AW Surgeries

Quality Report

Albion House Surgery
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Date of inspection visit: 12 March 2018
Date of publication: 10/05/2018

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?	Requires improvement
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. We previously inspected this practice on 24 March 2016 and rated it Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Requires Improvement

Are services well-led? - Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) - Good

We carried out an announced comprehensive inspection at A W Surgeries on 12 March 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice had developed systems to safeguard children and vulnerable adults from the risk of abuse and staff were aware of these. These systems were being adopted by Dudley Clinical Commissioning Group (CCG) to use as a model for other practices to adopt.
- The practice regularly reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence based guidelines.
- Staff worked extensively with other health and social care professionals to deliver effective care and treatment. Separate and dedicated meetings were held for palliative patients, patients experiencing poor mental health and patients identified as at higher risk of hospital admission.
- Staff involved and treated patients with compassion, kindness, dignity and respect.

Summary of findings

- Patients found the access a problem, most notably when trying to contact the practice by telephone. Data from the national patient survey showed that 28% of patients described their experience of making an appointment as good.
- The management team were aware of the challenges the practice faced and had implemented plans to address them. For example, they had implemented plans to improve access with the procurement of a new telephone system and upskilling of existing staff.
- The leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- Staff we spoke with were aware of the practice's vision to deliver a high quality, safe patient centred service. They were aware of their roles in achieving this.

We saw several areas of outstanding practice including:

- A single point of contact had been assigned to support patients and their families nearing end of life. The service offered a direct line for contact and an open door to those in need of support.
- A 'wellness centre' had been introduced to provide support for both registered and non-registered patients. Projects within the centre provided a support structure for patients living with life changing conditions.
- The practice had implemented a development plan for the diagnosis and treatment of dementia and committed to extensive training for clinicians and support for the carers of people with dementia.
- Members of the leadership team had been awarded for their work in primary care and support was provided to other practices. The practice used its resources to support primary care development and promote better outcomes for both its own patients and those within the Dudley area.
- A fibromyalgia project had been carried out to proactively support and manage patients with high attendances. Outcome data for the five patients who had completed the project showed a significant decrease in attendances at the surgery.

However there were areas of practice where the provider should make improvements:

- Explore ways to improve the uptake of vaccines for eligible patients.
- Continue to monitor the patient feedback on access following the implementation of the new telephone system.
- Ensure Patient Group Directions are completed.
- Review recruitment checks completed to ensure that they meet all requirements as set out in schedule three of the health and social care act.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

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

AW Surgeries

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector**.** The team included a GP specialist adviser and a nurse specialist adviser.

Background to AW Surgeries

Albion House surgery is a long established practice and is the main practice for AW Surgeries, registered with the Care Quality Commission (CQC) as a partnership provider and located in the Brierley Hill area of Dudley. There are two surgery locations that form the practice; these consist of the main practice at Albion House Surgery and a branch practice at Withymoor Surgery. There are approximately 17,500 patients of various ages registered and cared for across the practice and patients can be seen by staff at both surgery sites. The practice holds a General Medical Services (GMS) contract. A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract. The practice has expanded its contracted obligations to provide enhanced services to patients. An enhanced service is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients. The practice area is one of higher deprivation when compared with the national average. Demographically the practice has a patient age distribution comparable with the Clinical Commissioning Group (CCG) and national averages.

The clinical staffing comprises of:

- Nine GP partners 4 male, 5 female (7.25 whole time equivalent) (WTE)
- Three salaried GPs (1.25 WTE)
- Seven practice nurses (5 WTE)
- Five health care assistants.

The non-clinical staffing comprises of:

- A business manager
- Five departmental managers (covering appointments, data, secretarial duties, reception and prescriptions).
- Nine members of administrative staff working a range of hours.
- A team of four cleaners who are supervised by a cleaning supervisor.

The GP partners and the business manager form the practice management. The practice is an accredited postgraduate GP training centre provides postgraduate training for three GP Registrars. All staff members work across both practice surgeries.

The practice is open for appointments between 8am and 6:30pm during weekdays; the practice is open later on Tuesdays and Wednesdays when extended hours are offered between 6:30pm and 8pm. There are also arrangements to ensure patients receive urgent medical assistance when the practice is closed during the out-of-hours period.

The practice offers a range of services for example, management of long-term conditions such as diabetes, contraceptive advice, immunisations for children, travel vaccinations, minor operations and NHS checks. Further details can be found by accessing the practice's website at www.awsurgeries.co.uk

Good

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from the risk of abuse.

- The practice conducted safety risk assessments. It had safety policies which were regularly reviewed and communicated to staff. Staff received safety information as part of their induction and refresher training.
- The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and staff had access to safeguarding policies. The safeguarding policies outlined clearly who to go to for further guidance. All staff were trained to level three in safeguarding.
- The practice had two databases, one for Child and Adolescent Mental Health Services (CAMHS), one for adults and children with safeguarding concerns. These were used to track information such as discussion at safeguarding meetings and end dates for child protection plans (CPPs) and Children in Need (CIN). The Dudley Clinical Commissioning Group (CCG) safeguarding team had discussed adopting this model together with a training guide for other practices to use.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. Monthly safeguarding meetings were held with the health visitors.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). However there was no physical or mental health assessment of staff employed. A template was produced on the day for staff to complete. The practice were implementing a new DBS checking system that was a shared accessible database to advise of any change.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control. The most recent audit had been completed in September 2017 and the practice had scored 92% overall. An action plan had been completed.
- Clinical staff had not always received appropriate immunisations against health care associated infections and risk assessments had not been completed to demonstrate how potential risks to staff and patients would be mitigated. The day after our inspection the practice sent us completed risk assessments to mitigate these risks and shared their updated hepatitis B policy with staff.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.
- The practice had patient group directions (PGDs) for nurses. However we found examples of where some PGDs had not been signed. The practice wrote to us within two days of the inspection to assure us that these had been completed. There were patient specific directions for healthcare assistants to obtain authorise the administration of medicines.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. The practice had systems to review capacity requirement by clinician; e.g. healthcare assistants, nurses and GPs. This was also broken down using management information to future plan based on procedures and treatments carried out.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. Nursing staff had equipment available to assess potential sepsis, a sepsis poster was clearly displayed and a sepsis template was available on

the clinical system. Reception staff had been trained to identify rapidly deteriorating patients and had received training in what conditions should be referred to the on call GP.
- When there were changes to services or staff, the practice assessed and monitored the impact on safety. For example, the practice had adopted the NHS five year forward plan to employ associated healthcare professionals to reduce the reliance on GPs.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. For example, the practice had a system in place for sharing information with the out of hours service for patients nearing the end of their life or if they had a 'do not attempt cardiopulmonary resuscitation' (DNACPR) plan in place.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The GPs did not routinely take emergency medicines on home visits but assessed each request to determine if any specific emergency medicines were required. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed and administered medicines to patients and gave advice on medicines in line with legal requirements and current local and national guidance. For example, an audit carried out reviewed the antibiotics used for the treatment of acute coughs to ensure nationally recognised guidelines were followed. Repeat audits were planned to include this information.
- Patients' health was monitored to ensure medicines were being used safely and followed up appropriately. The practice audited their use of high risk medicines and involved patients in regular reviews of their medicines.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- There was an appointed health and safety lead who had received appropriate training for the role.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Staff told us that the GPs and practice business manager supported them when they did so.
- There were effective systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, a patient with dementia had been the victim of a robbery where the medication box was found empty. Once it had been established that the medication had been stolen, the CCG was informed, the medicines were reissued and the access for carers was reviewed. A second incident related to a patient on controlled medicines who was registered at another practice out of the area. A medicine review highlighted high use of medicines. This was reported to the second practice and became a national patient safety alert on the National Reporting and Learning System (NRLS).
- The practice shared their learning from relevant significant events externally with local stakeholders. The practice had been using Datix for approximately 12 months and had made approximately 14 entries (Datix is an electronic database that allows learning to be shared nationally).

Good

Are services safe?

- The practice had systems in place to monitor the effectiveness of any changes made that had resulted from learning from a significant event.
- There was a system for receiving and acting on safety alerts such as Medicines and Healthcare products Regulatory Agency (MHRA) alerts. Safety alerts were a standard agenda item for clinical and practice meetings and the practice learned from them.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all of the population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- The practice followed the National Institute for Health and Care Excellence (NICE) guidelines to ensure that patients' needs were fully assessed and care and treatment was delivered in line with national guidelines. This included their clinical needs and their mental and physical wellbeing. In addition, clinicians could access an extensive set of electronic guidelines from Dudley Clinical Commissioning Group (CCG), The Royal College of General Practitioners (RCGP), the British Heart Foundation (BHF) and the General Medical Council (GMC). The practice made use of mobile telephone applications to keep clinicians informed of guidelines.
- Data from electronic Prescribing Analysis and Costs (ePACT) for specific therapeutic medicines such as hypnotics (medicines used to aid sleep), antibacterial items and antibiotics was comparable with other practices (ePACT is a system which allows authorised users to electronically access prescription data). Clinical staff had received training in antimicrobial resistance to support their understanding and appropriate prescribing of antibiotics.
- Data from Dudley Clinical Commissioning Group (CCG) showed that the number of antibacterial prescription items prescribed per specific therapeutic group was 0.97; comparable with the CCG average of 0.99 and the national average of 0.98. The percentage of broad spectrum antibiotics prescribed by the practice was 6.4% which was higher that the CCG average of 5.9% but below the national average of 8.9%. It is important that antibiotics are used sparingly to avoid medicine resistant bacteria developing. These results indicate that the practice was following national and local guidance. The practice audited antibiotic prescribing and was able to demonstrate that reductions were being achieved each year.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice used technology and equipment to improve treatment and to support patients' independence. For example, the practice provided equipment to patients to carry out their own 24 hour blood pressure recording and a blood pressure monitor was positioned in the patient waiting area at the Withymoor branch.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs by the elderly care facilitator lead nurse. If they were housebound, this assessment was provided in their home.
- Advanced care plans had been completed for the top 2% of patients identified as at risk of hospital admission.
- The practice had developed a 'wellness centre' aimed at delivering a more extensive range of services. The practice ran a carer's campaign, a veteran's scheme, a dedicated memory clinic and an Alzheimer carer's course in the Wellness Centre.
- The practice had a database for frail and palliative patients. These patients were offered rapid access and a clinical support was provided by a member of the administration team who had a liaison role for patients and carers.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines' needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. Longer appointments were provided to facilitate this; 15 minutes with the healthcare assistant followed by 30 minutes with a nurse.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. GPs provided monthly training meetings and clinical supervision. An hour was protected at the end of each of the weekly respiratory and diabetes clinics to provide clinical support and feedback. Reflection from these sessions was recorded on the clinical system.

Good

Are services effective?

(for example, treatment is effective)

- The practice offered self-management plans for patients with long-term conditions such as diabetes or asthma.
- The practice held special long-term condition days, for example Wednesday for respiratory problems and Thursday for patients with diabetes. Positive feedback had been received from external stakeholders about leadership in these clinics.
- The Dudley Quality Outcome Framework results for 2017/18 showed that care and treatment provided for patients with long term conditions, such as high blood pressure, asthma and chronic obstructive pulmonary disease, were in line with Dudley CCG targets.
- Data for the year starting April 2017 showed that 80% of patients with a long-term condition had received a holistic comprehensive assessment in the last 12 months that included a medication review. The Dudley CCG target was 50-80%.
- Data for the year starting April 2017 showed that 70% of the 963 patients on the diabetes register had been monitored and were recorded as being within the target HbA1c (a measure of how well a person's diabetes is being controlled). The CCG target was 35-75%. The provider was approved to initiate insulin to diabetic patients.
- The practice was piloting group consultations in March 2018. This had started with teenagers diagnosed as asthmatic to provide peer support. This consultation was planned for two hours with a nurse and then the public health lead on asthma to target newly diagnosed patients.
- One of the GP partners with a background on cardiology supported the lead nurse in providing specialist cardiology clinics.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above the target percentage of 90%. For example, rates for all the vaccines given to under two year olds were between 98% and 99%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- There were alerts on children's' records to inform clinicians if a child had a child protection in place.
- There was a large number of children in need managed through a safeguarding database and discussed with both internal and external staff at monthly safeguarding meetings.
- The practice kept a database of patients they had referred to the NHS Child and Adolescent Mental Health Services (CAMHS).
- Children's' hour appointments were offered at 8.30am and 3.30pm for the on call GP to see children who for example, woke up unwell or were collected from school unwell. Children under five were seen as a priority and an external paediatric triage service was used to advise on referrals.

Working age people (including those recently retired and students):

- The practice's uptake for the cervical screening programme was 75%. This was comparable with the national average of 81%.
- Breast screening results for the last three years showed that 78% of eligible patients had been screened (national minimum standard is above 70%).
- The practice hosted an abdominal aortic aneurysm (AAA) screening service (a way of checking the main blood vessel that runs from the heart to the stomach).
- The meningitis vaccine was available for eligible patients such as those attending university for the first time. A total of 176 patients were eligible and 83 (47%) had received the vaccine.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. In the last 12 months, 1,295 eligible patients had been invited and 705 had received a check.
- The practice provided appointments outside core working hours, early morning, late evening and on Saturdays.
- The practice hosted a service called 'Family Matters' for the locality provided by the Citizens Advice Bureau (CAB) giving support and advice to unemployed people. This took place in the Wellness Centre and was open to all Dudley patients whether registered with the practice or not.

People whose circumstances make them vulnerable:

Good

Are services effective?

(for example, treatment is effective)

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice had a palliative care register of 106 patients and a member of staff was designated to provide a point of contact for these patients and their immediate families. A comprehensive template was used to help patients and other healthcare professions plan for future care.
- We were told examples of where families had provided support or guidance to provide in house bereavement support services where patients needed a sanctuary. There was a bereavement group among staff members that managed the administrative side of bereavement and a letter was sent out from the GP to offer condolences.
- The practice held a register of patients living in vulnerable circumstances including carers and those with a learning disability.
- The practice held a register of 61 patients registered with the practice and who had a learning disability (LD). A total of 46 were eligible for an annual health check and 41 had been completed. The practice had recently received a list of new patients from a LD service run by the trust and although health checks were planned, this had impacted the performance at the time of the inspection.

People experiencing poor mental health (including people with dementia):

- The practice had a clinical lead with expertise in mental health.
- A dedicated multidisciplinary team meeting was held monthly to discuss the needs of patients experiencing poor mental health.
- The practice hosted an Alzheimers carer's course run by the Alzheimers Society open to all Dudley patients. Two of the practice staff had attended the course and could signpost and provide home visits to patients with Alzheimers.
- The practice protected appointments to be used for acute episode monitoring.
- The practice proactively followed up patients who had been admitted to A&E due to self-harm and patients experiencing poor mental health who failed to attend for GP appointments.
- The practice carried out mental ability tests to diagnose dementia as well as regular reviews of patients diagnosed with dementia.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, the practice audited their end of life care; and in 2017, 75% of palliative patients had died in their preferred place. The audit programme also included the monitoring of antibiotic prescribing and adherence to NICE guidelines. Where appropriate, clinicians took part in local and national improvement initiatives. For example, the NHS health checks for working age patients.

The practice used the information collected for the Dudley CCG Outcomes for Health Framework and performance against national screening programmes to monitor outcomes for patients. (Dudley CCG is one of four vanguards in England to implement a system intended to improve the quality of general practice and reward good practice). The data for 2016/17 showed that the practice performance was similar to the Dudley CCG averages in all areas.

Data collated by the CCG showed the practice had a downward trend in the number of practice patient attendances to A&E. For example, the rate of A&E attendances for all age groups over a rolling 12 month period had fallen from 3,949 to 3,765, a reduction of 5%. Data for non-elective activity showed a decrease from 1,632 in 2016 to 1,286 for the corresponding period in 2017.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop, for example; three of the nurses were being supported and mentored to qualify as independent prescribers.
- A staff redesign strategy was underway to upskill receptionists to healthcare assistants and introduce triage and care coordinators.

Good

Are services effective?

(for example, treatment is effective)

- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, clinical supervision and support for revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. For example, the practice produced patient information leaflets. We saw that they used these to promote awareness and understanding of long term conditions such as diabetes.
- The practice supported national priorities and initiatives to improve the population's health. For example, they provided weight management advice and sign posted patients requiring smoking cessation support to appropriate services.
- There were failsafe systems to track smear results and follow up abnormal samples.
- The practice used their 'wellness centre' to promote local and national support services and campaigns.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. They supported patients to make decisions and involved family members or patient advocates to support patients who lacked capacity regarding elements of their care.
- The practice had written consent forms for surgical procedures which included appropriate advice.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. For example, the practice was knowledgeable about religions where burial is arranged soon after death.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Prior to our inspection we spoke with a member of the patient participation group (PPG). They told us that the practice engaged well and respected the views and suggestions of the PPG.
- We received 32 patient Care Quality Commission comment cards, 16 from Albion House and 16 from Withymoor. All were very positive about the care and treatment experienced although seven comments were mixed with negative comments around access to appointments.
- Results from the NHS Friends and Family Test highlighted that improvements were having a positive impact. In quarter one of 2017, only 16 out of 36 responses (44%) were positive (would recommend the practice to family and friends). However the most recent data suggested improvements were having a positive impact, in quarter one in 2018, eight out of 14 responses (57%) said they would recommend the practice to family and friends.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Two hundred and sixty two surveys were sent out and 101 were returned. This represented approximately 0.6% of the practice patient population. The practice was comparable with the local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 89% of patients said the GP was good at listening to them, the same as both the clinical commissioning group (CCG) and the national averages.
- 82% of patients said the GP gave them enough time compared with the CCG average of 87% and the national average of 86%.
- 95% of patients said they had confidence and trust in the last GP they saw compared with the CCG average of 96% and the national average of 95%.
- 81% of patients said the last GP they spoke to was good at treating them with care and concern compared with the CCG average of 85% and the national average of 86%.
- 85% of patients said the nurse was good at listening to them compared with the CCG average of 93% and the national average of 91%.
- 85% of patients said the nurse gave them enough time compared with the CCG average of 93% and the national average of 92%.
- 93% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 84% of patients said the last nurse they spoke to was good at treating them with care and concern compared with the CCG average of 92% and the national average of 91%.
- 63% of patients said they found the receptionists at the practice helpful compared with the CCG average of 86% and the national average of 87%.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Translation services were available for patients who did not have English as a first language. We saw a notice in the reception area in multiple languages informing patients this service was available. GPs could speak a number of foreign languages that included Urdu and Bangladeshi.
- The practice had the facilities to provide signing and text talk.
- Staff communicated with patients in a way that they could understand, for example, communication aids such as a hearing loop were available.

Good

Are services caring?

- Staff helped patients and their carers to find further information and access community and advocacy services. They helped them to ask questions about their care and treatment.

The practice proactively identified patients who were carers. The practice used new patient registration checks and GP consultations to identify any new carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 294 patients as carers (2% of the practice list). Carers were offered health checks and flu immunisations to support them to remain fit and well, and the practice had a patient recall system in place to promote the uptake. The practice had put together a carer's pack that signposted carers to support services. The practice gave out or posted out information from this pack when a carer had been identified. For example, a leaflet for a 'carer's tea and chat afternoon' held twice monthly and weekly at Russells Hall Hospital. The 'Dudley Carer' provided a quarterly newsletter that the practice posted out to all those patients registered as a carer. Events were organised specifically for carers and hosted in the wellness centre, for example; a dementia assessment gateway service had hosted an event in September 2017.

The practice liaised with families who had suffered bereavement through a dedicated reception team member who monitored the palliative and frail patient register. This member of staff supported by providing a point of contact to the family and provided a direct number for those patients. The families were advised of support services and the member of staff reviewed the needs individually, for example; a safeguarding referral had been made when a patient's personal circumstances led to a concern. We were told examples of where families had provided support or guidance to provide in house bereavement support services where patients needed a sanctuary. There was a bereavement group among staff members that managed the administrative side of bereavement and a letter was sent out from the GP to offer condolences.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages:

- 82% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 87% and the national average of 86%.
- 85% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and the national averages of 82%.
- 84% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 91% and the national average of 90%.
- 79% of patients said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 88% and the national average of 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect. Staff who chaperoned understood their responsibilities of maintaining a patient's dignity during an intimate examination.
- The practice complied with the Data Protection Act 1998 and all staff had signed confidentiality agreements.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as requires improvement for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, online services such as repeat prescription requests, advanced booking of appointments, and near patient blood testing for patients prescribed warfarin (a medicine that stops blood clotting).
- The facilities and premises were appropriate for the services delivered. The facilities were regularly used to host services and events to promote better outcomes in primary care to both registered and non-registered patients. For example, a community dermatology clinic was hosted by the practice. A consultant visited to provide the service to all Dudley patients and the administrative function was managed by the practice.
- The practice made reasonable adjustments when patients found it hard to access services. For example, mobile telephones had been used to reduce the volume pressure on the landlines.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other health and social care professionals.
- Minor ailments clinics were provided by the nurse prescriber.
- The practice had a 'wellness centre' to provide a community hub to promote the wellbeing of both registered and non-registered patients. Patient group members attended the centre for weekly coffee mornings, outside organisations, for example the Alzheimer's Society, were invited to hold events in the centre, and the practice had arranged the knitting of hats for babies at a local refuge centre where one of the GP partners carried out voluntary work.
- The practice piloted a Fibromyalgia project (Fibromyalgia is a long-term condition that causes pain all over the body, common symptoms include tiredness and sleep problems). This project had been developed with the local mental health service and targeted a proactive approach to managing groups of patients with high usage of health services, in particular the accident and emergency department. The pilot started with 15 patients, six of whom completed the course. The project consisted of a physical health check followed by a mental health check and the outcomes were monitored to show a reduction in unplanned hospital attendances among the group of patients included.
- The provider inititiated a fibromyalgia project working with the mental health team, Healthwatch and Integrated Plus (a social support service funded by Dudley CCG). Tea parties were held for patient engagement and patients were trained to self-manage their condition. Outcome data for the five patients who had completed the project showed a significant decrease in attendances at the surgery. The total attendance at the practice for the five patients had reduced from 271 in 2016, to 199 in 2017.

Older people:

- All patients had a named GP who supported them in the setting they lived, whether it was at home or in a care home.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice worked with the voluntary sector, such as Age UK to support older patients and those who may be socially isolated.
- The practice offered an onsite phlebotomy service for older patients so they did not have to travel far for blood testing.
- The practice used the frailty index to identify health risks to this population group.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the community healthcare team to discuss and manage the needs of patients with complex medical issues.
- The practice provided in-house electro cardiology monitoring, spirometry and lifestyle advice for patients with long term conditions.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- The practice held monthly meetings for patients with multiple sclerosis.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. The practice met monthly with the health visitor to discuss any children of concern.
- Twice weekly antenatal clinics were held with the midwife at each site.
- Dedicated appointments for children were offered in 'children's hour' held each week day morning and afternoon.
- Appointments were available outside of school hours.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, early morning and late afternoon appointments and telephone consultations.
- The practice offered online services to support repeat prescription requests and booking of appointments. A text messaging service was also available to remind patients of their appointment times.
- Patients aged over 40 years were offered NHS Health Checks to identify those at risk of cardiovascular disease and other chronic conditions.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including children with a child protection plan in place and those with a learning disability.
- The practice supported and signposted vulnerable patients, such as carers or those socially isolated, to access voluntary support services such as the voluntary and community sector hub.
- Reception staff had received training to support them to recognise vulnerable adults.
- A dedicated member of the reception team provided support to patients nearing end of life and their families. A direct telephone line and an open door policy were available to those patients in need of support.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Patients experiencing poor mental health who failed to attend practice appointments or attended A&E were proactively followed up by the practice.
- The provider implemented a 'dementia practice development plan'. The practice used the suggested tools from the National Institute for Health and Clinical Excellence (NICE) for diagnosis; all GPs including GP Registrars at the practice have dementia training. The dementia lead has completed a postgraduate diploma in community mental health and all nurses had been trained in dementia screening. Dementia patients and their carers were offered fortnightly support sessions.

Timely access to the service

Patient feedback highlighted problems in gaining access to care and treatment from the practice within an acceptable timescale for their needs, of note; problems when trying to contact the practice by telephone. The practice had been contractually tied into a telephone system that was due to be changed in April 2018. We found that:

- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was under improvement with the upskilling of nurses to take pressure off the GPs.
- The number of appointments provided per week was in line with the national average of 85 face to face contacts per 1,000 patients per week (the practice provided 87 face to face appointments per 1,000 patients per week, 58 of these were with a GP compared to the national average of 56).

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was significantly lower than local and national averages. Two hundred and sixty two surveys were sent out and 101 were returned. This represented approximately 0.6% of the practice patient population. These results were supported by our discussions with staff on the day of our inspection and completed comment cards.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- 56% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 78% and the national average of 76%.
- 12% of patients said they could get through easily to the practice by phone compared with the CCG average of 67% and the national average of 71%.
- 57% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 82% and the national average of 84%.
- 61% of patients said their last appointment was convenient compared with the CCG average of 80% and the national average of 81%.
- 28% of patients described their experience of making an appointment as good compared with the CCG average of 71% and the national average of 73%.
- 44% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 61% and the national average of 58%.

The provider described comprehensive plans that had been implemented to improve the access. For example, an automated cancellation line had been implemented and 36% of patients had registered to use the online access. The telephone contract was due to expire at the end of March and a new system that included more telephone lines was due to be installed. The provider told us that the current system did not have sufficient lines and mobile phones had been used to try and improve the telephone access. A plan had been implemented to increase the number of appointments available by upskilling nurses, healthcare assistants and pharmacists to relieve pressure on the GP appointments.

Results from the NHS Friends and Family Test highlighted that improvements were having a positive impact. In quarter one of 2017, only four out of 36 responses were positive (would recommend the practice to family and friends). In quarter one 2018, eight out of 14 responses were positive.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do.
- The complaints policy and procedures were in line with recognised guidance. Twenty-one written complaints were received in the last year; seven of which were in relation to access. We reviewed two complaints and found that they were satisfactorily handled in a timely way.
- There were accessible complaints leaflets for patients to refer to for advice regarding who they could complain to. We reviewed two response letters sent to patients and saw that they were responded to appropriately and in a timely manner. The letters informed patients of their right to complain to the Parliamentary and Health Service Ombudsman.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, the practice had replaced the telephone system to help improve access.
- The practice proactively monitored and acted on complaints posted on the national website and NHS Choices. Verbal complaints were communicated to the practice business manager.

Are services well-led?

Good

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

Our findings

We rated the practice, and all of the population groups, as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it. The practice had been identified as a vulnerable practice in 2016 due to staffing shortages but a plan had been implemented following the appointment of a new practice business manager. The plan aimed to evolve the service from a 'GP do' to a 'GP led' service and reflected the five year forward view for the NHS.
- There were appointed clinical leads for prescribing, diabetes, mental health, respiratory, cardiovascular disease and palliative care. We saw that these leads were using their respective expertise to drive and improve patient care. For example, the cardiovascular lead had hospital level skills and used them to manage patients in primary care reducing the need to attend a hospital setting.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. For example, the practice was aware of the Dudley demographics that included high levels of diabetes, alcohol and drug misuse and high levels of deaths from cancer in the under 75 age group.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.
- GPs at the practice held external leadership roles within Dudley Clinical Commissioning Group (CCG). For example, a GP partner was a member of the clinical advisory team for diabetes, involved in the setting up of Dudley clinical management guidelines. Two of the GPs had special interests, one in cardiology and one in sexual health. We saw that the knowledge and experiences they gained from these roles supported their leadership skills.
- In September 2016, the practice had been recognised for its leadership skills with a healthcare assistant having been awarded the 'Making a Difference Award' for making a difference to palliative and elderly care. The Practice Business Manager awarded the 'Practice Manager of the Year' for contribution to Primary Care Development across Dudley. These were awarded by the CCG and nominations were from all practices in Dudley.
- Support from the management team had been provided to other practices with Dudley CCG.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients. The strategy and supporting objectives are stretching, challenging and innovative, while remaining achievable.

- The practice mission statement was 'to deliver a high quality, safe patient centred service'.
- There was a clear vision and set of values. The practice had developed a mission statement to support their vision and values which included: 'ensuring continual quality improvement in the domains of safety, patient experience and clinical effectiveness'.
- The practice vision and mission statement were displayed throughout the practice. Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- One of the values, 'supporting innovative and forward thinking', was evident throughout the inspection. For example; the practice worked with a diverse range of professionals from the voluntary and public sectors to coordinate patient care.
- The practice planned its services to meet the needs of the practice population and the strategy was in line with health and social priorities across the region.
- The provider had adopted the Dudley CCG 'Enabling Practice to Improve and Change' (EPIC) programme, a service to share efficiency improvements across and all practices to support service improvements in primary care.

Culture

The practice had a culture of high-quality sustainable care. A systematic approach is taken to working with other organisations to improve care outcomes.

Are services well-led?

Good

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

- Staff stated they felt respected, supported and valued. They were proud to work in the practice. There was a low turnover of staff at the practice and staff told us they felt privileged to work at the practice.
- The practice focused on the needs of patients. A wellness centre had been established to promote better wellbeing for patients from both the practice and the surrounding area.
- Leaders and managers acted on behaviour and performance consistent with their vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. For example, a rapid access referral had not been processed correctly and a safety net was reiterated to patients asking them to contact the practice if they had not heard from the hospital within 10 days.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. For example, we saw how three practice nurses were being supported to qualify as independent prescribers. All staff had received regular annual appraisals and career development when needed. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work. Three practice nurses were being supported to complete appropriate prescribing training.
- There was a strong emphasis on the safety and well-being of all staff, patients and visitors to the premises.
- The practice actively promoted equality and diversity and gave examples of when they had supported a patient to ensure their equality was maintained. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams. We saw that leaders were highly respectful of the skills and knowledge each member of the leadership team provided.
- The practice had driven change externally, for example; safeguarding systems were being used as a potential model for other practice to adopt.
- Learning was shared to promote safety in the wider population, for example; a patient using multiple registrations to obtain high risk medication was escalated to the National Reporting and Learning System (NRLS).

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.
- Staff were clear of their roles and accountabilities in relation to safeguarding children and vulnerable adults and infection prevention and control.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. We saw that policies were regularly reviewed, updated and shared with staff.
- The practice management team held away days every six months to discuss strategy.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- Practice leaders had oversight of Medicines and Healthcare products Regulatory Agency (MHRA) alerts, incidents, and complaints. There were effective systems in place for reviewing and disseminating learning from these to relevant staff and monitoring of the actions taken.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence action had been taken to change practice and improve quality.

Are services well-led?

Good

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

- The practice had plans in place and had trained staff for major incidents. There was a business continuity plan in place to support unplanned disruptions to the service. The practice responded to the risk of patients not able to access appointments to their satisfaction.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. For example, the practice worked with the CCG to monitor patient attendance levels to the accident and emergency department (A&E). To reduce attendances to A&E, the practice had identified a group of patients who regularly attended and developed a proactive approach that achieved a reduction in attendances.
- Quality and sustainability were discussed in regular clinical and staff meetings where all staff had sufficient access to information.
- The practice used performance information which was reported on and monitored.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses. For example, the patient participation group were involved in discussion around the creation of a telephone hub to improve telephone access for patients.
- The practice used information technology systems to monitor and improve the quality of care. For example, a database to facilitate referrals along accepted pathways of care.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high quality sustainable services.

- There was an active patient participation group (PPG). Prior to our inspection we spoke with a member of the PPG. They told us the practice engaged positively with the PPG and listened to their concerns and suggestions. For example, the practice had installed a new front door and air conditioning in the patient waiting room in response to requests from the patient group.
- The PPG were actively involved in the 'wellness centre' and started groups to encourage attendance that allowed peer support, for example, there was a knitting group and a dominoes club established. The practice engaged with patients by sharing information about their service through their newsletter.
- The service was transparent, collaborative and shared learning from near misses or incidents with external stakeholders when appropriate.
- The practice produced an action plan in conjunction with the PPG to address the negative results from the 2017 GP National Patient Survey. The actions included the addition of mobile phone contracts to take the pressure off the telephone lines and the upskilling of nurses, healthcare assistants and pharmacists to increase the availability of appointments.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement within the practice. For example, the practice regularly participated in pilot projects, the most recent a long-term condition pilot across 11 sites where dedicated days and longer appointments were aimed at a more collaborative model of care with the patient. The practice was also involved in the design of a management information reporting suite.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements in the practice.
- The practice was a training practice for GP Registrars to gain experience in general practice and family medicine. The GP trainers supported GP registrars who experienced difficulties completing their training.
- The provider was in discussion with Birmingham University and Wolverhampton University to implement training for Physician's Associates.