All Saints and Rosevillas Medical Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at All Saints and Rosevillas Medical Practice on Tuesday 19 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. However not all staff were up to date with training.
- 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. Patients who experienced poor mental health were supported to access the practice at times that were suitable for them.
- 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 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.

There were areas of practice where the provider should make improvements:

- Consider a system that demonstrates that staff are up to date with relevant training.
- Ensure that the actions identified in the legionella risk assessment are regularly undertaken.
- Continue to complete the process of setting up a Patient Participation Group.

Summary of findings

- Continue to make improvements in the care and treatment of patients experiencing poor mental health (including patients with dementia).

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. When there were unintended or unexpected safety incidents, patients received reasonable support, feedback and a verbal and written apology. They were told about any actions to improve processes to prevent the same thing happening again. The practice had clearly defined systems, processes and practices in place to keep patients safe and safeguarded from 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 below average in comparison to the local and national averages. The practice was aware of this and had looked at ways to ensure improvement. This included recruiting appropriate and skilled staff to meet the needs of patients. Staff assessed 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. Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs. There was evidence of annual appraisals for all staff, however appraisal records did not show that individual objectives and personal development plans had been discussed and identified for staff.

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 similar to others for aspects of care. 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.

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

Summary of findings

these were identified. Urgent appointments were available the same day. The practice was improving its facilities to ensure it was well equipped to treat patients and meet their needs in the long term. 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 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 their strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. The provider 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.There was a strong focus on continuous learning and improvement at all levels. The practice proactively sought feedback from staff and 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

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 a care home for older people who required rehabilitation following discharge from hospital. There was effective communication between the practice and care home staff. Planned regular visits as well as requested visits were made to the home.

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 much lower than the national average (56.97% as compared to the national average of 94.41%). The practice had taken action to identify the causes and it planned to be involved in a local Clinical Commissioning Group (CCG) initiative to improve the care and treatment of patients with diabetes. Longer appointments and home visits were available when needed. All these patients had a named GP and structured annual reviews to check their health and medicines needs were being met had been planned for. The practice was working to re-establish formal multidisciplinary meetings with relevant professionals to support the care of patients with palliative care needs. 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 similar to local and national averages for all standard childhood immunisations. Data showed that 69.05% of patients on the practice register had had an asthma review in the last 12 months. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

Summary of findings

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, health visitors and the practice maintained a register of school nurses in the local area. The practice's uptake for the cervical screening programme was 62.71%, which was lower than the national average of 81.83%.

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 appointment telephone line was open between 8.30am and 6.30pm and extended hours were offered one evening per week. The practice was proactive in offering online services 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. An easy read (pictorial) letter was sent to patients with a learning disability inviting them to attend the practice for their annual health check. Staff had been trained to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding 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.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The practice was aware that they had only reviewed a small number of their patients who experienced poor mental health. Data showed that 53.33% of this group of patients on the practice register had had a comprehensive agreed care plan in the preceding 12 months. This was lower than the national average of 88.47%. The practice had taken steps to address this. This included a counselling clinic held weekly at the practice to support patients who experienced mental health problems. The practice had told patients experiencing poor

Summary of findings

mental health about how to access various support groups and voluntary organisations. The practice had established links with a local dementia advisory service to promote regular working with multi-disciplinary teams in the diagnosis and case management of people with dementia. It had started work on 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 50%, which was lower than the national average of 84.01%. The practice was on target to improve these figures for 2015/2016.

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 in line with local and national averages. A total of 452 surveys (13.7% of patient list) were sent out and 80 (17.7%) responses, which is equivalent to 2.4% 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:

- 88.4% 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%.
- 76.4% 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%).
- 94.1% described the overall experience of their GP surgery as fairly good or very good (CCG average 70.7%, national average 73.3%).
- 64% 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 77.5%).

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 40 comment cards which were overall positive. Patients said they received good care from the practice; staff were very satisfactory, helpful, professional and polite, understanding and always take time to listen. Patients said they were treated with respect and dignity at all times, staff were reassuring and an excellent service was provided by the staff. Three comment cards contained some less positive comments related to difficulty in getting an appointment to see a GP.

We also spoke with two patients on the day of our inspection; 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. Information presented by the practice showed that 190 responses had been received for the period September 2015 to December 2015. The results showed that of the190 responses, 80 patients were extremely likely to recommend the practice to friends and family if they needed similar care or treatment and five patients were extremely unlikely to recommend the practice.

Areas for improvement

Action the service SHOULD take to improve

- Consider a system that demonstrates that staff are up to date with relevant training.
- Ensure that the actions identified in the legionella risk assessment are regularly undertaken.
- Continue to complete the process of setting up a Patient Participation Group.
- Continue to make improvements in the care and treatment of patients experiencing poor mental health (including patients with dementia).

All Saints and Rosevillas Medical Practice

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 All Saints and Rosevillas Medical Practice

All Saints and Rosevillas Medical Practice is located in a deprived inner city area of Wolverhampton. It is part of the NHS Wolverhampton Clinical Commissioning Group. The practice provides medical services to approximately 5,700 patients over two sites. The main practice is based at All Saints, 17 Cartwright Street, Wolverhampton and the branch practice is at Rosevillas, Shale Street, Bilston, Wolverhampton. We visited both sites for this inspection. The practices merged together on 11 September 2015. The practice has a higher proportion of patients between the ages of 19 to 64 years compared with the practice average across England. There is a higher practice value for income deprivation affecting children and older people than the practice average across England. The practice population is culturally diverse with a higher than average number of patients from Asian, African and East European backgrounds.

The practice staff team consists of two GP partners and two salaried GPs, (two male and two female). The practice also use regular GP locums from time to time to support the clinicians and meet the needs of patients at the practice. The clinical practice team includes a practice manager, an advanced nurse practitioner who is also a prescriber, a practice nurse and a healthcare assistant. There are eight receptionists/administration support staff. In total there are 16 staff employed either full or part time hours to meet the needs of patients across both sites.

The practice is open between 8am and 6.30pm Monday, Tuesday, Wednesday, Friday and Thursday 8am to 1pm. Morning clinic appointments are from 8am to 12pm. Afternoon appointments are 3pm to 6pm Monday to Friday except Thursday. Extended hours are from 6.30pm to 8pm on Mondays and are held at both sites on alternate Mondays. 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 NHS 111 service between 6.30pm and 8am and a local Walk-in Centre on Thursday afternoon from 1pm to 6.30pm.

The practice has a contract to provide Primary 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.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 19 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 partners and or 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. Information available showed records of significant events from 2007. Lessons were shared to make sure action was taken to improve safety in the practice. The practice had recorded five significant events over the past 12 months, both clinical and operational. One of the events was related to a breach of confidentiality when giving test results over the telephone. The incident was investigated, discussions were held with the staff and appropriate action taken to decrease the risk of this occurring again.

We found that significant event records were maintained and systems put in place prevented further occurrence. Completed significant event records and minutes of meetings demonstrated that appropriate learning from events had been shared with staff and external stakeholders. We found that when there were unintended or unexpected safety incidents, patients received reasonable support, truthful 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 adults and children from 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. One of the GP partners 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. Following the change to a new patient software system the practice was in the process of transferring and updating the records of vulnerable patients' to ensure safeguarding records were up to date. 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 vulnerable 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. We noted that the practice was using cleaning wipes that were not suitable for cleaning a clinical environment. The practice removed these at the time of inspection and told us they would seek advice on the most appropriate cleaning product they should use. 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. One of the GPs was the current clinical lead for infection control. Plans were in place for the newly appointed advanced nurse practitioner to take over this role.

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 drugs 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 Clinical Commissioning Group (CCG) pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Records available showed

that two medication audits had been completed and appropriate actions to review patients' medicines where necessary. Prescription pads were securely stored and systems were in place to monitor their use.

The practice had recently employed an advanced nurse practitioner who was also a qualified independent prescriber and could therefore prescribe medicines for specific clinical conditions. The nurse told us that they were supported by the medical staff for this extended role. Patient Group Directions 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 to enable health care assistants to administer vaccinations after the completion of specific training and when a doctor or nurse were on the premises.

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. The practice used locum GPs and told us that systems were in place to ensure appropriate checks were carried out to confirm their suitability to work with patients. Evidence was available to confirm this for example employment check details required from the locum agencies were received prior to confirmation of the use of a locum. Induction information introduced locum staff to clinical and health and safety procedures carried out at the practice.

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. 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 Legionella risk assessment carried out. In-house legionella checks of flushing taps and water temperature checks to monitor and control the risk of legionella had not been carried out as recommended by the assessment and national guidance. An infection control audit was undertaken by the local CCG infection control team and we saw evidence that action was taken to address recommendations made.

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. 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 at both sites 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 fit for use.

The practice had a business continuity plan but it needed updating. However, procedures for staff to follow in the event of a major incident such as power failure or loss of access to medical records were included. 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 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 92.7% of the total number points available for 2014-2015 which was comparable to the practice average across England of 94.2%. Further practice QOF data from 2014-2015 showed:

- Performance for diabetes assessment and care was much lower than the national average (56.97% as compared to the national average of 94.41%).
- The percentage of patients with hypertension having regular blood pressure tests was slightly below the national average (75.62% as compared to the national average of 83.65%).
- Performance for mental health assessment and care was much lower than the national average (53.33% as compared to the national average of 88.47%).
- The dementia diagnosis rate was much lower than the national average (50% as compared to the national average of 84.01%).

We found the GPs were aware of the fact that the practice was performing much lower in comparison to the local and national averages in the area related to diabetes, mental health assessments and dementia diagnosis. The practice had identified that the merger of the two practices and the absence of clinical staff had had an adverse effect on the level of care in these areas. The GPs felt that improvements had been made as action had been taken to identify the causes and additional clinical staff which included an advanced nurse practitioner had been recruited. A recent audit on the management of patients with diabetes showed that improvements had been made.

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 five clinical audits carried out over the last 12 months. A second cycle had been completed for three of the audits to review whether improvements had been made. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from QOF. For example, the practice had reviewed its patients diagnosed with atrial fibrillation (AF) a heart condition that causes an irregular and often an abnormally fast heart rate to ensure that they had been assessed for the risk of a stroke and had appropriate treatment commenced. As a result of the audit the practice had completed a risk assessment of all patients diagnosed with AF. The number of patients identified had increased from 20 to 27 patients and they had all commenced appropriate treatment in a timely manner.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. Records we looked at showed that staff had annual appraisals. However the records did not show that staff learning needs and personal development plans had been identified. Our interviews with staff confirmed that the practice provided training opportunities. A staff training matrix showed that some staff had received training in basic life support, infection control, fire safety and safeguarding. However there were gaps for both clinical and non-clinical staff in all training areas. These included safeguarding children and vulnerable adults, fire safety, health and safety, information governance and mental capacity. Staff had access to and made use of training opportunities with their peer groups, in-house and external training. The nurses and healthcare assistant received training and attended regular updates for the care of patients with long-term conditions and administering vaccinations.

Good

Are services effective?

(for example, treatment is effective)

The 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). All GPs were up to date with their revalidation training requirements.

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 patients to secondary care such as hospital or to the out of hours service.

Staff worked 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. The practice had recently accepted a contract with the local Clinical Commissioning Group (CCG) to provide a service to a care home that helped patients to rehabilitate following discharge from hospital and prior to discharge home.

The practice told us that multi-disciplinary team meetings to discuss patients on the practice palliative care register did not take place on a formal basis. This was due to the limited availability of community staff, district nurses, community matron and social workers. The practice maintained one to one and telephone contact with this group of professionals to discuss the care of patients. The practice monitored and ensured that care plans were routinely reviewed and updated. The practice maintained regular contact with the local mental health teams and drug and alcohol liaison services.

Consent to care and treatment

We found that although staff had not received formal training they had an awareness of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We saw there was a MCA 2005 policy in place to support staff in making decisions when capacity was an issue for a patient. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a diagnosis of dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. When interviewed, staff gave examples of how patients' best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, there was a formal consent form for patients to sign which demonstrated they were aware of the relevant risks, benefits and complications of the procedure. Consent forms were scanned into patients' notes. We saw an anonymised record where this had been completed.

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, patients who experienced poor mental health, carers, those at risk of developing a long-term condition and those requiring advice on their diet and smoking. Patients were then signposted to the relevant service for example, smoking cessation clinics and dietary advice was available from the healthcare assistant. We saw that information was displayed in the waiting area in different languages and also made available and accessible to patients on the practice website. Patients had access to appropriate health assessments and checks.

Effective needs assessment

The practice assessed 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

Good

Are services effective?

(for example, treatment is effective)

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 92.7% of the total number points available for 2014-2015 which was comparable to the practice average across England of 94.2%. Further practice QOF data from 2014-2015 showed:

- The practice clinical exception rate of 2.4% was lower than the Clinical Commissioning Group (CCG) average of 7.5% and national average of 9.2%. Clinical exception rates relate to the number of patients who did not attend a review. A lower clinical exception rate indicated that more patients had attended a review or received treatment than the local and national averages.
- Performance for diabetes assessment and care was much lower than the national average (56.97% as compared to the national average of 94.41%).
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We found the GPs were aware of the fact that the practice was performing much lower in comparison to the local and national averages in the area related to diabetes, mental health assessments and dementia diagnosis. The practice had identified that the merger of the two practices and the absence of clinical staff had had an adverse effect on the level of care in these areas. The GPs felt that improvements had been made as action had been taken to identify the causes and additional clinical staff which included an advanced nurse practitioner had been recruited. A recent audit on the management of patients with diabetes showed that improvements had been made.

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 five clinical audits carried out over the last 12 months. A second cycle had been completed for three of the audits to review whether improvements had been made. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from QOF. For example, the practice had reviewed its patients diagnosed with atrial fibrillation (AF) a heart condition that causes an irregular and often an abnormally fast heart rate to ensure that they had been assessed for the risk of a stroke and had appropriate treatment commenced. As a result of the audit the practice had completed a risk assessment of all patients diagnosed with AF. The number of patients identified had increased from 20 to 27 patients and they had all commenced appropriate treatment in a timely manner.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. Records we looked at showed that staff had annual appraisals. However the records did not show that staff learning needs and personal development plans had been identified. Our interviews with staff confirmed that the practice provided training opportunities. A staff training matrix showed that some staff had received training in basic life support, infection control, fire safety and safeguarding. However there were gaps for both clinical and non-clinical staff in all training areas. These included safeguarding children and vulnerable adults, fire safety, health and safety, information governance and mental capacity. Staff had access to and made use of training opportunities with their peer groups, in-house and external training. The nurses and healthcare assistant received training and attended regular updates for the care of patients with long-term conditions and administering vaccinations.

Good

Are services effective?

(for example, treatment is effective)

The 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). All GPs were up to date with their revalidation training requirements.

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 patients to secondary care such as hospital or to the out of hours service.

Staff worked 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. The practice had recently accepted a contract with the local Clinical Commissioning Group (CCG) to provide a service to a care home that helped patients to rehabilitate following discharge from hospital and prior to discharge home.

The practice told us that multi-disciplinary team meetings to discuss patients on the practice palliative care register did not take place on a formal basis. This was due to the limited availability of community staff, district nurses, community matron and social workers. The practice maintained one to one and telephone contact with this group of professionals to discuss the care of patients. The practice monitored and ensured that care plans were routinely reviewed and updated. The practice maintained regular contact with the local mental health teams and drug and alcohol liaison services.

Consent to care and treatment

We found that although staff had not received formal training they had an awareness of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We saw there was a MCA 2005 policy in place to support staff in making decisions when capacity was an issue for a patient. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a diagnosis of dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. When interviewed, staff gave examples of how patients' best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, there was a formal consent form for patients to sign which demonstrated they were aware of the relevant risks, benefits and complications of the procedure. Consent forms were scanned into patients' notes. We saw an anonymised record where this had been completed.

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, patients who experienced poor mental health, carers, those at risk of developing a long-term condition and those requiring advice on their diet and smoking. Patients were then signposted to the relevant service for example, smoking cessation clinics and dietary advice was available from the healthcare assistant. We saw that information was displayed in the waiting area in different languages 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 CCG

Good

Are services effective?

(for example, treatment is effective)

average. For example, childhood immunisation rates for the vaccination of children under two years of age ranged from 63.5% to 98.1%, children aged two to five 90.2% to 97.6% and five year olds from 83.7%% to 93%.

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 62.71% which was much lower than the national average of 81.83%. The practice was aware of the low performance in this area and felt confident that this would improve following the recent recruitment of two female clinicians, an advanced nurse practitioner and a GP partner. Other information available showed that the uptake of cancer screening by patients registered at the practice varied. Public Health England national data showed that the practice was comparable with local and national averages for the uptake of females attending for breast cancer screening. The number of patients who were screened for bowel cancer screening however was lower than the local CCG and national averages. The practice planned to review the reasons for this.

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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 practice staff could offer patients who wanted to discuss sensitive issues or appeared distressed 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 40 completed cards. Overall the cards contained positive comments about the practice and staff. Patients commented that they were satisfied with the services offered, they were listened to, treated with respect and dignity and that GPs and staff were professional, caring and friendly. We also spoke with two patients on the day of our inspection. 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:

- 89.8% 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%.
- 86.2% said the GP gave them enough time (CCG average 83.7%, national average 86.6%).
- 99.2% said they had confidence and trust in the last GP they saw (CCG average 93.5%, national average 95.2%).
- 84.8% said the last GP they spoke to was good at treating them with care and concern (CCG average 80.3%, national average 85.1%).
- 84.3% said the last nurse they spoke to was good at treating them with care and concern (CCG average 89.2%, national average 90.4%).
- 87.6% 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 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 88.4% 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%.
- 78.9% said the last GP they saw was good at involving them in decisions about their care (CCG average 76.8%, national average 81.4%).
- 81.1% 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. Information was also available in different languages to meet the diverse needs of patients from different cultural backgrounds. There were 13 carers on the practice carers register and 10 patients who were identified as cared for. This represented 0.40% of the practice population. This was less than the expected 2% for the practice population size. The practice had identified some of the reasons for this. The practice had a lower number of patients aged 65 to 85 plus years (15.4% compared to the practice average across England of 26.5%). Many of the elderly patients registered at the practice were of varied ethnic origins and lived within the family home occupied with other family members who looked after them. The family members had not identified themselves as carers as this was linked to their cultural way of life. The practice's computer system

Good

Are services caring?

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 with the local clinical commissioning group (CCG) to plan services and to improve outcomes for patients in the area. Services were planned and delivered to take into account the needs of different patient groups, flexibility, choice and continuity of care. For example:

- There were longer appointments available for patients with a learning disability, older people and patients with long-term conditions.
- The practice offered longer appointments to patients who had recently moved to England from Eastern Europe and asylum seekers. This helped to overcome difficulties with language barriers.
- 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.
- Facilities for patients were all available on the ground floor of both buildings. There were disabled toilet facilities and the practice was wheelchair accessible.
- Plans were in place to move the practice and branch practice into one building to improve access, the services and facilities for patients.
- Telephone consultations were available every day after morning clinics.
- Patients were offered health screening and e
- The practice provided a service to patients who experienced poor mental health appointments at a time that suited them. This included early morning visits (prior to the practice opening times) to patients at their home who did not like to remain in the house during the day and would not attend the practice.
- To help meet the needs of patients from different countries the practice provided information on the services available at the practice and some health care leaflets in different languages. Translation services were available and access to this service was advertised.

Access to the service

The practice was open between 8am to 6pm Monday to Friday. Appointments were from 9am to 11.20am and 3.30pm to 4.50pm Monday to Friday. Extended surgery hours were from 6.30pm to 7pm on Wednesdays. 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, the NHS 111 service and the local Walk-in Centres. This information was available on the practice answerphone, patient leaflet and practice website.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 77% of patients were satisfied with the practice's opening hours compared to the CCG average of 76.7% and national average of 74.9%.
- 88.4% patients said they could get through easily to the surgery by phone (CCG average 72.8%, national average 73.3%).
- 76.4% 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 in the practice. 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 three complaints received over the last 12 months and found that all had been responded to, satisfactorily handled and dealt with in a timely way. Lessons were learnt from concerns and complaints and action was taken to improve the quality of care. For

Good

Are services responsive to people's needs?

(for example, to feedback?)

example a complaint was made about staff conduct when speaking on the telephone. The patient was sent a written apology, with details of the action to be taken by the practice to prevent a reoccurrence. A meeting was held with staff and plans were in place for staff to receive customer care training.

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 promote good outcomes for patients through high quality, effective, treatment and care. The practice had a comprehensive five year business plan in place detailing the plans for the growth of the practice. Staff felt that they were involved in the future plans for the practice, for example staff were aware of the plans to move the merged practices to one site. The practice did not have a patient participation group (PPG) but had been actively advertising and encouraging patients to form a group to work with the practice and be involved in its future plans for development.

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:

- We found that systems were supported by a newly developed and 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 some gaps in training for both clinical and non-clinical staff these included safeguarding children and vulnerable adults, fire safety, health and safety, information governance and mental capacity.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- Health and safety risk assessments had been conducted to limit risks from premises and environmental factors.
- There was a clear staffing structure and staff were aware of their own roles and responsibilities
- Practice specific policies were implemented and were available to all staff.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. The partners were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff. There was a clear leadership structure in place and staff felt supported by 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.

The provider 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. When there were unexpected or unintended safety incidents the practice gave affected people reasonable support, truthful information and a verbal and written apology

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 staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff 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 valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service through an active patient suggestion box, surveys and complaints received. The practice had plans in place to encourage more structured and regular feedback from patients. It was actively advertising and encouraging patients to form a

Are services well-led?

Good

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

patient participation group to work with the practice and be involved in its future plans for development. The practice had developed an action plan which addressed the feedback and showed the progress they had made.

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. Information recorded showed that these were shared with relevant staff and demonstrate learning and appropriate improvements were made.

The priority for the practice was to ensure a stable environment following a change in the GP partnership. The practice had commenced the required process with the Care Quality Commission (CQC) to register this change. The practice had reviewed the skill mix of staff and new staff employed to ensure the needs of patients could be met in the long term. New staff recruited included a GP partner, an advanced nurse practitioner and an experienced health care assistant. The advanced nurse practitioner assessed and treated patients with minor health conditions and was also a qualified independent prescriber. The new GP partners had plans to take part in medical research projects and for the practice to be a training practice for medical students. The new GP partner was a GP trainer and a programme director for GP training. The practice had progressed their plans for the development of the new premises and the planned transfer of both practices into one building. The practice is part of the Wolverhampton GP Federation. (A group of Wolverhampton Doctors who wished to improve local services by integration across practices and with other health and social care providers).