Bloxwich Medical Practice

Quality Report

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Date of inspection visit: 16 October 2014
Date of publication: 26/03/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Bloxwich Medical Practice provides a range of primary care medical services to approximately 4600 patients.

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them. We carried out an announced visit on 16 October 2014 and was a comprehensive type of 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.
- The practice had effective procedures in place that ensured care and treatment was delivered in line with appropriate standards.
- The practice was caring. Patients were treated with dignity and respect. Patients spoke very positively of their experiences and of the care and treatment provided by staff.
- The practice was responsive to patients' needs and provided services that reflected the needs of the patients.
- We found that the service was well led with well-established leadership roles and responsibilities with clear lines of accountability.

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

- Where audits were being carried out to improve care they were not always followed up to demonstrate sustained improvement.
- The practice had increased the capacity of the advanced nurse practitioner to address issues in access. However, the practice had not conducted audits on DNAs (did not attend) so that it can manage a stepped reduction in DNA rates as a service objective.

Summary of findings

- A formal arrangement should be in place to share information with other healthcare professionals such as health visitors.

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 service is rated as good for safe. The practice used a range of information to identify risks and improve quality regarding patient safety. There was a system for reporting, recording and monitoring significant events. Systems were in place to recognise and support patients at risk of abuse. Staff were suitably qualified, trained and competent to carry out their roles and a system was in place to enable sufficient staff numbers to meet service requirements. Equipment required to manage foreseeable emergencies were available, was regularly serviced and maintained. Medicines were appropriately stored, checked and the records were accurately maintained in line with legal and safety requirements. Patients were cared for in an environment which was visibly clean and reflected good infection control practices though no practice audits were available.

Are services effective?

Good

The service is rated good for effective. Patients' care and treatment was delivered in line with recognised best practice standards and guidelines. Patient care was improved by the monitoring and review of their treatment. Data we viewed showed that the practice compared favourably with other practices in the area. The practice had carried out audits to check the quality of clinical care and acted on the findings, but had not re-audited to ensure the improvements made were being sustained. Staff received the training and support to undertake their roles. Systems were in place to monitor and support staff performance within the practice. The practice worked with other primary care providers such as community nurses to co-ordinate care but there was no formal arrangement in place. Patients had timely referrals to secondary care services.

Are services caring?

Good

The service is rated as good for caring. Patients told us that staff were kind, considerate and compassionate and that the practice staff treated them with respect and dignity at all times. The annual GP National Patient Survey 2014 indicated 89% of respondents from the practice rated the service as good. This was above average compared to other practices in the locality. Patients' privacy and dignity was respected. Patients were involved in treatment choices. Patients told us doctors and nurses explained their care and they were involved in care decisions.

Summary of findings

Are services responsive to people's needs?

Good

The service is rated as good for responsive to the needs of people. The practice delivered core services to meet the needs of the main patient population they treated. For example, patients had access to screening services to detect and monitor certain long term conditions. There were immunisation clinics for babies and children. The practice had arrangements in place to support patients with disabilities. The practice was located in a purpose built health centre where five other GP services were also located. The layout of the building enabled patients with mobility needs to gain access without assistance. The practice had a complaints system. We saw that complaints were reviewed, responded and actioned to inform improvement where appropriate.

Are services well-led?

Good

The service is rated as good for well led. Patients were cared for by staff who were aware of their roles and responsibilities for managing risk and improving quality. There were clear governance structures and processes in place to keep staff informed and engaged in practice matters. Patients' views on the service were listened to and were used to improve services. The practice had a patient participation group (PPG) to promote and support patient views and participation in the development of services provided by the practice. PPGs are groups of active volunteer patients that work in partnership with practice staff and to achieve quality care. There was a satisfactory system to review complaints. Staff were supported to undertake their roles. Each member of staff had an annual performance review and personal development plan.

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 had allocated a designated GP for all patients over the age of 75. This is a named accountable GP assigned to each patient to ensure they receive co-ordinated care. Patients over 75 years old had a personalised care plan to enable increased monitoring and follow up. The practice was providing an enhanced service to avoid unplanned hospital admissions. 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). Patients were contacted after discharge from unplanned hospital admissions and monthly meetings were held between the GPs and practice nurse to review unplanned admissions and liaise with other professionals for better management of their care. This helped to prevent unnecessary admission to hospital. We spoke with local care home managers about the arrangements for reviewing patients who were unable to attend the practice. They were 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 home manager told us that the nurse undertook home visits to offer people the flu vaccines. These arrangements help to minimise unnecessary admissions to hospital. A care home manager also praised the practice for supporting the staff at the care home as well as the family of a resident after bereavement.

People with long term conditions

Good

There was evidence that patients with long term conditions were reviewed regularly. The practice offered clinics for management of long term conditions and also provided services such as weight management, Influenza and pneumonia vaccinations to support patients live healthier lives. There were systems in place to ensure patients had regular review of their medicines. The GPs were aware of prescription medication abusers and only small quantities were prescribed to them.The appointment system was flexible and allowed pre bookable appointments three months in advance. Same day and urgent appointments were also available which allowed better management of patients with long term conditions.Patients with dementia and learning disabilities had annual reviews undertaken by the GPs and there were arrangements to review patients in their own home if they were unable to attend

the practice. This included visits to care homes. We spoke with 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.

Families, children and young people

Good

Midwife led clinics were available every Wednesday and the GPs undertook eight week checks for babies. This was coordinated with the babies first set of childhood vaccinations and the practice nurse delivered the childhood vaccination programmes. The most recent data available to us showed that the practice was achieving a high rate of vaccinations. The practice had achieved 100% vaccination rates for children aged 24 months and five years. There was a recall system in place for cytology screening which was carried out by the practice nurse to encourage women to attend this important check. Young adults had access to sexual health services. Information, including lifestyle advice on healthy living was given to expectant mothers and fathers by the midwife. GPs also provided preconception counselling upon request. There was a lead GP for children's safeguarding. We were sent a training log which demonstrated that staff that had completed training. An alert system was in place to highlight vulnerable children. There were policies, procedures and contact numbers to support and guide staff should they have any safeguarding concerns about children. All consultation rooms were on the ground floor and access was via automatic doors that made the practice accessible for pushchairs. We saw that patients with push chairs were able to access the practice.

Working age people (including those recently retired and students)

Good

The practice opened extended hours on Monday evenings from 6:30pm to 7:45pm 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 and advice on smoking and obesity. The practice nurse led weight management and smoking cessation clinics. Access to further services was available including phlebotomy (collection of blood from patients for examination in

Summary of findings

laboratories), spirometry (test that can help diagnose various lung conditions, most commonly chronic obstructive pulmonary disease (COPD)), ear syringing and holiday vaccination and family planning advice was also available through consultation with a practice nurse. Information leaflets and posters were available in the patient waiting area and on the practice website to support and signpost people to support groups and organisations and provide information about self-management of minor illnesses. The practice website had a 'live well' area which provided health information on a wide range of conditions. Patients were offered choices when referred to other services. The practice used 'choose and book' for hospital referrals. Choose and Book is an electronic service that enables patients needing an outpatient appointment to choose which hospital they are referred to by their GP, and to book a convenient date and time for their appointment.

People whose circumstances may make them vulnerable

Good

There were appropriate safeguarding policies in place. Staffs had appropriate training and were clear and confident on how they would respond to any concerns. The practice ensured it invited all patients with a learning disability along with any carers, where appropriate, for a review by searching its patient database. Vulnerable patients with long term conditions were assessed and patients over 75 years old were started on a care plan to enable increased monitoring and follow up. The practice stated that they did not have groups of patients who lived in vulnerable circumstances such travellers, homeless people and vulnerable migrants. However, records showed that most staff had received training in equality and diversity. This ensured that staff recognised, respected and valued differences and allowed patients access to the practice's services without fear of stigma and prejudice.

People experiencing poor mental health (including people with dementia)

The practice offered (depot) injections used for some types of mental distress or illness. Patients with mental health problems had the choice of having this injection at their GP surgery rather than an outpatient clinic or mental health clinic. Patients on the mental health register were offered an annual review of their physical and mental health needs. Patients were also offered mental health checks at post natal reviews. Both GP partners had received training in areas such as dementia and alcohol, management of drug misuse and introduction to psychiatry. We saw that the primary care mental health services team were based in the same building but were due to move away. We spoke with a mental health nurse who told us that the practice referred patients appropriately and sought further help and advice if necessary.

Summary of findings

What people who use the service say

We spoke with six patients including two 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. Both members of the PPG were positive about the practice and felt that they were listened to. One PPG member stated that because the practice did not own the building it was difficult for the practice to act on feedback regarding the practice building.

Nearly all of the patients who we spoke with were satisfied with the service. All of the patients described the staff at the practice as caring and told us that their privacy and dignity was respected. Patients said that the GPs listened to their concerns and were understanding and that they felt involved in making decisions about their care and treatment.

As part of the inspection we sent the practice comment cards so that patients had the opportunity to give us feedback. We received forty three completed cards. Forty one cards were positive about the practice and staff. One of the 43 patient comment cards stated that it was difficulty to get an appointment at times and another made a suggestion for weekend opening hours.

We looked at results of the national GP patient survey 2013. Out of the 287 surveys sent 113 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). 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 area. This included, respondents who said they usually got to see or speak to their preferred GP, respondents found it easy to get through to this surgery by phone. Areas that were slightly below the average included opening hours and being able to get an appointment to see or speak to someone the last time they tried.

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 service and the staff at the practice. However, some patients wanted better accessibility for appointments and opening hours.

Areas for improvement

Action the service SHOULD take to improve

- Where audits were being carried out to improve care they were not always followed up to demonstrate sustained improvement.
- The practice had increased the capacity of the advanced nurse practitioner to address issues in access. However, the practice had not conducted audits on DNAs (did not attend) so that it can manage a stepped reduction in DNA rates as a service objective.
- A formal arrangement should be in place to share information with other healthcare professionals such as health visitors.

Bloxwich Medical Practice

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 GP advisor.

Background to Bloxwich Medical Practice

Bloxwich Medical Practice is part of Walsall Clinical Commissioning Group (CCG) area. There are 63 member practices serving communities across the borough, covering a population of 274,000.

The practice has two GP partners, one male and female. There was also a locum GP working at the practice. In addition, there is a practice manager, two practice nurses, one health care assistant (HCA) and a team of administrative staff.

The practice opening times are from 8:00am until 6.30pm Monday to Thursday and 8:00am until 1:00pm on Friday. When the practice was closed out-of-hours primary medical services was delivered by another provider. The practice had opted out of providing out-of-hours services to their own patients. This service was provided by an external out of hours service contracted by the CCG.

The practice register is made up of approximately 4600 patients. The practice has a higher proportion of patients aged over 45 compared to the average (England). It also has a lower proportion of patients between the ages of 25 and 40 compared to the national average.

Why we carried out this inspection

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

How we carried out this inspection

We conduct our inspections of primary medical services, such as Bloxwich Medical Practice, by examining a range of information and by visiting the practice to talk with patients and staff.

We carried out an announced visit on 16 October 2014. During our visit we spoke with four patients whilst they were waiting to attend appointments and two members of the PPG before our inspection visit. We spoke with a range of staff, including a nurse, both GP partners, administration staff, and the practice manager. We looked at the practice's policies and other general documents.

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

Detailed findings

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

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We also spoke with five care home managers about their experience of using the service.

Good

Are services safe?

Our findings

Safe track record

We spoke with six patents about their experience at the practice. None of the patients we spoke with reported any safety concerns to us.

There were arrangements for reporting safety incidents and the staff we spoke with were able to describe their role in the reporting process and knew their responsibility in identifying and acting on risks that affected patient care. We saw evidence that feedback was provided following incidents during staff meetings. We saw that the practice had recorded 18 incidents this year and records of incidents were also available from the previous year. We saw examples where action was taken and changes made as a result of a significant event to reduce the likelihood of reoccurrence.

The practice had a whistle blowing policy which was reviewed in September 2014 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'.

Learning and improvement from safety incidents

There was evidence that staff were reporting incidents and these had been recorded. We reviewed the significant event reports and saw that these had been analysed with clear evidence of learning and dissemination of information to staff. 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. Staff members we spoke with confirmed that learning from incidents was discussed in monthly team meetings. Records we looked at confirmed this.

We saw an example where, as a result of an incident the practice had added an alert to patient records because of similar names. Staff members were advised to inform management if they came across similar patient names so that further alerts could be added. This ensured that any correspondence was sent to the right patient and did not compromise confidentiality.

There was a process to receive and disseminate safety alerts. This ensured any patient safety issues and guidance relevant to patient care were cascaded in a timely way to all concerned staff. The practice manager was responsible for receiving and disseminating alerts so that appropriate action could be taken. In the absence of the practice manager another staff member was responsible. We saw an example of a patient safety alert regarding the signs and symptoms of Ebola that was also discussed in a team meeting. All relevant alerts were logged in a folder or on the shared computer drive and categorised for easy reference. This ensured staff had easy access if they needed further information.

Reliable safety systems and processes including safeguarding

There was a safeguarding children policy in place and this was reviewed in June 2014. The policy covered recognising signs and symptoms of abuse, the training required and the process for referral to appropriate safeguarding authorities. There was a safeguarding lead who had attended the appropriate update training and we saw evidence that they had provided feedback and learning to staff after their training.

Staff we spoke with were able to demonstrate knowledge and awareness of safeguarding vulnerable adults and children and were clear and confident they would recognise and respond to any concerns. Staff were aware of the role of the safeguarding lead GP and said they would refer to them for advice and guidance.

There was evidence that safeguarding concerns were identified and acted on in line with local safeguarding procedures. We saw alerts were put on the computer system to notify staff where there were concerns raised about patients safeguarding. The safeguarding lead showed that they kept a register for children at risk and looked after children. We saw evidence that referrals were made where appropriate.

There was a chaperone policy in place which had been reviewed in February 2014. A chaperone is a person who acts as a witness for a patient and a clinician during a personal medical examination. We saw evidence that staff had attended chaperone training. Staff we spoke with confirmed that they had received training and were able to demonstrate knowledge of their role and responsibilities when undertaking this duty.

Medicines management

Good

Are services safe?

There were systems in place to ensure emergency medicine and equipment were safe and effective to use in the event of a medical emergency.

There were two dedicated secure fridges where vaccines were stored. The nurse was responsible for ensuring regular checks were undertaken and recorded of the fridge temperatures. This provided assurance that the vaccines were stored within the recommended temperature range and was safe and effective to use.

There were standard operating procedures (SOP) in place for the use of certain medicines and equipment. The nurses used patient group directives (PGD). PGDs are specific written instructions which allow some registered health professionals to supply and/or administer a specified medicine to a predefined group of patients, without them having to see a doctor for treatment. For example, we saw a protocol for the Administration of an injectable form of vitamin B12 to adults. We also saw patient specific direction for administration of vaccinations. PGDs ensure all clinical staff follow the same procedures and do so safely.

There were systems in place to ensure patients had regular review of their medicines. The GPs were aware of patients who may not use their medication safely and only small quantities were prescribed to them.

Cleanliness and infection control

Patients told us that they found the practice to be clean. During the inspection we found the practice was visibly very clean and tidy.

There were arrangements in place to ensure that patients and staff were protected from the risks of acquiring health care associated infections and that the relevant guidance and codes of practice on infection control were followed.

We looked at an infection control audit conducted by Walsall Manor Hospital which gave the practice an overall score of 93%. We saw that the areas of improvement were around staff training. We saw that a GP, practice nurse and one admin staff were due their refresher training in infection control. There was no overall record of staff training and it was difficult to identify which staff members had attended this training. However, we saw that the practice manager was developing a training matrix designed to address this. Furthermore, the practice did not conduct its own audit to measure its compliance to relevant infection control standards.

To ensure that all staff were aware of the expectations to maintain standards of infection prevention and control, a policy was available. The policy covered issues such as the protective personal equipment (PPE) staff should use and actions to take in the event of a spillage or needle stick injury.

The practice had a contract with an external agency and we saw schedules were in place covering areas to be cleaned daily, weekly and monthly. Although all areas we looked at appeared to be clean and uncluttered there were no spot-checks or documentary evidence that cleaning was being done according to the schedule.

There was a waste policy for the management, storage and collection of healthcare waste and this was reviewed recently. This ensured waste was disposed of in a safe and appropriate way that ensured the health and safety of staff, patients and visitors.

Equipment

We saw that the practice had had contracts in place for the testing of portable electric appliances (PAT testing) on an annual basis.

Records showed that equipment had been calibrated and serviced at regular intervals such as the vaccine fridges, blood pressure monitors and the electrocardiogram (ECG).

Staffing and recruitment

The practice had a list size of 4627 patients and the staffing level reflected the patient list size. Staffing consisted of two GP partners, a locum GP covering two sessions and a GP registrar. A GP registrar is a fully qualified doctor with hospital experience, learning the new skills required for General Practice. There was an advanced nurse practitioner (ANP) and a practice nurse supported by one healthcare assistant (HCA). An ANP is a registered nurse who has acquired the knowledge base, decision-making skills, and clinical competencies for expanded practice. Further support was provided by a team of six administration staff including the practice manager.

Most of the staff worked at the practice for many years which provided stability within the staff team that ensured

Good

Are services safe?

patients received continuity in their care. The practice manger told us that any shortfall in administrative staff as a result of sickness or leave was covered by other staff. The practice manager told us that recently the GP partners had approved overtime to cover a staff on sick leave and this was confirmed by staff we spoke with. The business continuity plan detailed contact details of some locum agencies so that clinical staff could be recruited quickly.

We looked at the recruitment records for four members of staff and found that Disclosure and Barring Service (DBS) checks had been completed. The practice manager confirmed that two administrative staff who also worked as phlebotomists (collect blood from patients) also had DBS checks undertaken. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. However, other administrative staff including the practice manager did not have DBS checks. A DBS check for non-clinical staff is not required as long as the practice had documented a clear rationale for not doing so. The practice manager confirmed that this was not in place and would make appropriate arrangements.

We saw evidence that the recruitment interview process was carried out, references were sought and that any gaps in working histories had been discussed where appropriate with applicants to ensure that the recruitment process was safe. Through these strategies the practice aimed to ensure that only suitable and appropriately qualified staff were employed.

Monitoring safety and responding to risk

Records showed that essential risk assessments had been completed, where risks were highlighted measures had been put in place to minimise the risks. Various risk assessments had been reviewed recently, including fire and health and safety.

The practice had considered the equipment required to manage foreseeable emergencies and made this available for use by all trained and competent staff. Routine checks of this equipment were undertaken by a designated GP. Emergency medicines were available and were routinely audited to ensure all items were in date and fit for use.

Arrangements to deal with emergencies and major incidents

The practice had a business continuity plan which covered a range of areas of potential risks relating to foreseeable emergencies such as adverse weather and loss of power. The plan demonstrated how these risks could be mitigated to reduce the impact on the delivery of the service.

We saw that there was a fire safety evacuation plan and fire marshals in place to promote health and safety and to reduce hazards.

There was a defibrillator that was shared with another practice in the building and emergency oxygen was available. A defibrillator is used to attempt to restart a person's heart in an emergency. We saw checks were in place to ensure oxygen and the defibrillator was checked regularly to ensure it was in working order.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. Clinical staff we spoke with were aware of and had applied practice based on evidence. For example, we saw monthly meetings where National Institute of Health and Care

Excellence (NICE) guidance was discussed and disseminated. NICE provides national guidance and advice to improve health and social care. It develops guidance, standards and information on high quality health and social care.

Vulnerable patients with long term conditions were assessed and patients over 75 years old were started on a care plan to enable increased monitoring and follow up of patients. This was an Enhanced Service (ES) that had been introduced as part of a move to reduce unnecessary emergency admissions to secondary care. This puts emphasis on the practice to have better access to appointments for patients at risk of hospital admission

Clinical staff at the practice ensured they developed their knowledge and skills through continuous professional development. For GPs this included an annual appraisal and revalidation which happened every five years. Revalidation is a process by which the GPs demonstrate that they are meeting the standards set by the General Medical Council. Records we looked at also showed practice nurses had renewed their license to practice annually.

Data taken from Public Health England outcomes were at or above average for the locality for some areas. For example the practice mostly achieved 100% vaccination rates for the financial year 2012-2013 of children aged 12 months to five years.

Management, monitoring and improving outcomes for people

Performance information on patient outcomes was available to staff and the public, which included monitoring reports on the Quality and Outcomes Framework (QOF). QOF is a national performance measurement tool. We saw evidence that the practice was ahead of meetings its targets for managing patients with long term and complex needs such as diabetes, asthma and COPD (Chronic obstructive pulmonary disease).

There were arrangements in place to ensure women received cervical smear tests by staff that were appropriately trained. Samples were sent to a local NHS hospital to be analysed and reported on. Results were recorded in a book by the staff and where required patients were requested to attend for further tests. The nurse did not do an audit of the smear tests but the local hospital did and the results were sent to the practice. Although no follow up action was required from the last audit, it was carried out 18 months previously.

Patients told us that their health needs were managed well. They told us that where necessary they received regular follow up monitoring of their condition. They also told us that the GPs and other clinical staff they saw explained to them any lifestyle changes that may give them a better health outcome in a way they understood.

The practice had a system in place for completing clinical audit cycles. We saw that many audits had been completed, actions taken and learning shared where appropriate. However, the practice but had not been re-auditing to ensure the improvements made were being sustained. For example, we were an audit for leg ulcers that was carried out in March 2014. We saw that learning identified were carried out but there were no further re-audit planned to show evidence of improvement. We also saw another audit for patient transport booking which found that some patients were incorrectly booked for hospital transport. The audit stated that further monitoring will be done by the practice manager to ensure patients transport needs were being recorded appropriately for access to secondary care. However, we saw no further evidence of this monitoring.

Effective staffing

We saw arrangements were in place for the effective induction and supervision of staff. We saw evidence where a senior nurse supervised a junior nurse as well as evidence of supervision of HCAs.

Are services effective?

(for example, treatment is effective)

The practice had systems in place for annual appraisals for all staff and staff that we spoke with confirmed this. This allowed identification of any learning needs and acted as a feedback mechanism for any performance issues or support required.

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.

The practice manager told us that they had appropriate staffing levels. The administration staff said they were flexible and all helped out when necessary by sharing the workload. The practice manager told us that two members of staff fell ill recently and the GP partners authorised overtime so that they could be covered. We saw that the business continuity plan contained contact details of locum agencies where staff could he hired in an emergency. We saw that a locum GP was also employed at the practice working two sessions per week.

Working with colleagues and other services

There were arrangements in place to share information of concern with health care professionals. We spoke with a health visitor who was based in the same building and covered patients registered to the practice. They told us that they had an informal arrangement for information sharing regarding child protection, looked after children, concerns about mental health and domestic abuse. The health visitor said that the practice manager was good at sharing information with them and they found the GPs easy to approach if they needed to discuss any issues. However, the health visiting team were moving from the building and there would be a greater need to have a more formal arrangement to share information.

Clinical staff attended regular meetings with relevant health care professionals and agencies to discuss and review patients who had complex needs, in vulnerable circumstances or were receiving end of life care. This ensured that their wishes were respected, and they received appropriate support and treatment. For example, we saw evidence that regular meeting were held with the palliative care team as well as meetings with the community matron in regards to unplanned admissions avoidance.

We spoke with the managers of three care homes who had patients registered at the practice The managers told us that the practice responded promptly to patients' needs, and visited when required. One of the care home mangers told us how a patient on end of life care was supported. They also praised the practice for supporting the family as well as the staff at the care home to cope with bereavement.

We saw evidence that a robust system was in place to review test results, relevant letters, and referrals and follow ups for patients.

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 GPs at the practice.

Information sharing

The practice was located in a health centre where other GP surgeries and other health professionals such as the community psychiatric nurse (CPN) and health visitors were also located. We found that the practice worked with other service providers sharing information to meet the needs of patients and manage complex care needs. Multidisciplinary working was evidenced, for example joint working arrangements were in place with the pharmacist, CPN and health visiting team.

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

Consent to care and treatment

We found the healthcare professionals understood the purpose of the Mental Capacity Act (2005). The Mental Capacity Act 2005 is a law that protects and supports people who do not have the ability to make decisions for themselves. Staff files we looked at showed that staff had attended relevant training and Staff we spoke with confirmed their understanding of capacity assessments and how these were an integral part of clinical practice.

Are services effective?

(for example, treatment is effective)

The patients we spoke with said they had been involved in decisions about their care and treatment. They told us their treatment was fully explained to them and they understood the information. Patients felt they could make an informed decision.

Health promotion and prevention

The practice leaflet was available in the practice and to download online. The information leaflet listed the types of health services available at the practice. This included general health promotion advice as well as weight control advice. The practice website also had a '**Live Well'** area with a library of articles covering a wide range of topics such as men's, women's and children's health issues.

We spoke to the chair of the PPG who told us that they regularly had set up stalls highlighting specific medical issues aligned along local and national agenda. During the year some of the events have included awareness days on breast, bowel and male cancer. There was a notice board in the reception area for the exclusive use of the PPG. This was updated regularly with information on upcoming health promotion events.

We saw evidence of referrals to specialists such as alcohol and substance misuse. We saw example of referrals to DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) programme for newly diagnosed patients. DESMOND is patient education programme for people with diabetes, developed by a number of NHS Organisations. We saw evidence that a specialist diabetes nurse attended the practice monthly to review complex patients with diabetes. We also saw evidence where patients with other conditions such as angina or those that had a recent heart attack were referred for exercise and support.

There was a clear process in place to follow up any patients identified as having potential health problems. Patients over the age of 75 years were offered health checks, and the practice had employed a separate nurse to do these checks.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

On the day of the inspection we spoke with five patients attending the practice one of whom represented the patient participation group. In addition we looked at 43 patient comment cards and feedback from the 2014 practice patient survey, NHS choices website and the national GP Patient Survey. We also spoke with managers of three care homes to get their feedback.

Patients we spoke with were very satisfied with the care and treatment they had received. They said staff were friendly and caring. They felt involved during consultation as any results of tests were explained to them in a way they understood. Patients told us the doctors and nurses not only addressed their physical problems but also supported their emotional needs. This was confirmed by a care home manager who told us that staff at the home and the family members of a patient were supported to cope after bereavement.

The findings of the national GP patient survey 2014 and comment cards supported what patients told us on the day of the inspection. This was that patients were overall happy with the staff at the practice.

Records showed that most staff had received training in equality and diversity. This helped to ensure that staff recognised, respected and valued differences and allowed patients access to the practice services without fear of stigma and prejudice.

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 / 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 to staff. We observed staff were careful to maintain confidentiality when discussing patients' treatments in order that confidential information was kept private. There was a poster informing patients that they could discuss any issues in private away from the main reception desk. However, the poster was away from reception, the practice manager explained that the building was not owned by the partners and they were limited to where they could display posters.

Where appropriate patient s told us that they were offered chaperones (a member of staff to accompany a patient during their consultation).There was information for patients in the waiting area and in the consultation rooms we looked in. We saw staff who carried out chaperoning duties had received training and had the relevant DBS checks.

Care planning and involvement in decisions about care and treatment

Patients told us that the doctors explained their care to them and that they were involved in making decisions about their care. We saw that 84% of the practice respondents who participated in the GP National Patient Survey 2014 said GPs involved them in care decisions. Furthermore, 85% felt the GP was good at explaining treatment and results to them and was above average. The figures for nurses were 70% and 79% respectively which was lower than the CCG average. However, patients we spoke with on the day of the inspection were equally happy with the GPs and nurses.

The practice also had access to an interpreting service for patients whose first language was not English. There was a hearing loop induction system in place to help people with hearing problems. Also, one member of the administration staff was British sign language trained which helped those patients who experienced hearing difficulties.

Patient/carer support to cope emotionally with care and treatment

We discussed bereavement support with the GPs. We saw that there was a system in place to pick up any bereavement support issues by a GP for non-routine deaths so that the family members could be contacted for further support and signposted to other organisations where appropriate. We spoke with a care home manager who told us that family members of a patient were supported after bereavement by the GPs. They also told us that staff at the home were supported to cope with the bereavement.

Are services caring?

Carer packs were available for newly identified carers and help offered on an individual basis. We saw posters in the practice advising carers to inform the surgery so that they could be registered as a carer and access help.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

All consulting rooms were located on the ground floor and there where toilets for disabled 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.

Patients who had appointments could use an electronic touch screen monitor in the waiting room to confirm their arrival, or by speaking with the staff at the reception desk. The touch screen is designed to let patients book in for their appointments automatically and several languages were available so that patients who did not speak English as a first language could use it. The practice could also book interpreters if required.

There was a hearing induction 'loop system' for patients with hearing difficulties and a staff member was trained in British Sign Language.

The practice engaged with the local Clinical Commissioning Group (CCG) to deliver local priorities. We saw evidence that the senior GP partner attended CCG meetings and implemented required service provisions.

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. A PPG member we spoke with told us that changes to appointment system had been made following discussion with the PPG. For example, patients were now able to make appointments online.

Patients with immediate, or life-limiting needs, were discussed at the monthly clinical meetings as well as regular multidisciplinary meetings to ensure all clinicians involved in their care delivery were up-to-date and knew of any changes to their care needs.

Tackling inequity and promoting equality

The practice was accessible to patients who had difficulties with their mobility and hearing. The practice also had access to an interpreting service for patients whose first language was not English.

There were disabled parking spaces in the large on-site car park which was free of charge. The practice building was purpose built and was accessible to patients with mobility difficulties. Doors to the entrance of the surgery were automated and other doors were activated by a push button which was visible and easy to locate.

There was an active patient participation group (PPG) group who provided views of the patients to the practice so that they could be addressed. We saw posters in the waiting room informing patients about the PPG and encouraged patients to join the group. We spoke to the PPG chair on the day of the inspection and they told us that they also approached patients in the surgery to join the group.

Access to the service

The findings of the national GP patient survey 2014 and comment cards supported what patients told us on the day of the inspection. This was that patients were overall happy with the staff at the practice. However, accessibility for appointments, opening hours and the level of involvement in consultations by nurses were areas highlighted for improvement. We saw that the practice had conducted its own survey through the PPG. We saw that an action plan was developed and changes made as a result of the feedback. Six additional appointments were made available with the Advanced Nurse Practitioner (ANP) who has extra qualifications including prescribing. The practice had extended their surgery hours once weekly from 6:30pm to 7:45pm to facilitate working and other patient groups who could not attend during normal surgery hours.

The surgery closed for training on the last Wednesday of every month from 1.00pm to 6.30pm for training and development. This Monthly Protected Learning Time (PLT) enabled staff to take advantage of learning and development opportunities in meeting together and also in their professional groups. We saw examples in minutes of meetings where staff were trained to be effective chaperones.

The practice was located within a purpose built health centre and was designed to be accessible for wheelchairs and pushchairs. There were disabled toilet facilities and a Loop Induction System for patients with hearing impairment.

There were disabled parking and the practice had recently completed a Disability Discrimination Act (DDA) audit to ensure compliance with the Disability Discrimination Act

Are services responsive to people's needs?

(for example, to feedback?)

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.

All surgery opening times were detailed in the practice leaflet which was available in the patient waiting room and on the practice's website. The practice website also outlined how patients could book appointments and organise repeat prescriptions online.

Home visits and urgent on the day appointments were available each week day. Telephone consultations were also available so that any patients who had urgent queries could speak to a GP or a Practice Nurse. We spoke with managers of three care homes where patients had been registered with the practice and they confirmed that they could arrange prompt home visits without any problems.

We spoke with five patients including two members PPG who told us that access to the surgery was not an issue. Patents were seen promptly and did not have to wait too long after their appointment time to be seen. We saw that this was reflected in the national GP survey where the practice had performed better than the CCG average. However, the survey also showed that patients were not happy with the level of access to the practice. The practice recognised this when they had carried out a survey through the PPG. As a response, extra appointments were made available with the ANP.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This out of hours service was provided by an external service contracted by the CCG. Details of out of hours providers were on the practice website and patients were also left an answerphone message on the telephone system informing them what to do when they rang the practice out of hours.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. We saw that a review of complaints had been carried out looking at complaints from April 2013 to August 2014. We saw that there were 10 complaints in total and they were analysed to identify trends, lessons learnt and any actions taken were recorded. Lessons learned were shared with staff in meetings.

Are services well-led?

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

Our findings

Vision and strategy

There was a clear leadership structure and staff felt supported by management. Staff we spoke with felt supported and were aware of their roles and responsibilities. There were leads for e.g. safeguarding and infection control and staff were aware who to approach if they needed further advice. The practice had a number of policies and procedures to govern activity and there were systems in place to monitor and improve quality and identify risk.

Governance arrangements

Staff were aware of their roles and responsibilities for managing risk and improving quality. GPs and nurses had lead responsibilities. For example, safeguarding, clinical governance and infection control. The practice manager was responsible for the day to day running of the practice and the GP partners were responsible for clinical governance arrangements.

The senior GP partner at the practice attended meetings with the local Clinical Commissioning Group (CCG) to ensure they were up to date with any changes. The practice manger told us that meetings for managers for the CCG locality area had started and they had attended a meeting in September 2014. These meetings allowed for the practice managers to get information, updates and learning for a variety of areas such as appointment systems and finances. Nurses and GPs also met with other healthcare professionals regularly to review patients with complex care needs. Learning from significant events, complaints and best practice guidance was shared with practice staff in meetings.

Leadership, openness and transparency

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

We saw evidence where leadership, openness and transparency were displayed by both staff and management during the phased return of a staff member after being away off work for a period due to illness. The practice supported staff member back to work after a period off work due to illness.

The practice manager was responsible for day to day running of the practice including reviewing policies and procedures. We reviewed a number of policies, for example safeguarding and whistleblowing which were in place to support and guide staff. During our inspection, staff members knew the location of the policies and were able to locate them quickly. Regular practice meetings were held with protected learning time where staff received training chaperoning and cardiopulmonary resuscitation (CPR).

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

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 evidence from minutes of team meetings where issues were raised by staff and evidence where action had been taken.

We saw evidence that the practice sought feedback from staff through regular appraisals and staff meetings. We saw minutes of a meeting held in September 2014 where feedback from staff was acted upon. Staff members we spoke with felt well supported.

We saw that the practice had an active and engaged patient participation group (PPG) to promote and support patient views and participation in the development of services provided by the practice. Support by the patient participation group had led to improvements in getting new signage and re-painted lines on the car park to clearly define the one way system and parking areas. We saw that there was an annual report written by the PPG chairman highlighting some of their achievements and also future goals. This was available to download on the practice website.

The Patient Participation Group organised a patient satisfaction survey each year for the practice. Data of the last survey was submitted to Healthwatch Walsall for analysis of results. Healthwatch Walsall is an independent organisation, speaking for communities and individuals in Walsall. Healthwatch Walsall challenge commissioners and providers of services to make improvements important to

Are services well-led?

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

people and support them in promoting best practise. Healthwatch Walsall also helps individuals understand what choices are available to them and help them to get information and advice.

The survey revealed that 95% of patients who responded would recommend their practice to others. However, the survey also identified areas for improvement and an action plan was developed so that they could be addressed. Amongst areas for improvement were findings that appointments and prescriptions were areas causing confusion for some patients. Consequently, a detailed explanation of how the appointment system worked and how to order repeat prescriptions and the various methods that this can be done had been publicised via information sheets and posters displayed on the electronic message board within the surgery. Information was also available on the practice website including the patient survey report, analysis and action plan. Importantly, Healthwatch Walsall also identified how the survey could be better designed for future reviews to get better results.

Management lead through learning and improvement

The practice is a training practice for GP Registrars (fully qualified doctors who wish to become general practitioners). One of the GP partners also supervised Community matron prescribing training. Community matrons are experienced senior nurses who work closely with patients in the community to provide, plan and organise their care. They mainly work with those with a serious long term or complex range of conditions.

The practice had responded to feedback on service delivery from the PPG as well as other patients through surveys and complaints. We saw that changes had been made to improve service as a result of feedback.

The practice carried out many clinical audits including medication audits. An audit on patients prescribed long term antibiotics resulted in better management and care for some patients.

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