Glebefields Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We first inspected Dr Raymond Sullivan's surgery on 16 November 2016 as part of our comprehensive inspection programme. The overall rating for the practice was requires improvement. The full comprehensive report on the November 2016 inspection can be found by selecting the 'all reports' link for Dr Ray Sullivan's surgery on our website at www.cqc.org.uk. During the inspection, we found the practice was in breach of legal requirements this was because appropriate processes were not in place to mitigate risks in relation to the safety and quality of the services offered. Following the inspection, the practice wrote to us to say what they would do to meet the regulations.

This inspection was an announced focussed inspection, carried out on 13 October 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations we identified in our previous inspection. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall we found improvements had been made to the concerns raised at the previous inspection and as a result of our inspection findings the practice is now 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 report incidents and near misses. Since the previous inspection, an effective system had been implemented to ensure all incidents were acted on and learning was shared with all staff members. The practice carried out an analysis of each event with a documented action plan.
- We found that the practice had reviewed their processes for receiving safety alerts and all alerts were actioned upon receipt and actions taken were recorded and discussed as part of the clinical team meetings, which were held every week.
- At this inspection, we saw a programme of clinical audits had been implemented to monitor patients' outcomes and improve the quality of care provided.
- We saw evidence to confirm that staff had received the appropriate checks with the disclosure and barring service (DBS).

Summary of findings

- At our previous inspection we found the practice did not have effective systems and processes to monitor patients on high risk medicines. This risk had been mitigated with the implementation of guidelines to monitor patients on high risk medicines, the support of a clinical pharmacist and a review of all patients to ensure they were receiving the appropriate care.
- The practice had a number of governance policies and procedures in place, which had been reviewed and updated. The governance arrangements to assess and monitor the

quality of services showed improved outcome with a schedule of regular governance meetings in place since the last inspection in November 2016. This included monthly team meetings and weekly clinical meetings.

- At this inspection we saw evidence that an IT training needs analysis had been completed and identified gaps in staff's IT knowledge had been actioned.
- The practice proactively sought feedback from staff and patients, however at our previous inspection, we were told there was a patient participation group (PPG) but they did not meet regularly and were not actively involved in practice developments. At this inspection, the practice told us they had tried to encourage patients to join the group and had sought support from the clinical commissioning group (CCG). A virtual group had been planned and the practice were still looking at this possibility. A PPG meeting had been arranged for the end of October 2017 which was on display in the waiting room to advise patients.
- The practice had achieved in cervical screening with 91% of patients having had a cervical screening test in the past five years, the practice had been asked to participate in a cervical screening workshop for primary care providers by Public Health England to share good practice and educate primary care about strategies to increase cervical screening coverage.
- Following our previous inspection, the practice had recruited a clinical pharmacist to support the GPs in monitoring prescribing and effective auditing of medicines.

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

At our previous inspection, we rated the practice as requires improvement for providing safe services as some areas relating to the management of risk needed improving. These arrangements had improved when we undertook a follow up inspection on 13 October 2017 and the practice is now rated as good for providing safe services.

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents. The practice operated an effective system for reporting and recording significant events. The practice carried out analysis of each incident and documented action plans. The practice reported all events to the local clinical commissioning group through web based incident reporting and risk management software. Since the previous inspection, an effective system had been implemented to ensure all incidents were acted on and learning was shared with the practice team to mitigate further risks.
- At our previous inspection we found the practice did not have effective systems and processes to monitor patients on high risk medicines. This risk had been mitigated with the implementation of guidelines to monitor patients on high risk medicines, the support of a clinical pharmacist and a review of all patients to ensure they were receiving the appropriate care.
- At this inspection, we found that recruitment procedures had been reviewed and all staff had received a disclosure and barring service (DBS) check.
- The practice had implemented clearly defined and embedded systems and processes to minimise risks to patient safety and had an effective process in place for monitoring and actioning safety alerts.
- Staff demonstrated they understood their responsibilities regarding safeguarding and all had received training on safeguarding children and vulnerable adults relevant to their role. There was an open culture in which all concerns raised by staff were valued and used for learning and improvement.

Are services effective?

Good

At our previous inspection, we rated the practice as requires improvement for providing effective services as clinical audits did

not demonstrate quality improvement. These arrangements had significantly improved when we undertook a follow up inspection on 13 October 2017 and the practice is now rated as good for providing effective services.

- Quality and Outcomes Framework (QOF) data showed patient outcomes were at or above average compared to local and national average. The practice used this information to monitor performance against national screening programmes and outcomes for patients.
- Since the previous inspection the practice had introduced a programme of clinical audits which demonstrated quality improvement and the monitoring patient outcomes.
- Staff had access to guidelines from National Institute for Health and Care Excellence (NICE) and used this information to deliver care and treatment that met patients' needs. The lead GP trained nurses on how to monitor the guidelines effectively at weekly clinical meetings.
- The practice had improved how guidelines were monitored since the previous inspection with risk assessments, audits and random sample checks of patient records being completed and the practice had also employed a clinical pharmacist to support the GPs in monitoring their prescribing and ensure best practice guidelines were being followed.
- We saw evidence that an IT training needs analysis had been completed and identified gaps in staff's IT knowledge had been actioned.
- We saw evidence to confirm that consent forms relevant to procedures were in place and the process for seeking consent was monitored through patient records audits.
- The practice had achieved 91% for patients having had a cervical screening test in the past five years, which was higher than the CCG average of 80% and the national average of 81%. The practice had been asked to participate in a cervical screening workshop for primary care providers by Public Health England to share good practice and educate primary care about strategies to increase cervical screening coverage.
- The practice participated in the Sandwell & West Birmingham Clinical Commissioning Group primary care commissioning framework to improve the overall quality of clinical care. Data provided by the practice showed an achievement of 97%.

Summary of findings

Are services well-led?

Good

At our previous inspection, we rated the practice as requires improvement for providing well led services as some areas of the practice governance arrangements needed improving. These arrangements had significantly improved when we undertook a follow up inspection on 13 October 2017.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients.
- There was a clear leadership structure and staff felt supported by the management team.
- At this inspection, we saw evidence to confirm that various monthly meetings governed by an agenda were taking place which staff were able to contribute to.
- We found an overarching governance framework had been implemented to support the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. Policies had been reviewed and were accessible to all staff on the practice computer system.
- The practice proactively sought feedback from staff and patients, however at our previous inspection, we were told there was a patient participation group (PPG) but they did not meet regularly and were not actively involved in practice developments. At this inspection, the practice told us they had tried to encourage patients to join the group and had sought support from the clinical commissioning group. A virtual group had been planned and the practice were still looking at this possibility. A PPG meeting had been arranged for the end of October 2017 which was on display in the waiting room to advise patients.

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
The provider had resolved the concerns for safety, effective and well-led identified at our previous inspection on 16 November 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

People with long term conditions
The provider had resolved the concerns for safety, effective and well-led identified at our previous inspection on 16 November 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

Families, children and young people
The provider had resolved the concerns for safety, effective and well-led identified at our previous inspection on 16 November 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

Working age people (including those recently retired and students)
The provider had resolved the concerns for safety, effective and well-led identified at our previous inspection on 16 November 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

People whose circumstances may make them vulnerable
The provider had resolved the concerns for safety, effective and well-led identified at our previous inspection on 16 November 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

People experiencing poor mental health (including people with dementia)
The provider had resolved the concerns for safety, effective and well-led identified at our previous inspection on 16 November 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

Glebefields Surgery

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 adviser.

Background to Glebefields Surgery

Dr Raymond Sullivan (also known as Glebefields Surgery) is located at Glebefields Health Centre, Tipton an area of the West Midlands. The health centre is owned by NHS Property Services with consulting rooms on two floors. The surgery is located on the upper floor with access to lifts. There is easy access to the building and disabled facilities are provided.

The practice has a General Medical Services contract (GMS). A GMS contract is a nationally agreed contract to provide essential services for people who are sick as well as, for example, chronic disease management and end of life care. The practice also provides some enhanced services such as childhood vaccination and immunisation schemes.

The practice provides primary medical services to approximately 4,300 patients in the local community. The practice is run by a lead male GP (provider) and one long term locum (female). There are two female nurses and one female health care assistant. (HCA). The non-clinical team consists of administrative and reception staff, a practice manager and a personal assistant.

Based on data available from Public Health England, the levels of deprivation in the area served by Dr Raymond Sullivan are below the national average ranked at one out of ten, with ten being the least deprived.

The practice opening times are 8am until 6.30pm Mondays to Fridays. The practice did not offer extended hours appointments, but had joined the Black Country extended hours hub where patients were able to access appointments from 6.30pm to 8pm Monday to Friday and 9am to 12pm on Saturdays and 9am to 11am on Sundays. The practice also offered an express clinic after each morning surgery for patients who needed to see the GP urgently. When the practice is closed, primary medical services are provided by Primecare, an out of hours service provider and NHS 111 service.

The practice is part of NHS Sandwell & West Birmingham CCG which has 91 member practices. The CCG serve communities across the borough, covering a population of approximately 559,400 people. (A CCG is an NHS Organisation that brings together local GPs and experienced health care professionals to take on commissioning responsibilities for local health services).

Why we carried out this inspection

We carried out a comprehensive inspection of Dr Raymond Sullivan's surgery on 16 November 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as requires improvement for providing safe, effective and well led services. We carried out a further comprehensive inspection on 13 October 2017 to ensure improvements had been made and to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. We carried out an announced visit on 13 October 2017. During our visit we:

- Spoke with a range of staff including the GPs, practice nurse, health care assistant, practice manager, personal assistant, reception and administration staff and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

At our previous inspection, we rated the practice as requires improvement for providing safe services as some areas relating to the management of risk needed improving. These arrangements had improved when we undertook a follow up inspection on 13 October 2017 and the practice is now rated as good for providing safe services.

Safe track record and learning

There was a system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- The practice carried out a thorough analysis of all significant events and these were discussed with staff at monthly practice meetings to ensure appropriate action was taken and learning was shared with staff to minimise further risks. The practice reported all events to the local clinical commissioning group through web based incident reporting and risk management software.
- Since the previous inspection 12 significant events had been documented and from the examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support and information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.

Staff we spoke with were able to explain processes in place to minimise risks to patient safety, this included systems in place to ensure compliance with alerts received from central alerting system (CAS) and alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). All alerts were discussed at weekly clinical meetings. For example, searches had been carried out in response to an MHRA alert regarding a medicine used to treat epilepsy and bipolar disorder and to prevent migraine headaches and the links to pregnant women. Patients on the medicine were reviewed by the GP and offered advice and support to ensure compliance with recommended guidelines.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. 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. There was a lead member of staff for safeguarding.
- Staff we spoke with demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. The GPs and practice nurses were trained to child safeguarding level three. The health care assistant had received child safeguarding level two and non-clinical staff were trained to level one child safeguarding.
- A notice in the waiting room advised patients that chaperones were available if required. Disclosure and barring (DBS) checks were in place. (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 practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place and staff had access to appropriate hand washing facilities and personal cleaning equipment.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and the latest audit had been completed in September 2017 with the practice having achieved 100%. All staff received regular infection control training.

Good

Are services safe?

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being issued to patients and there was a reliable process to ensure this occurred. At our previous inspection we found the practice did not have effective systems and processes to monitor patients on high risk medicines. This risk had been mitigated with the implementation of guidelines to monitor patients on high risk medicines, the support of a clinical pharmacist and a review of all patients to ensure they were receiving the appropriate care.
- The practice had recruited a clinical pharmacist to support the GPs in monitoring prescribing to ensure prescribing was in line with best practice guidelines for safe prescribing and the effective auditing of medicines.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use.
- One of the practice nurses had qualified as a nurse prescriber and Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

We reviewed two personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available and regular risk assessments were carried out by NHS Property Services.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There was a fire evacuation plan in place.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. A rota system was in place to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to 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 received annual basic life support training and there were emergency medicines available in the treatment room.
- 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 and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage since the last inspection. The plan included emergency contact numbers for staff and a copy of the plan was kept off site by each staff member.

Good

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection, we rated the practice as requires improvement for providing effective services as clinical audits did not demonstrate quality improvement and the practice were unable to demonstrate that they effectively monitored guidelines risk assessments, audits and random sample checks of patient records. These arrangements had improved when we undertook a follow up inspection on 13 October 2017 and the practice is now rated as good for providing effective services.

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice had improved how guidelines were monitored since the previous inspection with risk assessments, audits and random sample checks of patient records being completed and the practice had also employed a clinical pharmacist to support the GPs in monitoring their prescribing and ensure best practice guidelines were being followed.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results (2015/16) were 97% of the total number of points available compared with the clinical commissioning group (CCG) average of 95% and national average of 95%. Exception reporting was 8% which was comparable to the CCG average of 9% and the national average of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/16 showed:

- Performance for diabetes related indicators was 87% which was comparable to the CCG average of 88% and the national average of 90%.
- Performance for mental health related indicators was 100% which was higher than the CCG average of 91% and the national average of 93%. Exception reporting rate was 11%, which was comparable to the CCG average of 13% and the national average of 11%.
- Performance for chronic obstructuive pulmonary disease (COPD) related indicators was 100% which was higher than the CCG and national averages of 96%. Exception reporting rate was 6%, which was lower than the CCG average of 15% and the national average of 13%.

There was evidence of quality improvement including clinical audit:

- We saw evidence that a programme of clinical audits had been undertaken in the past 12 months. We reviewed two audits to see what improvements had been implemented, this included patients on medicines used to control blood pressure. The results showed no patients were overdue a blood test. The second audit we reviewed was for Disease-modifying anti-rheumatic drugs (DMARDs) to ensure patients were being monitored appropriately. The audit showed all patients were being reviewed through a shared care agreement with secondary care.
- The provider had set up a schedule of audits to be carried out through the year; this included a review of the quality of care provided in relation to evidence based guidance.

The practice participated in the Sandwell & West Birmingham Clinical Commissioning Group primary care commissioning framework to improve the overall quality of clinical care. Data provided by the practice showed an achievement of 97% for 2016/17. The practice also participated in peer reviews. For example with the Local Medical Committee (LMC) of which the principal GP was the chairperson.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

Good

Are services effective?

(for example, treatment is effective)

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- We saw evidence that an IT training needs analysis had been completed and identified gaps in staff's IT knowledge had been actioned.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- Staff had yearly appraisals and development plans. We reviewed two personnel folders and found that the learning needs of staff had been identified and staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

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 intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From the documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- The practice worked together with the community specialist consultants and nurses for diabetes and regular Diabetes in Community Extension (DiCE) clinics were held bi-monthly.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals every month when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- At the previous inspection we found the process for seeking consent was recorded on a

generic form which was used to obtain written consent for all relevant care and treatment, but did not include information about the specific procedure and the potential side effects. This had been reviewed and we saw evidence to confirm that consent forms relevant to procedures were in place and the process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients were signposted to the relevant service advice on their diet, smoking and alcohol cessation.
- The practice offered NHS health checks for patients aged 40-70 years, this included patients with caring responsibilities.
- The health care assistant provided a weight management service to patients and smoking cessation

Good

Are services effective?

(for example, treatment is effective)

advice was available from a local support group. Data provided by the practice showed 44 patients had been referred to the stop smoking service in the past 12 months.

The practice's uptake for the cervical screening programme was 91%, which was higher than the CCG average of 80% and the national average of 81%. The exception reporting rate at the practice was 2% which was lower than the CCG average of 9% and the national average of 6%. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available. Due to the results the practice had achieved, they had been asked to participate in a cervical screening workshop for primary care providers by Public Health England to share good practice and educate primary care about strategies to increase cervical screening coverage.

The uptake of national screening programmes for bowel and breast cancer screening were higher than the CCG and national averages. For example:

- 68% of females aged 50-70 years of age had been screened for breast cancer in the last 36 months compared to the CCG average of 66% and the national average of 72%.
- 53% of patients aged 60-69 years, had been screened for bowel cancer in the last 30 months compared to the CCG average of 45% and the national average of 58%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were higher than the CCG and national averages. For example, rates for vaccines given to under two year olds were 96% to 97% in comparison to the national average of 90% and five year olds ranged from 97% to 100% in comparison to the national average of 88% to 94%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74 years. Annual health checks were also offered to patients with caring responsibilities and data provided by the practice showed 179 patients on the carers register and 79 patients had received a health check since January 2017. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services well-led?

Good

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

Our findings

At our previous inspection, we rated the practice as requires improvement for providing well led services as some areas of the practice governance arrangements needed improving. These arrangements had improved when we undertook a follow up inspection on 13 October 2017 and the practice is now rated as good for providing well led services.

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had a mission statement which was on display in the waiting areas and staff knew and understood the values. The mission statement was:

"Our aim is to provide excellent care and support for our patients on a daily basis, in a clean and safe environment and to treat all patients with dignity and respect".

At the previous inspection we saw no evidence of a strategy or business plan, however this has been implemented at this inspection and was clearly on display for both patients and staff to see.

We spoke with a range of staff who spoke positively about working at the practice and demonstrated a commitment to providing a high quality service to patients. During the inspection, practice staff demonstrated values which were caring and patient centred. This was reflected in feedback received from patients.

Governance arrangements

When we carried out our previous inspection we found the practice had a governance framework in place, however some systems and processes were not effective. For example, managing and learning from incidents, cascading information received and actions taken following receipt of safety alerts, processes for managing medicines which required closer monitoring was not effective. At this inspection we saw that systems and processes had improved. For example:

- Systems for managing safety incidents were well established and embedded. As a result, documentation we viewed demonstrated effective management of incidents with clear evidence of shared learning to prevent the same thing happening again.
- The practice established an effective process for distributing patient safety alerts throughout the practice. Staff we spoke with were aware of alerts and weekly clinical meetings were in place to review actions taken to ensure compliance with guideline recommendations.
- The practice had implemented guidelines to monitor patients on high risk medicines, the support of a clinical pharmacist and a review of all patients to ensure they were receiving the appropriate care.
- The practice had a number of governance policies and procedures in place, which had been reviewed and updated. The governance arrangements to assess and monitor the quality of services showed improved outcome with a schedule of regular governance meetings in place.
- A programme of continuous clinical and internal audit had been implemented to monitor quality and make improvements.
- Practice specific policies had been reviewed and updated and were available to all staff.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- The practice had tried to address the lack of appointments with the GP and had set up an express clinic after each morning surgery for patients who needed to see the GP urgently. The practice told us they found this had been effective with an average of seven extra patients seen daily. The practice did not offer extended hours appointments, but had joined the Black Country extended hours hub where patients were able to access appointments between 6.30pm to 8pm Monday to Friday and 9:00am to 12pm on Saturdays and 9am to 11am on Sundays.

Leadership and culture

On the day of the inspection the GP, practice manager and personal assistant demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the GP and managers were approachable and always took the time to listen to all members of staff.

Are services well-led?

Good

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

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The GP and managers encouraged a culture of openness and honesty. The practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. The GP and nurse had lead roles in key areas.
- The practice demonstrated joint working with other health care providers. Members of the management team provided evidence of a range of multi-disciplinary meetings with district nurses, palliative care nurses and the practice clinical team to monitor vulnerable patients. The practice also supported patients in a local nursing home and feedback from the managers at the nursing home was positive about the care patients received at the home.
- Staff told us that monthly staff meetings were in place with standing agenda items which provided staff with the opportunity to contribute to meetings. Minutes were comprehensive and were available for practice staff to view.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported and they were involved in discussions about how to run and develop the practice and all staff were encouraged to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients and staff.

- At our previous inspection, we were told there was a patient participation group (PPG) but they did not meet regularly and were not actively involved in practice developments. At this inspection, the practice told us they had tried to encourage patients to join the group and had sought support from the clinical commissioning group. A virtual group had been planned and the practice were still looking at this possibility. A PPG meeting had been arranged for the end of October 2017 which was on display in the waiting room to advise patients. The practice told us that a representative for the local health and wellbeing team had been asked to join the meeting to advise patients on the services available.
- Documents provided by the practice showed that regular appraisals were carried out and development plans were in place.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local schemes to improve outcomes for patients in the area. For example:

- The practice participated in the Sandwell & West Birmingham Clinical Commissioning Group primary care commissioning framework to improve the overall quality of clinical care. Data provided by the practice showed an achievement of 97% for 2016/17.
- The practice had actively encouraged staff development and the practice nurse had completed an advanced nurse prescriber course at the university.