access to and made use of training opportunities with their peer groups, in-house and external training. The practice was a training practice for GP registrars and medical students to gain experience and higher qualifications in general practice and family medicine.

The practice could demonstrate how they ensured clinical staff attended role-specific training and updating for relevant staff. For example, the nurse and healthcare assistants received training and attended regular updates for the care of patients with long-term conditions and administering vaccinations. The learning needs of staff were identified through a system of meetings and reviews of practice development needs. This included ongoing support during one-to-one meetings and appraisals. The

Good

Are services effective?

(for example, treatment is effective)

practice was discussing with the practice nurses the support needed for revalidation (A process to be introduced in April 2016 requiring nurses and midwives to demonstrate that they practise safely).

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their shared computer drive. This included risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available. The practice shared relevant information with other services in a timely way, for example when referring patient's to secondary care such as hospital or to the out of hours service.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included providing a service to patients in care homes, when people moved between services, including when they were referred, or after they were discharged from hospital. Multi-disciplinary team meetings to discuss patients on the practice palliative care register took place on a monthly basis. The minutes we looked at were documented and used a risk assessment system to review patients care and treatment. The practice monitored and ensured that care plans were routinely reviewed and updated.

Consent to care and treatment

We found that staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and where appropriate, recorded the outcome of the assessment. We saw that patients' consent had been recorded clearly using nationally recognised standards. For example, when consenting to certain tests and treatments such as vaccinations and in do not attempt cardio-pulmonary resuscitation (DNACPR) records.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. This included patients with conditions that may progress and worsen without the additional support to monitor and maintain their wellbeing. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet and smoking. One of the healthcare assistants ran a smoking cessation clinic where patients received one to one counselling. Patients were signposted to the relevant service for dietary advice. We saw that information was displayed in the waiting area and also made available and accessible to patients on the practice website. Patients had access to appropriate health assessments and checks.

The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. Data collected by NHS England for 2014 -2015 showed that the performance for all childhood immunisations was comparable to the local Clinical Commissioning Group (CCG) average. For example, childhood immunisation rates for the vaccination of children under two years of age ranged from 81.3% to 97.9%, children aged two to five 81.8% to 95.5% and five year olds from 86.7%% to 97.8%.

We saw that the uptake for cervical screening for women between the ages of 25 and 64 years for the 2014-2015 QOF year was 80.56% which was comparable to the national average of 81.83%. The practice was proactive in following these patients up by telephone and sent reminder letters. Public Health England national data showed that the practice was comparable with local and national averages for screening for cancers such as bowel and breast cancer.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard. We saw that reception staff knew when patients wanted to discuss sensitive issues or appeared distressed and patients were offered a private area where they could not be overheard to discuss their needs.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 37 completed cards. The cards contained mostly positive comments about the practice and staff. Patients commented that the service was excellent, they were treated with respect and dignity and that GPs and staff were knowledgeable and caring. We also spoke with a member of the patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. Their comments were in line with the comments made in the cards we received.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 98% said the GP was good at listening to them compared to the local Clinical Commissioning Group (CCG) average of 84.5% and national average of 88.6%.
- 94.4% said the GP gave them enough time (CCG average 83.7%, national average 86.6%).
- 100% said they had confidence and trust in the last GP they saw (CCG average 93.5%, national average 95.2%).
- 95% said the last GP they spoke to was good at treating them with care and concern (CCG average 80.3%, national average 85.1%).
- 96.1% said the last nurse they spoke to was good at treating them with care and concern (CCG average 89.2%, national average 90.4%).
- 97.3% said they found the receptionists at the practice helpful (CCG average 86.5%, national average 86.8%).

Care planning and involvement in decisions about care and treatment

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

Results from the national GP patient survey published on 2 July 2015 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were above local and national averages. For example:

- 94.7% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82.6% and national average of 86%.
- 90.5% said the last GP they saw was good at involving them in decisions about their care (CCG average 76.8%, national average 81.4%).
- 94.8% said the last nurse they saw was good at involving them in decisions about their care (CCG average 84.9%, national average 84.8%).

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. There were 44 carers on the practice carers register and 111 patients who were identified as cared for. This represented 2.2% of the practice population. The practice's computer system alerted GPs if a patient was also a carer. Written information was available for carers to ensure they understood the various avenues of support available to them. Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked proactively with the local Clinical Commissioning Group (CCG) to plan services and to improve outcomes for patients in the area. The practice was involved in a number of local innovations which supported improvement in patient care. This involvement meant the practice had the opportunity to pilot and have a say in the development and implementation of local initiatives that would benefit the patient groups registered at the practice. The practice provided services that were planned and delivered to take into account the needs of different patient groups, flexibility, choice and continuity of care. For example:

- Longer routine appointment of 13 minutes were allocated which allowed flexibility based on patient need.
- There were longer appointments available for patients with a learning disability, older people and patients with long-term conditions.
- There was a strong relationship with local care homes. Joint visits and ward round type visits were made to review the care of patients living at the home.
- Home visits were available for older patients and patients who would benefit from these, which included patients with long term conditions or receiving end of life care.
- Urgent access appointments were available for children and those with serious medical conditions.
- An annual audit linked to the Equality Act to ensure the premises were safe for use by all patients and visitors to the practice was carried out. An action plan was developed to address any issues identified.
- Telephone triage and consultations were provided every day.
- Extended opening hours were available one morning per week for people who worked.

Access to the service

The practice was open Monday to Friday. Opening times were 8.30am to 12pm and 1pm to 6pm Monday to Wednesday, Thursday 8.30 to 1pm and Friday from 7am to 6pm. Appointments were from 8.30am to 11.30am and 3.30pm to 5.30pm Monday to Wednesday, 8.30am to 11.30am on Thursdays and from 7am to 8am, 8.30am to 11am and 3.30pm to 5.30pm on Fridays. Extended surgery hours are from 7am to 8am on Friday mornings. The practice did not provide an out-of-hours service to its patients but had alternative arrangements for patients to be seen when the practice was closed. Patients were directed to the out of hours service Primecare, the NHS 111 service and the local Walk-in Centres. This information was available on the practice answerphone, on the front door, patient leaflet and practice website.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was similar to or better than local and national averages.

- 75.5% of patients were satisfied with the practice's opening hours compared to the CCG average of 76.7% and national average of 74.9%.
- 82.6% patients said they could get through easily to the surgery by phone (CCG average 72.8%, national average 73.3%).
- 82.5% patients said they always or almost always see or speak to the GP they prefer (CCG average 82.1%, national average 85.2%).

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints at the practice. We found that not all staff were aware of who this person was, however all staff told us that they would report complaints to a senior person. We saw that information was available to help patients understand the complaints system including a summary leaflet available in the reception area. Patients we spoke with were aware of the process to follow if they wished to make a complaint. Records we examined showed that the practice responded formally to both verbal and written complaints.

We saw records for five complaints received between 1 April 2015 and 18 January 2016. We found that all had been responded to, satisfactorily handled and dealt with in a timely way. Complaints were discussed at practice meetings. This was confirmed by staff. Lessons were learnt and action was taken to improve the quality of care.

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 had a clear vision to deliver high quality care, continuous improvement and promote good outcomes for patients. Staff and patients felt that they were involved in the future plans for the practice. For example the practice sought the views of patients and input of the patient participation group (PPG) on ways in which preventative health education could be delivered. The practice had a noticeboard and information corner at the practice where health education information was displayed. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the practices strategy for good quality care. This outlined the structures and procedures in place and ensured that:

- Systems were supported by a strong management structure and clear leadership.
- Risk management systems and protocols had been developed and implemented to support continued improvements.
- A programme of clinical and internal audit had been implemented and was used to monitor quality and to make improvements.
- The GPs, nurses and other staff were all supported to address their professional development needs.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- There was a clear staffing structure and that staff were aware of their own roles and responsibilities
- Practice specific policies were implemented and were available to all staff
- There was a lack of minuted meetings to show that learning from incidents and any action taken to prevent reoccurrence had been appropriate.

Leadership and culture

The GPs and the management team in the practice had the experience, capacity and capability to run the practice and ensure high quality care. The principle GP and the management team were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff. The provider was aware of and complied with the requirements of the Duty of Candour. The practice encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents. When there were unexpected or unintended safety incidents the practice gave affected people reasonable support, truthful information and a verbal and written apology

There was a clear leadership structure in place and staff felt supported by the management. Staff we spoke with were positive about working at the practice. They told us they felt comfortable enough to raise any concerns when required and were confident these would be dealt with appropriately. Staff described the culture at the practice as open, transparent and very much a team approach. This was encouraged and supported by team away events.

Regular practice, clinical and team meetings involving all staff were held and staff felt confident to raise any issues or concerns at these meetings. All the staff were involved in discussions about how to run and develop the practice. Staff were encouraged to identify opportunities to improve the service delivered by the practice. There was a practice whistle blowing policy available to all staff to access on the practice's computer system. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG consisting of 20 members 12 of which were active members. The group met regularly and submitted proposals for improvements to the practice management team. The practice completed a survey in February 2016 to determine patients' opinions on the service they received. The outcome was analysed, and an action plan to show what action if any was planned to be taken in response to

Are services well-led?

Good

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

patient feedback were available. Members of the PPG told us that as a result of patient suggestions some of the chairs in the waiting area had been replaced with higher chairs with arms. This made it easier for patients to sit or get up from the chair with ease.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and the management team. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

The practice had completed reviews of significant events and other incidents. We saw records to confirm this, however there was a lack of written information to show that these were followed up to ensure that learning and appropriate improvements had been made.

The principal GP was the clinical lead for modernisation at Wolverhampton Clinical Commissioning Group (CCG) and had been responsible as clinical lead for a number of local innovations which supported improvement in patient care across Wolverhampton. Some of these innovations had included:

- Devolving the diagnosis and management of acute eye conditions from secondary care to primary care optometrists.
- Development of a service that would be responsive to supporting care homes with nursing. This had demonstrated improvements in care, reductions in hospital admissions and safer prescribing for this group of vulnerable patients.

The practice was registered to take part in medical research projects and had started working with a local university to become a training practice for medical students. The practice had reviewed the skill mix of staff following feedback from patients and an additional salaried GP employed to ensure the needs of patients could be met in the long term.