Dr Sinha, Rischie, Sinha, Shanker

Quality Report

Pleck Health Centre
16 Oxford Street,
Pleck
Walsall
West Midlands
WS2 9HY
Tel: Tel: 01922 604400
Website: http://www.pleckhealthcentre.co.uk/

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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 inspected Dr Sinha, Rischie, Sinha, and Shanker on 6 October 2014 as part of a comprehensive inspection.

We found that the practice was safe, effective, caring, responsive and well-led. We rated the practice overall as good.

Our key findings were as follows:

- There were systems in place to ensure patients received a safe service.
- There was evidence of completed audit cycles undertaken to ensure patients care and treatment was effective and achieved positive outcomes.
- Patients were complimentary about the staff at the practice and said they were caring, listened and gave them sufficient time to discuss their concerns.
- The practice had arrangements in place to respond to the needs of the practice population. This included services aimed at specific patient groups.
- Leadership roles and responsibilities were well established with clear lines of accountability.

We saw an area of outstanding practice this was:

- A clinic every Thursday where patients with high blood pressure were reviewed by the pharmacist. The clinic targeted high risk patients to ensure early intervention and achieve positive outcomes for patients.

However, we also identified areas that the practice should improve.

The practice should:

- Ensure fire policies and procedures are reviewed so that regular fire drills take place and fire training for staff is up to date.
- Review the impact on patients when the practice is closed every Wednesday afternoon and the high number of patients who do not attend their appointments, to assess if this affects the accessibility of appointments for patients.

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?

There were systems in place to ensure patients received a safe service. There was evidence of regular checks of emergency medicines and equipment. There was information and guidance on local reporting arrangements for safeguarding children and vulnerable adults so that any concerns could be appropriately investigated and addressed.

Good

Are services effective?

There was evidence of completed audit cycles to ensure patients care and treatment was effective and improved the quality of the service. We found the practice had joint working arrangements with other health care professionals and services. There were effective arrangements to identify, review and monitor patients with long term conditions and those in high risk groups to ensure positive outcomes were achieved.

Good

Are services caring?

Patients were complimentary about the staff at the practice and said they listened and gave them sufficient time to discuss their concerns and were understanding. Patients told us that their privacy and dignity was respected and they were involved in making decisions about their care and treatment.

Good

Are services responsive to people's needs?

The practice had arrangements in place to respond to the needs of the practice population. These included services aimed at specific patient groups. The service was accessible to a variety of patients with different health needs. The practice had a system in place to respond to complaints and concerns in a proactive manner.

Good

Are services well-led?

Leadership roles and responsibilities were well established with clear lines of accountability. There was evidence that the provider had systems in place for assessing and managing risks and monitoring the quality of the service provision. There was evidence of improvements made as a result of audits and feedback from patients.

Good

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice population included 476 patients over the age of 75 years. The practice was in the process of allocating these patients a designated GP. This is an accountable GP to ensure patients over the age of 75 years received co-ordinated care.

Patients over the age of 75 years were offered health checks at dedicated clinics that took place every Monday and Thursday. This included a clinic held by a pharmacist once a week for those patients who were identified with high blood pressure. The aim was to review and monitor the patients health needs.

People with long term conditions

Good

Patients with long term conditions were reviewed by the GPs and the practice nurses to assess and monitor their health condition so that any changes could be made. The nurses contacted patients with long term conditions by telephone or letter and invited them to attend a review.

There was evidence of specialist clinics to review patients with long term conditions. This included a dedicated diabetes clinic and a clinic every Thursday where patients with high blood pressure were reviewed by the in house pharmacist. We spoke with the pharmacist, they told us that the communication with the GPs was very good. The clinic targeted high risk patients to ensure early intervention and achieve positive outcomes for patients. The practice also provided services such as weight management and smoking cessation to support patients live healthier lives.

Patients with long term conditions such as dementia and learning disability had annual reviews undertaken by the GPs and nurses. There were arrangements to review patients in their own home if they were unable to attend the practice. This included visits to care homes. Health checks and medication reviews took place and repeat prescriptions were accessible. These arrangements help to minimise unnecessary admissions to hospital.

Families, children and young people

Good

Antenatal care was provided by the midwife who undertook a clinic at the practice twice a week. The post natal check was completed by the practice nurse to ensure a holistic assessment of a women's physical and mental wellbeing following child birth.

The practice had an allocated health visiting team, although they were not based within the practice, children under the age of 5 years

Summary of findings

had access to the Healthy Child Programme. Priority was given to appointment requests for babies and young children to ensure they were assessed promptly. The GPs undertook eight week checks for babies and childhood vaccination programme was undertaken by the practice nurse.

Working age people (including those recently retired and students)

Good

The practice opened extended hours on Monday evenings from 6:30pm to 8:20pm to accommodate the needs of working age patients. Patients were able to book non urgent appointments around their working day by telephone or on line. Telephone consultations were available so patients could call and speak with a GP or a nurse where appropriate if they did not wish to or were unable to attend the practice.

NHS checks were available for people aged between 40 years and 74 years. The practice offered a range of health promotion and screening services which reflected the needs for this age group. Opportunistic health checks and advice was offered such as blood pressure checks advice on, smoking and obesity and there were nurse led weight management and smoking clinics.

People whose circumstances may make them vulnerable

Good

The practice had a registration policy in place which enabled people without a permanent address to register at the practice; this could often be people who are living in vulnerable circumstances.

Patients who were vulnerable due to their health or social circumstances were offered health checks. Some of the staff at the practice were multilingual and one member of staff was a trained interpreter. The practice also had access to an interpreting service for patients whose first language was not English, this included telephone translation service for urgent appointments. If a translator was required a double appointment was booked to allow sufficient time for the consultation.

The practice was due to start a scheme to avoid unplanned hospital admissions by providing an enhanced service. This focused on coordinated care for the most vulnerable patients and included emergency health care plans. The aim was to avoid admission to hospital by managing their health needs at home. An enhanced service is a service that is provided above the standard general medical service contract (GMS).

Summary of findings

People experiencing poor mental health (including people with dementia)

Good 

Patients with serious mental illnesses were offered an annual review of their physical and mental health needs, including a review of their medicines.

Staff worked closely with local community mental health teams to ensure patients' mental health needs were reviewed, and that appropriate risk assessments and a care plan was in place. A mental health counsellor held a clinic twice a week at the practice to support patients and referred them to specialist service if necessary.

Summary of findings

What people who use the service say

We looked at results of the national GP patient survey 2013. Out of the 454 surveys sent 101 were completed and returned. Findings of the survey were based on comparison to the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

There were areas that the practice was doing well in comparison to other practices in the local CCG. This included, respondents who said the last nurse and GP they saw or spoke to was good at giving them enough time ,listening to them and involving them in decisions about their care. Areas below the average included being able to see their preferred GP, waiting to be seen for appointments and recommending the practice to someone new to the area.

We spoke with nine patients including three members of the patient participation group (PPG). PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. Nearly all of the patients who we spoke with were satisfied with the service. Patients described the staff at the practice as caring and told us that their privacy and dignity was respected. The main issue that people felt needed improving was the appointment system. From our discussion it was apparent that patients preferred to see a specific GP and this meant the waiting time for this GP was longer than others.

As part of the inspection we sent the practice comment cards so that patients had the opportunity to give us feedback. We received 27 completed cards, of these 19 contained positive feedback mostly about staff attitude and behaviour. There were areas identified for improvement which included the appointment system and waiting times.

We reviewed comments made on the NHS Choices website to see what feedback patients had given. There were four comments posted on the website from January 2014 to October 2014. We saw there was a mixture of positive and negative feedback. Areas of positive feedback included GPs who were efficient and helpful. Areas of negative feedback included difficulties with registering at the practice and accessing the service. The practice had not replied to any of the comments. Replying to comments would provide the practice the opportunity to engage with and listen to feedback to improve the quality of the service.

The findings of the GP patient surveys and comment cards supported what patients told us on the day of the inspection which was that patients were overall happy with the staff at the practice. However, accessibility for appointments and waiting times needed to be improved.

Areas for improvement

Action the service SHOULD take to improve

- Ensure fire policies and procedures are reviewed so that regular fire drills take place and fire training for staff is up to date.
- Review the impact on patients when the practice is closed every Wednesday afternoon and the high number of patients who do not attend their appointments, to assess if this affects the accessibility of appointments for patients.

Summary of findings

Outstanding practice

• A clinic every Thursday where patients with high blood pressure were reviewed by the pharmacist. The clinic targeted high risk patients to ensure early intervention and achieve positive outcomes for patients.

Dr Sinha, Rischie, Sinha, Shanker

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a second CQC inspector. The team also included a specialist advisor GP who is currently employed as a GP with experience of primary care services.

Background to Dr Sinha, Rischie, Sinha, Shanker

Dr Sinha, Rischie, Sinha, Shanker is a registered provider of primary medical services with the Care Quality Commission (CQC) and has two registered locations (practices). They are Dr Sinha, Rischie, Sinha, Shanker practice also known as 'Pleck Health Centre' and more recently New Invention Health Centre. This inspection focused on Dr Sinha, Rischie, Sinha, Shanker,Pleck Health Centre,16 Oxford Street, Pleck,Walsall,West Midlands,WS2 9HY.

The practice is based in a purpose built GP health centre. The practice is a training practice for GP Registrars (fully qualified doctors who wish to become general practitioners) and an approved teaching practice for medical students in their final year. The registered patient list size is approximately 7625 patients. The practice is opened Monday, Tuesday, Thursday and Friday 08:00am to 6:30pm. However, the practice is closed every Wednesday from 1:00pm until Thursday morning 0800am. During this period of time when the practice is closed in normal working hours the practice subcontracts GP access for patients through a local GP provider. There is extended opening hours on Monday from 6:30pm to 8.20pm.

There are four permanent GPs (three male and one female) who are also partners at the practice, two GP registrars (one male and one female) and one sessional locum GP (male). The practice employs a nurse prescriber (female), a practice nurse (female) and a health care assistant (female) who also undertake phlebotomy (the taking of blood). There are also eight administrative staff and a practice manager

The practice has a General Medical Service contract (GMS) with NHS England. A GMS contract ensures practices 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 minor surgery. An enhanced service is a service that is provided above the standard GMS contract.

We reviewed the most recent data available to us which showed that the practice is in one of the most deprived areas in Wasall with the 13th highest deprivation score in the CCG area. The practice has an above average patient population who are aged 0-4 years old and lower than average practice population of older patients aged 75 years and over in comparison to other practices in the CCG area. The practice is only one of two practices that achieved 100% points for the Quality and Outcomes Framework (QOF) for the last financial year 2012-2013. The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes.

Detailed findings

The practice has opted out of providing out-of-hours services to their own patients. This service is provided by an external out of hours service contracted by the CCG.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This provider had not been inspected before and that was why we included them.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we held about the service and asked other organisations and health care professionals to share what they knew about the service. We also sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received 27 completed cards where patients shared their views and experiences of the service. We carried out an announced inspection on 6 October 2014. During our inspection we spoke with a range of staff including the practice manager, clinical and non clinical staff. We spoke with patients who used the service. We observed the way the service was delivered but did not observe any aspects of patient care or treatment.

Are services safe?

Our findings

Safe Track Record

Patients spoken with did not report any safety concerns to us and we were not aware of any major safety incidents that had occurred at the practice.

The practice had a whistle blowing policy and staff told us that they felt confident to raise any concerns about poor care that could compromise patient safety. Whistleblowing is when staff are able to report suspected wrong doing at work, this is officially referred to as 'making a disclosure in the public interest'.

The practice manager told us that when they received patient safety alerts they would discuss these with the lead GP and these would be actioned where appropriate and shared with staff. Patient safety alerts are issued when potentially harmful situations are identified and need to be acted on. This was an informal approach to managing alerts as they were not recorded to provide a clear audit trail of actions undertaken.

There were systems in place to report any incidents that occurred at the practice. When an incident occurred a report was completed and this included any actions required. Discussions with staff demonstrated that they were aware of the process for incident reporting and they told us they received feedback following incidents during meetings that were held. We found that these meetings were not regular as they were held on an annual basis. A list of all incidents that had occurred over the last 12 months was recorded and an annual review took place.

Learning and improvement from safety incidents

The Practice had a system in place for reporting, recording and monitoring significant events. This included significant event analysis (SEA). A significant event is any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice. A detailed policy was in place with the aim to foster an open and fair culture committed to learning and ensuring lessons were learnt. We saw that two significant events had been recorded over the last year although our discussion with staff indicated a medical emergency that had taken place. This however, was not recorded as a significant event. There was some evidence to demonstrate learning points were identified in response to significant events. However, the last meeting to discuss significant events with staff took place in November 2013. The practice manager and lead GP told us that informal discussions took place with staff on an on-going basis.

Reliable safety systems and processes including safeguarding

There were arrangements in place for ensuring patient safety, this included clear safeguarding policies and procedures for staff to respond to any concerns and contact numbers for local safeguarding teams. There was a lead GP for children's safeguarding. The practice manager told us that all of the staff had received safeguarding vulnerable adults and children's training. There was no overall log for staff training to demonstrate this. However, we saw training certificates for some of the staff that demonstrated they had completed training. An alert system was in place to highlight vulnerable adults and children. We saw evidence of a recent referral completed by a GP at the practice following concerns about a vulnerable adult. This demonstrated concerns were identified and acted on in line with local safeguarding procedures.

The practice had a chaperone policy in place. Some of the staff who acted as chaperones had received training in this area. Staff who we spoke with were aware of their role and responsibilities when undertaking this duty.

Medicines Management

The practice had medicines and equipment available to use in the event of a medical emergency. We noted that information on most of the medicines stated that they should not be stored above a specified temperature range. Staff confirmed that there was no system in place to monitor the temperature so they could be confident that the medicines were stored within the recommended temperature ranges. Emergency medicines need to be stored in a safe place but should be readily accessible in the event of a medical emergency. However, we saw that they were stored in an unlocked room that was accessible to patients. We discussed this with the practice manager and the registered manager at the time of the inspection. Following our inspection the practice manager confirmed that actions had been taken to address the issue.

There was a dedicated secure fridge where vaccines were stored. There were systems in place to ensure that regular checks of the fridge temperature was undertaken and recorded. A cold storage vaccine policy was in place to further guide staff. The cold chain ensures that all activities

relating to the supply and storage of vaccinations maintain the required temperature range so that they are safe and effective to administer. There was a clear audit trail of when vaccines were received and placed in fridge. This provided assurance that the vaccines were stored within the recommended temperature ranges and were safe and effective to use.

Prescriptions were stored appropriately to ensure they were only accessible to appropriate staff. However, there was no system in place for recording the serial number of prescriptions. This is recommended as it ensures a clear audit trail of used prescriptions so that all prescriptions can be accounted for and traced in the event this was necessary. This reduced the likelihood of misuse. We discussed this with the practice manager and the registered manager at the time of the inspection. Following our inspection the practice manager confirmed that appropriate action had been taken.

A system was in place for repeat prescribing so that patients were reviewed appropriately to ensure their medications remained relevant to their health needs. There was an alert system for issuing repeat prescriptions when medication reviews were due. These were undertaken as planned and opportunistic reviews.

Cleanliness & Infection Control

On the day of our inspection we observed that the practice was visibly clean and tidy. There were systems in place to reduce the risk of cross infection such as the availability of personal protective equipment (PPE) and colour coded cleaning equipment. Information about hand hygiene was on display to help promote good hand hygiene. There was no system in place to record all of the training that staff had completed. However, we looked at a sample of training certificates which showed that staff had received training in infection prevention and control. Our discussion with staff also demonstrated their understanding. We noted that the infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement infection control measures and to comply with relevant legislation. Staff told us that these policies and procedures were accessible to them.

We found that suitable arrangements were in place for the storage and the disposal of clinical waste and sharps. Sharps boxes were dated and signed with the date of use to enable staff to monitor how long they had been in place. A clinical waste management protocol was in place that included detail of colour coding systems to ensure appropriate segregation of clinical waste.

The practice employed cleaners to carry out daily cleaning duties. Cleaning specifications were in place which included the task and frequency of cleaning per area such as the kitchens. However, the cleaning schedules were not signed to demonstrate that the cleaning had taken place consistently.

An audit had been completed in February 2014 by the local Clinical Commissioning Group (CCG) on minor surgery performed at the practice. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. The practice had an overall score of 97%, there was evidence that improvements action had been made as a result of the findings of the audit.

An infection prevention and control audit had also been completed by Walsall Healthcare NHS Trust for the whole surgery in February 2014. The practice had an overall score of 96%, there was evidence that the action plan from the audit had been fully completed

A legionella risk assessment had been reviewed recently to ensure that any risks to patients from potential contaminated water was identified and acted on. Legionnaires' disease is a form of bacteria which can live in all types of water.

Equipment

The fire alarm system and emergency lighting was serviced and electrical appliances were tested to ensure they were in good working order.

Records showed that medical equipment had been calibrated and serviced so that they were safe and effective to use.

Electrical appliances had been tested to ensure they were in good working order and safe to use.

Staffing & Recruitment

The registered patient list size was approximately 7625 patients. There were four permanent GPs (three male and one female) who were also partners at the practice, two GP registrars (one male and one female) and one sessional locum GP (male). The practice employed a nurse prescriber

Are services safe?

(female), a practice nurse (female) and a health care assistant (female) who also undertook phlebotomy (the taking of blood). There were also eight administrative staff and a practice manager.

The practice was a training practice for GP Registrars (fully qualified doctors who wish to become general practitioners) and an approved teaching practice for medical students in their final year.

There were systems in place to monitor and review staffing levels to ensure any shortages were addressed and did not impact on the delivery of the service. The practice manager was aware of busy times and gave an example of when additional staff were on reception desk during busy times. There was an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

The practice manager told us that they rarely used locum GPs however, in the event this was required appropriate documentation was sought prior to them working at the practice. We saw evidence to support this.

The practice manager confirmed that most of the staff had worked at the practice for a number of years which provided stability within staff team that ensured patients received continuity in their care.

We looked at 3 staff files, including the file of the most recent member of staff employed at the practice. There was evidence that appropriate pre-employment checks were completed prior to staff commencing their post. This included references and a Disclosure and Barring Service (DBS) check. The DBS check is a criminal records check that helps identify people who are unsuitable to work with children and vulnerable adults. The practice manager told us that on commencement of their post new members of staff received an induction. However, this was done on an informal basis. In the staff file for a new member of staff there were no records to demonstrate they had received an induction and that any competency assessment had taken place.

Monitoring Safety & Responding to Risk

Records showed that risk assessments had been completed including the control of substances hazardous to health (COSHH) and information governance.

We saw that a fire risk assessment had been completed in May 2013 by an external contractor. The practice manager told us that this service was contracted out because the local fire service no longer carried out routine fire risk assessments. The practice manager confirmed that there had been no further review of the risk assessment. Following our inspection the practice manager told us that they had consulted with the external agency that carried out the initial fire risk assessment. The advice was that an annual assessment was not required unless there had been a change. The practice manager sent us evidence to confirm that no changes had occurred. However, an action identified in the risk assessment in May 2013 was that automatic door releases were required and these were still not in place. Following our inspection the practice manager told us that the door releases had been ordered.

We saw that there was a fire safety policy, a fire lead and fire marshals in place. However, there were gaps and inconsistencies in the policy. There was no reference to the frequency of fire risk assessments and the policy stated that fire drills would take place although the practice manager confirmed that fire drills were not taking place. The practice manager confirmed that although staff had been briefed on fire evacuation in May 2013 there had been no further training. Regular fire drills and training would ensure that staff were better equipped to respond in the event of a fire emergency.

There was evidence that the fire alarms were tested and a recent maintenance check of the fire alarm system had taken place. Fire equipment had been checked within the last year and the lift in the practice had also been serviced recently. Emergency lighting was last checked in August 2014 and identified areas for actions, the practice manager confirmed that the actions had not been completed but were in progress.

There were arrangements to deal with a foreseeable medical emergency. Staff had received training in responding to a medical emergency. There were emergency medicines and equipment available that were checked regularly so that staff could respond safely. The practice had an automated external defibrillator (AED). This is a piece of life saving equipment that can be used in the event of a medical emergency. All of the staff asked (including receptionists) knew the location of the emergency medicines and equipment.

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had an up to date disaster handling and recovery policy in place. This covered a range of areas of potential risks relating to foreseeable emergencies that could impact on the delivery of the service. There was a named lead and contact details of staff and main suppliers that would be needed in the event of an emergency and major incident.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians who we spoke with were able to describe and demonstrate how they accessed guidelines from the National Institute for Health and Care Excellence (NICE). Each GP had an area of clinical expertise and updated guidelines with regards this area. NICE provides national guidance and advice to improve health and social care. There was a lack of evidence to demonstrate that updated guidelines were routinely disseminated to clinical staff.

The most recent data available to us from Public Health England showed patient outcomes were at or above average for the locality for some areas .The practice was only one of two practices that achieved 100% points for the Quality and Outcomes Framework (QOF) for the last financial year 2012-2013. The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes. The practice nurse undertook childhood vaccination programmes and the most recent data available to us showed that the practice was achieving a high rate.

Antenatal care was provided by the midwife who undertook a clinic at the practice twice a week. The post natal check was completed by the practice nurse to ensure a holistic assessment of a women's physical and mental wellbeing following child birth. The GPs undertook six week checks for babies and this was coordinated with the babies first set of childhood vaccinations.

Patients with a learning disability and mental health needs had annual reviews and care plans in place. For example we saw that there was a register in place which identified 26 patients with a learning disability. Systems were in place to monitor their health need and ensure care plans were reviewed. Learning disability patients were reviewed at the practice facilitated by the learning disability nurse or if they were unable to attend the practice contacted their carers and a home visit was arranged. The practice manager told us that the learning disability nurse accompanied the GPs on these visits.

Patients with long term conditions were reviewed by the GPs and the practice nurses to assess and monitor their health condition so that any changes could be made. The nurses contacted patients with long term conditions by telephone or letter and invited them to attend a review. Patients over the age of 75 years were offered health checks. A clinic was held by a pharmacist once a week for those patients who were identified with high blood pressure. The clinic targeted high risk patients to ensure early intervention and achieve positive outcomes for patients. We spoke with the pharmacist, they told us that communication with the GPs was very good.

Patients who were receiving end of life care had a named doctor and there were arrangements to share information with out of hours services for when the practice was closed. Meetings were held with the palliative care teams to ensure coordinated care that respected patient's needs and wishes.

There were systems in place to ensure patients had regular review of their medicines, to assess their progress and ensure their medications remained relevant to their health needs. This included reviews undertaken by the pharmacists and the GPs

The practice was due to start a scheme to avoid unplanned hospital admissions by providing an enhanced service. This focused on coordinated care for the most vulnerable patients and included emergency health care plans. The aim was to avoid admission to hospital by managing their health needs at home. Our discussions with health care professionals indicated that there was good communication systems in place with the GPs and staff at the practice to ensure the care needs of older people were acted upon to prevent unnecessary admission to hospital. Home visits were undertaken to care homes to review patients who were unable to attend the practice.

The practice referred patients appropriately to secondary and other community care services such as district nurses. We saw evidence of appropriate use of 'Two Week Wait' referrals and these were audited to ensure they were used effectively.

Staff who undertook reception duties discussed how they responded to patients who required for sick notes. They told us that such requests were not necessarily medically urgent however; they recognised the importance of a sick note to working age patients and would ensure these requests were acted on.

Good

Are services effective?

(for example, treatment is effective)

Management, monitoring and improving outcomes for people

The practice showed us a number of clinical audits that had been undertaken in the last year. These were generally completed audits where the practice was able to demonstrate the changes resulting since the initial audit. It should be noted that if a practice is commissioned to undertake enhanced services such as minor surgery their commissioner and their accrediting body will expect an audit of all patients receiving the service. We saw evidence that audit was completed on minor surgery undertaken. Findings were shared with staff in clinical meetings however, these meetings were not documented. This did not provide good evidence to support dissemination of learning to staff.

Effective staffing

Discussion with staff and evidence viewed on the day suggested that most of the staff had received training appropriate to their roles. However, we identified there were gaps in training for some of the staff. This included Mental Capacity Act training, only the lead GP had completed this training, there was also no evidence that a member of clinical staff had completed infection prevention and control training. However, there were examples of staff being encouraged and supported to address learning needs identified. A member of reception staff had received chlamydia awareness training and explained that they were confident to discuss this with patients. There was no overall training log to ensure training needs could be easily identified and addressed.

The GPs at the practice had various lead roles in areas such as mental health and safeguarding. This provided the opportunity for staff to develop specialist knowledge and expertise.

The practice had systems in place for annual appraisals for all staff and staff that we spoke with confirmed this.

All of the GPs who worked at the practice had undergone or were due external revalidation of their practice. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise medicine.

Working with colleagues and other services

We spoke with two local care home managers about the arrangements for reviewing patients who were unable to attend the practice. They were very positive about the service received from the practice. They told us that the GPs were approachable and undertook home visits on request. Health checks and medication reviews took place and repeat prescriptions were easily accessible. One told us that the nurse undertook home visits to offer people the flu vaccines. These arrangements helped to minimise unnecessary admissions to hospital.

The practice had opted out of providing out of hours services (OOH). This had been contracted by the CCG to an external service provider. The practice received an electronic summary for patients who had accessed the OOH service. These patients were reviewed and followed up where necessary by the doctor who was on duty each day.

There were systems in place to ensure that the results of tests and investigations were reviewed and actioned as clinically necessary. This included review of tests and investigations by the nurse and the GPs to ensure any abnormal results were acted on.

Information Sharing

We found that the practice worked with other service providers to meet people's needs and manage complex cases. Multidisciplinary working was evidenced for example joint working arrangements were in place with the pharmacist, community psychiatric nurse (CPN) and learning disability nurse.

The practice had an allocated health visiting team, although they were not based within the practice, children under the age of 5 years had access to the Healthy Child Programme and there were arrangements in place to share important information

Consent to care and treatment

The practice had a consent policy in place which provided guidance to staff when they gave care and treatment to patients. The consent policy made reference to the Gillick competency for assessing whether children under 16 were mature enough to make decisions without parental consent. This allowed professionals to demonstrate that they had checked a person's understanding of proposed treatment, and used a recognised tool to record the decision making process. The practice had no current examples where they had needed to apply the Gillick competency.

There was a lead GP for mental health who had training in the Mental Health Capacity Act as part of a Diploma course.

Good

Are services effective?

(for example, treatment is effective)

Clinical staff who we spoke stated that they would follow guidelines with regards to capacity and consent and were confident that they could assess it. We saw that there were mental capacity assessment and best interest decisions templates to assist staff in the assessment process.

Health Promotion & Prevention

The practice offered all new patients registering with the practice a health check with the health care assistant or practice nurse. The GP was informed of all health concerns detected. NHS checks were available for people aged between 40 years and 74 years.

There was a recall system in place for cytology screening which were carried out by the practice nurse so that women received this important check including their results in a timely manner.

The practice offered contraceptive services and sexual health advice, screening and referral for patients. Free condoms and chlamydia screening tests were available. There were posters informing patients that these were available. The practice offered a range of health promotion and screening services which reflected the needs for this age group. Opportunistic health checks and advice was offered such as blood pressure checks advice on smoking and obesity and there were nurse led weight management and smoking clinics.

Information leaflets and posters were available in the patient waiting area to support and signpost people to support groups and organisations. This included information about self-management of minor illnesses. We saw a notice board with details for elderly care services that patients could refer to for support and advice. The practice website also had a link to patient information leaflets on health conditions and diseases provided by Patient.co.uk.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We looked at results of the national GP patient survey 2013. Out of the 454 surveys sent 101 were completed and returned. Findings of the survey were based on comparison to the regional average for other practices in the local Clinical Commissioning Group (CCG).

There were areas that the practice was doing well in comparison to the average for other practices in the local CCG. This included, respondents who said the last nurse and GP they saw or spoke to was good at giving them enough time ,listening to them and involving them in decisions about their care. Areas below the average included being able to see their preferred GP, waiting to be seen for appointments and recommending the practice to someone new to the area.

We spoke with nine patients including three members of the PPG. Nearly all of the patients who we spoke with were satisfied with the service. Patients described the staff at the practice as caring and told us that their privacy and dignity was respected.

As part of the inspection we sent the practice comment cards so that patients had the opportunity to give us feedback. We received 27 completed cards, of these 19 contained positive feedback mostly about staff attitude and behaviour.

The findings of the GP patient surveys and comment cards supported what patients told us on the day of the inspection which was that patients were overall happy with the staff at the practice. However, some patients felt that accessibility for appointments and waiting times needed to be improved.

We saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room and that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be easily overheard.

The layout of the patient waiting areas meant that patients approaching the reception desk could be easily overheard when talking o staff. However, we observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the main reception desk which helped keep patient information private. There was a poster informing patients that they could discuss any issues in private away from the main reception desk. We saw this system in operation during our inspection and noted that it was effective in maintaining confidentiality.

The practice had recently completed a Disability Discrimination Act (DDA) audit that showed compliance with the Disability Discrimination Act 1995. This act ensures providers of services do not treat disabled people less favourably, and must make reasonable adjustments so that there are no physical barriers to prevent disabled people using their service.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 76% of practice respondents said the GP involved them in care decisions and 83% felt the GP was good at explaining treatment and results. Both these results were above average compared to other practices in the CCG area.

Patients we spoke to on the day of our inspection told us that their health issues were discussed with them and they felt involved in decision making about the care and treatment they received. 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 they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

We asked staff about bereavement support for patients. They told us they would signpost patients to bereavement services. We saw that there were information leaflets in the patient waiting area with details of bereavement support groups. A GP at the practice would also call bereaved relatives to offer support. There were arrangements in

Good

Are services caring?

place to refer patients to counselling services for emotional support. Clinical staff attended regular meetings with relevant professionals and agencies to discuss and review patients who were receiving end of life care.

We saw information leaflets in in the patient waiting area for people who were carers. Our discussion with the lead GP and practice manager did not clearly demonstrate that consideration had been given to support carers in a proactive manner. This was because we were unable to see evidence of how their health needs were identified and acted on.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the service was responsive to people's needs and had sustainable systems in place to maintain the level of service provided.

We saw that the practice had an active and engaged patient participation group (PPG). PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service There was evidence that the PPG group had acted on feedback from the General Practice Survey. As a result of patient feedback improvements had been made in the telephone system which included more telephone consultations. The PPG had organised a 'Health and Wellbeing' day in April 2013 to raise awareness on conditions such as diabetes, obesity and smoking, there were external speakers and health promotion and prevention advice was given.

The practice had achieved and implemented the gold standards framework for end of life care. They had a palliative care register and regular multidisciplinary meetings to discuss patient and their families care and support needs

There had been very little turnover of staff during the last three years which enabled continuity of care. All patients who needed to be seen urgently were offered same-day appointments and there was a triage system in place to ensure this was done effectively.

The practice had responded to feedback on the service delivery. For example the practice had moved from having a high number of patient attendances to A/E. This had made them the number one practice in the CCG area to moving to number 27 (out of a total of 60 practices).

Tackling inequity and promoting equality

The practice had a registration policy in place which enabled people without a permanent address to register at the practice; this could often be people who are living in vulnerable circumstances

Some of the staff at the practice were multilingual and one member of staff was a trained interpreter. The practice also had access to an interpreting service for patients whose first language was not English, this included telephone translation service for urgent appointments. We did not see any posters on display informing patients of the availability of an interpreting service. This would ensure the service was more accessible to patients who may benefit from it. If a translator was required a double appointment was booked to allow sufficient time for the consultation. A patient at the practice required a sign language interpreter and this was arranged.

A poster in the waiting room informed patients about the PPG and encouraged patients to join.

Access to the main surgery entrance was at one level and there were automatic doors that made the practice accessible to patients who required the use of a wheelchair. There were disabled parking and toilet facilities and a Loop Induction System for patients with hearing impairment.

Access to the service

We spoke with nine patients including three members of the PPG. Nearly all of the patients who we spoke with were satisfied with the service. The main issue that people felt needed improving was the appointment system. From our discussion it was apparent that patients preferred to see a specific GP and this meant the waiting time for this GP was longer than others. Although changes had been made to the appointment system as a result of feedback the issue of patient wanting to see a specific GP had not been fully explored or addressed by the practice.

As part of the inspection we sent the practice comment cards so that patients had the opportunity to give us feedback. We received 27 completed cards, eight cards identified areas for improvement which included the appointment system and waiting times.

We confirmed with the practice manager that the practice had had a high number of patients who did not attend their appointments (DNA). Between the months of February 2014 to October 2014 there was a total of 2323 DNA. There had been no analysis of this data and no actions had been taken. We were told that no reminders were sent to patients regarding their appointments such as a mobile text message. Feedback from patients suggested that accessing appointments was an issue. The lack of response to high DNA rates could further impact on the accessibility of appointments and was not an effective management of resources.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice website outlined how patients could book appointments and organise repeat prescriptions online. Patients could also make appointments by telephone and in person to ensure they were able to access the practice at times and in ways that were convenient to them.

The practice was opened Monday, Tuesday, Thursday and Friday 08:00am to 6:30pm. However, the practice was closed every Wednesday from 1:00pm until Thursday morning 0800am. During this period of time when the practice was closed during normal working hours the practice subcontracted GP access for patients through a local GP provider. We confirmed with NHS England that they were aware of this arrangement and there were other practices within the Walsall area that closed during normal working hours and utilised a local GP provider.

The practice had opted out of providing out of hours service. This was provided by an external out of hours service contracted by the CCG. We identified that the answer phone message did not automatically transfer patients to the local GP provider or the out of hours service when the practice was closed. We discussed this with the practice manager who explained the answerphone message provided the contact details for the local GP provider and the out of hours provider. However, patients had to put the phone down and redial the out of hours provider so that the call was not chargeable. Calls made to the NHS 111 service was also not chargeable. Calls to the local GP provider was charged at a local rate. NHS England told us that the answerphone message for the practice was appropriate as it provided the relevant contact details.

There was extended opening hours on Monday 6:30pm to 8.20pm which would be particularly useful to patients with work commitments.

There were a number of urgent appointment slots daily as well as walk in clinic for urgent reviews. A triage system was in place and telephone consultations were available. Reception staff were confident that if a patient needed to see a GP urgently then they would see one; they told us that issues arose when patients request to see a specific GP. This supported the feedback we received from some of the patients.

We noted the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Toilet facilities were available for all patients of the practice.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website.

Listening and learning from concerns & complaints

There was an accessible complaints system with evidence demonstrating that the practice recorded and responded to issues raised. The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England. An annual complaints review took place and complaints were analysed to identify trends, lessons learnt were recorded and any actions taken were recorded. Sharing of lessons learnt and discussions with staff were not routinely recorded other than the annual review.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice manager and staff we spoke with demonstrated the values of the practice and a commitment to improving the quality of the service for patients. We spoke with all three partners at the practice. The partners at the practice had recently taken over the management of another practice in the Walsall area which was New Invention Health Centre. This was part of a 'care taking' arrangement with NHS England. This was seen as an opportunity to strengthen the partnership arrangement with a vision to develop and expand service provision for the future. These plans had not been formally documented. The GP partners wanted to be recognised as a good practice and had already established themselves as a post graduate training practice. During the inspection we identified an area of outstanding practice which supported their aspiration to develop innovative practice.

Governance Arrangements

There was a clear leadership structure and staff felt supported by the management team. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG) who engaged with patients and acted on feedback such as increasing the appointments system and organising a 'Health and Wellbeing day'.

Two of the partners including the lead GP spent a proportion of their time at New Invention Health Centre. From our discussion with the lead GP it was evident that the overall management of the practice was the role of the practice manager. Our discussions with some of the staff demonstrated that that they were clear of the management arrangements at the practice.

The practice manager was responsible for human resources. We saw that there were a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at some of these policies and procedures and found that they had been reviewed annually and were up to date.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead for safeguarding and mental health. Staff members who we spoke were clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We saw that team meetings were held.

Practice seeks and acts on feedback from users, public and staff

We reviewed comments made on the NHS Choices website to see what feedback patients had given. There were four comments posted on the website from January 2014 to October 2014. We saw there was a mixture of positive and negative feedback. Areas of positive feedback included GPs who were efficient and helpful. Areas of negative feedback included difficulties with registering at the practice and accessing the service. The practice had not replied to any of the comments. Replying to comments made would provide the practice the opportunity to engage with and listen to feedback to improve the quality of the service.

We looked at results of the national GP patient survey 2013. Out of the 454 surveys sent 101 were completed and returned. Findings of the survey were based in comparison to the regional average for other practices in the local Clinical Commissioning Group (CCG). There were areas that the practice was doing well in comparison to the average for other practices in the local CCG. We saw evidence that some changes had been made as a result of feedback. This included changes to the telephone on hold system so that patients were aware they were on hold and the introduction of additional lines.

The practice had gathered feedback from staff through for example staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Are services well-led?

Good

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

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was very supportive of training and that clinical meetings sometimes included guest speakers.

The practice was a training practice for GP Registrars (fully qualified doctors who wish to become general practitioners) and an approved teaching practice for medical students in their final year.

When an incident occurred at the practice an incident t report was completed and this included any actions required. Discussions with staff demonstrated that they were aware of the process for incident reporting and they told us they received feedback following incidents during meetings that were held. We found that these meetings were not regular as they were held on an annual basis. A list of all incidents that had occurred over the last 12 months was recorded and an annual review took place.

An audit had been completed in February 2014 by the local CCG on minor surgery performed at the practice. The practice had an overall score of 97%, there was evidence that improvements action had been made as a result of the findings of the audit.