River Brook Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of River Brook Medical Centre on 12 December 2016. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Learning was shared with staff and reported to external agencies when required.
- Effective systems were in place to mitigate risks to patients who took high risk medicines.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice offered extended hours, and services were available to patients seven days a week
- Feedback from patients about their care was consistently positive and was reflected in the national patient survey published in July 2016.
- The practice had reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice had carried out a re-audit of A&E attendances and shared their findings with the local CCG to inform the development of future services.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice actively reviewed complaints and how they were managed and responded to, and made improvements as a result.
- The practice had a vision which was to provide high quality primary care to their practice population seven days a week. There was a supporting business plan that reflected this vision to ensure the future direction

Summary of findings

of the practice was monitored and evaluated. There were clearly defined strategies in place and strong evidence of how these strategies had shaped the development of services offered.
- The practice had visible clinical and managerial leadership.
- There were some gaps in the governance arrangements. The provider had addressed a number of the on-going areas prior to the inspection and sent evidence of action taken in other areas immediately after the inspection.
- Staff had received some training but their training needs had not been identified and not all staff had received regular appraisals.
- Some staff recruitment checks had been completed but there were gaps in obtaining all of the required checks to meet the legal standards.

The areas where the provider must make improvement are:

- Put effective recruitment and selection procedures in place to ensure that persons employed meet the required conditions.
- Ensure the risks to the health and safety of patients with learning disabilities are assessed by completing annual health checks.

The areas where the provider should make improvement are:

- Update safeguarding policies to include updated categories or definitions of the types of abuse such as modern slavery.
- Arrange infection prevention control (IPC) training for staff and document and action the findings from IPC audits.
- Implement an appraisal programme for all staff
- Consider the completion of a training needs analysis to identify any skill gaps within the workforce.
- Implement a patient call/recall system to invite carers for annual health checks and flu immunisations.
- Revise the administration of annual health checks for patients aged 75 and over to provide accurate data.
- Obtain masks for children in the event of having to administer oxygen.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services.

- There was an effective system in place for reporting and recording significant events.
- Lessons were shared internally to make sure action was taken to improve safety in the practice and externally to share learning with other practices.
- When things went wrong patients received reasonable support and a written apology. They were told about any actions to improve processes to prevent the same thing from happening again.
- The practice had an effective system to log, review, discuss and act on alerts received that may affect patient safety.
- Effective systems were in place to monitor risks to patients who took high risk medicines.
- The practice had processes and practices in place to keep patients safeguarded from the risk of abuse. However, the safeguarding policies were not up to date as they did not include updated categories or definitions of the types of abuse such as modern slavery.
- Some recruitment checks had been carried out on staff employed to work at the practice but gaps included no employment history and no assessment of their physical or mental health.
- The practice had not carried out regular fire evacuation drills.
- The practice had processes in place to respond to medical emergencies and major incidents.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average. The most recently published results showed the practice had achieved 98% of the total number of points available.
- The clinical staff were able to describe a structured approach to how National Institute for Health and Care Excellence (NICE) best practice guidelines and standards were disseminated, audited and actioned.

Summary of findings

- Clinical audits had been completed and repeated audit cycles demonstrated that the practice monitored the findings to drive improvements in patient outcomes.
- An overarching training matrix and policy had been put in place to monitor that all staff were up to date with their training needs. However, there were some gaps where training needs had not been identified and not all staff had received regular appraisals.
- Childhood immunisation rates for the vaccinations given were similar to the national averages.
- Staff worked with health care professionals to understand and meet the range and complexity of patients' needs.
- The practice had a system 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.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey, published in July 2016, showed patients rated the practice higher than others for most aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice had identified 77 patients as carers (1.2% of the practice list) and offered them flu immunisations and annual health checks. However, there was no patient call/recall system in place to promote the uptake of these services.
- The practice provided support to families who had suffered bereavement and had an effective system in place to notify staff and other health care professional to minimise the risk of inappropriate correspondence.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice offered extended hours and services were available to patients seven days a week.
- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical

Summary of findings

Commissioning Group to secure improvements to services where these were identified. For example, the practice had carried out a re-audit of A&E attendances and shared their findings with the local Clinical Commissioning Group (CCG) to inform the development of future services.

- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. This was supported by the results of the national patient survey published in July 2016.
- Patient feedback was positive about the appointment system. Data from the national patient survey, published in July 2016, showed that 83% of respondents described their experience of making an appointment as good.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Are services well-led?

Good

The practice is rated as good for being well-led.

- The practice had a vision to provide high quality primary care to their practice population seven days a week and to increase the services available in the community and through information technology. Staff were clear about the vision and their responsibilities in relation to it.
- The practice had a supporting business plan to ensure the future direction and challenges to the practice were assessed, monitored and evaluated.
- There was a clear leadership structure and staff felt supported by the management. The practice had a number of policies and procedures to govern activity and held regular team meetings, social events and team development sessions.
- The practice had some systems and processes in place to support an overarching governance framework that improved the quality and safety of their service. However, we identified several areas which required review.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- Older patients were offered a GP hosted telephone assessment service.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Patients over 75 years of age were invited for an over 75 health check. We saw that 18 out of 372 patients (5%) had received a health check in the last 12 months. The provider believed that more checks had been carried out but had not been coded correctly on the system.
- The care of older patients was co-ordinated with the primary care team based in the community.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- The provider held dedicated clinics and had an effective patient call and recall system to invite patients with long term conditions for regular reviews.
- The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 98% of the total number of points available.
- All these patients had a named GP and a structured annual review to check their health and medicine needs were being met. For those patients with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The provider was signed up to a local scheme that focussed on early diagnosis and prevention of long term conditions.
- The provider offered extended diagnostics and services to both registered and non-registered patients that included an ultrasound and anticoagulation (prevention of blood clotting) services.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- The practice's uptake for the cervical screening programme was 77%, which was comparable to the CCG average of 80% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives and health visitors.
- New mothers were offered post-natal checks and development checks for their babies.
- Data from NHS England for the time period 1 April 2015– 31 March 2016 showed that childhood immunisation rates for the vaccinations given were similar to the national averages.
- The provider had an open door policy for sick children to be seen the same day.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Extended hours appointments were available on week day evenings up to 8pm and at weekends, between 8am and 2pm on a Saturday and between 10am and 2pm on a Sunday, for working aged patients. Telephone consultations were also available.
- The practice was proactive in offering online services including an electronic prescription service as well as a full range of health promotion and screening that reflected the needs for this age group.
- All patients between the age of 40 and 74 years of age were offered NHS health checks.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

Summary of findings

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability and patients with drug related problems who received medication to help them in the management of their addiction.
- The practice offered longer appointments for patients with a learning disability but did not have a formal system in place to invite patients with a learning disability for an annual health check.
- The practice regularly worked with other health and social care professionals, to provide effective care to patients nearing the end of their lives and other vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The GP was trained in the assessment of deprivation of liberty safeguards (DOLS). These safeguards ensure that important decisions are made in people's best interests.
- The practice had shared 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.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- Weekly clinical sessions with a counsellor were held at the practice for patients experiencing poor mental health.
- The percentage of patients with a diagnosed mental health condition who had a comprehensive, agreed care plan documented in their record, in the preceding 12 months was 86%. This was below the CCG average of 93% and the national average of 89% however, their exception reporting rate was 5.5% which was lower than the CCG average of 7.6% and the national average of 12.7% meaning more patients had been included.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.

Summary of findings

- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- Staff had a good understanding of how to support patients with mental health needs and dementia. The practice was working towards becoming a dementia friendly practice.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing above local and national averages. Two hundred and ninety-two survey forms were distributed and 111 were returned. This represented a 38% return rate (1.8% of the practice population.

- 82% of respondents found it easy to get through to this practice by phone compared to the Clinical Commissioning Group (CCG) average of 70% and the national average of 73%.
- 94% of respondents were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 81% and the national average of 85%.
- 92% of respondents described the overall experience of this GP practice as good compared to the CCG average of 82% and the national average of 85%.
- 92% of respondents said they would recommend this GP practice to someone who had just moved to the local area compared to the CCG average of 75% and the national average of 78%.

As part of our inspection we also asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received 34 comment cards of which 32 were positive about the standard of care received. Patients told us staff were helpful, caring, treated them with dignity and respect and they felt listened to. Two of the cards had negative comments from patients who felt that staff could be more attentive.

Areas for improvement

Action the service MUST take to improve

- Put effective recruitment and selection procedures in place to ensure that persons employed meet the required conditions.
- Ensure the risks to the health and safety of patients with learning disabilities are assessed by completing annual health checks.

Action the service SHOULD take to improve

- Update safeguarding policies to include updated categories or definitions of the types of abuse such as modern slavery.
- Refresh staff awareness of the location of equipment used to treat a medical emergency.
- Arrange infection prevention control (IPC) training for staff and document and action the findings from IPC audits.
- Implement an appraisal programme for all staff
- Consider the completion of a training needs analysis to identify any skill gaps within the workforce.
- Implement a patient call/recall system to invite carers for annual health checks and flu immunisations.
- Revise the administration of annual health checks for patients aged 75 and over to provide accurate data.
- Obtain masks for children in the event of having to administer oxygen.

River Brook Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to River Brook Medical Centre

River Brook Medical Centre is registered with the Care Quality Commission (CQC) as a GP partnership in Stirchley, Birmingham. The practice holds a General Medical Services (GMS) contract with NHS England. 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 area is one of lower deprivation when compared with the local Clinical Commissioning Group (CCG) area but pockets of deprivation make it higher than the national averages. For example, 22% of the older patients are affected by income deprivation compared to the national average of 16%. At the time of our inspection the practice had 6,200 patients. The practice age distribution is in line with the national and CCG area. The percentage of patients with a long-standing health condition is 58%, which is higher than the local CCG average of 52% and the national average of 54%.

The practice is open between 8am and 8pm Monday to Friday except Wednesdays when it closes between 1.30pm and 5pm (during this time a telephone message directed patients to the NHS 111 service and out of hours GP cover is in place). The practice provide a mixture of pre-bookable and urgent appointments between 8am and 11.50am and 1.30pm to 8pm Monday to Friday. On a Saturday appointments are available between 8am and 2pm and on a Sunday between 10am and 2pm. Appointments can be booked four weeks in advance. The practice does not routinely provide an out-of-hours service to their own patients but patients are directed to the out of hours service, Badger when the practice is closed. The nearest A&E department is at the Queen Elizabeth Hospital in Birmingham and the nearest walk in centre is South Birmingham Walk In Centre in Selly Oak.

The practice team consisted of:

- Three GP partner (one male, two female)
- Two salaried GPs (one male, one female)
- An advanced nurse practitioner (seconded)
- One practice nurse (currently seconded, new nurse recruited for January 2017)
- One research nurse (funded by Birmingham University)
- A health care assistant
- Clinical pharmacists (4 working total of 16 hours per week provided by Southdoc)
- A practice manager
- Six reception and administrative staff.

The practice provides a number of specialist clinics and services. For example joint injections, acupuncture and cryotherapy (the use of low temperatures in medical therapy). It also hosts other services for external providers available to both registered and non-registered patients. For example, pre-diabetes education and ultrasound services. The practice is a teaching practice for medical students to gain experience and higher qualifications in general practice and family medicine. They are also a training practice and provide postgraduate training for newly qualified doctors as well as support placements for GP associates and nurses.

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before our inspection, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 12 December 2016. During our inspection we:

- Spoke with a range of staff including GPs, the healthcare assistant, the practice manager and administrative staff.
- Observed how patients were cared for.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record and learning

The practice operated an effective system to report and record significant events.

- Staff knew their individual responsibilities, and the process, for reporting significant events.
- The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- The practice had recorded and carried out a thorough analysis of 18 significant events in the previous 12 months. When required, action had been taken to minimise reoccurrence and learning had been shared within the practice team. Significant events were discussed as a standing item within practice and clinical meetings, or sooner if required.
- Internal events were recorded through a shared electronic system and external events through a database reporting system coordinated by the Clinical Commissioning Group (CCG). Of the events recorded, 11 had been shared with the CCG and seven were internal.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, the practice was able to demonstrate how an event relating to a dispensing error at a local pharmacy and confirmation that it had been reported to the superintendent pharmacist. Records showed that this had been received.

The practice's process to act on alerts that may affect patient safety, for example from the Medicines and Healthcare products Regulatory Agency (MHRA), was effective. We saw evidence that alerts had been acted upon by the CCG pharmacist. For example, a MHRA alert issued in September 2016 for a hormone used to control blood sugar levels. We saw a computer search had been carried out by the practice to identify any patients who may have been receiving this treatment. When appropriate, the patients had been seen and their medication changed. The practice also had an electronic folder for fraud warnings that included any patient warnings. Patient fraud warnings had been added onto the clinical system as inactive patients with a major alert added. This ensured that all staff would see a warning each time the patients' electronic record was accessed.

Overview of safety systems and processes

The practice had some systems, processes and practices in place to keep patients safe and safeguarded from the risk of abuse. For example:

- All staff knew their individual responsibility for safeguarding children and vulnerable adults from the increased risk of harm. All staff had received role appropriate training to nationally recognised standards. For example, the GP had attended level three training in safeguarding children. There was a lead member of staff for safeguarding. Policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. However, the policy for safeguarding vulnerable adults did not reflect updated categories or definitions of the types of abuse such as modern slavery.
- Chaperones were available when needed. All staff who acted as chaperones had received training, a Disclosure and Barring Service (DBS) check and knew their responsibilities when performing chaperone duties. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. The availability of chaperones was displayed in the practice waiting room and in clinical and treatment rooms.
- The practice was visibly clean and tidy. Clinical areas had appropriate facilities to promote current Infection Prevention and Control (IPC) guidance. IPC audits had been undertaken and although actions had been discussed, a documented action plan was not in place to mitigate any risks identified. Clinical staff had received immunisations to protect them from the risk of healthcare associated infections. There were infection control protocols in place that included handwashing and needlestick injuries but staff had not received up to date training.
- We saw that a recruitment policy had been developed that outlined the legal requirements for the recruitment of all staff. We reviewed three personnel files and found that some checks had been completed. For example, photographic identification and criminal checks through the Disclosure and Barring System (DBS) and an

induction programme. However, there were gaps that included a health check on staff to demonstrate that the physical and mental health of newly appointed staff had been considered to ensure they were suitable to carry out the requirements of the role, no interview summary, no references and no employment history. Locum GPs were used through an approved agency and an agreement was in place that all appropriate checks had been carried out. A human resource advisor had been asked to support the practice to ensure that all checks were carried out in future.

- Arrangements for managing emergency medicines and vaccines were in place. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. A health care assistant was trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.

The arrangements for managing medicines in the practice promoted patient safety:

- We found that the practice had an effective system to monitor patients prescribed high risk medicines.
- An effective system for the management of uncollected repeat prescriptions was in place. Uncollected prescriptions were checked monthly and any uncollected items over a month old were given to a GP to review and take appropriate action.

Monitoring risks to patients

Environmental risks to patients were assessed and generally well managed.

- The practice had up to date fire risk assessments but had not carried out regular fire evacuation drills. The provider had not carried out a fire evacuation drill in the previous 12 months. Following the inspection, the practice planned to complete an evacuation and revised its fire safety policy to include regular drills and named fire wardens.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs.
- The practice had a variety of other risk assessments in place to monitor safety of the premises such as maternity and manual handling.
- A legionella risk assessment had been carried out and regular testing for the presence of legionella and water temperature checks had been carried out. (Legionella is a bacterium which can contaminate water systems in buildings).

Arrangements to deal with emergencies and major incidents

The practice had processes in place to respond to emergencies and major incidents.

- There was a panic button in all the consultation and treatment rooms which could alert staff in the event of an emergency. In addition there was a panic button linked directly to the police station from the reception desks.
- All staff had received recent annual update training in basic life support.
- The practice had emergency equipment which included an automated external defibrillator (AED), (which provides an electric shock to stabilise a life threatening heart rhythm), oxygen and pulse oximeters (to measure the level of oxygen in a patient's bloodstream).
- Emergency medicines were held to treat a range of sudden illnesses that may occur within a general practice. All medicines were in date, stored securely and staff knew their location.
- An up to date business continuity plan detailed the practice's response to unplanned events such as loss of power or water system failure. A copy was kept off site.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Practice staff told us that they assessed patients' needs and delivered care in line with relevant and current based guidance and standards including National Institute for Health and Care Excellence (NICE) best practice guidelines. There was a structured approach to ensure these guidelines and standards were disseminated, audited and actioned in a comprehensive manner. The practice showed us clinical audits they had carried out based on recommendations from NICE guidelines. These included the 24 hour blood pressure monitoring of patients with high blood pressure.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 98% of the total number of points available.

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

- The overall performance for diabetes related indicators was similar to the Clinical Commissioning Group (CCG) and national averages (89% compared with 91% and 90%). There were a number of diabetes related indicators that were below the CCG and national averages. For example, the percentage of patients newly diagnosed with diabetes who had been referred to a structured education programme within nine months of being added to the register was 82% which was lower than the CCG average of 95% and the national average of 92%. However the exception reporting rate of 8.3% was lower than the CCG average of 16.7% and the national average of 23% meaning more patients had been included. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.
- Performance for mental health related indicators was slightly below the CCG and national averages. For example, the percentage of patients with a diagnosed mental health condition who had a comprehensive, agreed care plan documented in their record, in the preceding 12 months was 86%. This was below the CCG average of 93% and the national average of 89%. The exception reporting rate was 5.5%. This was lower than the CCG average of 7.6% and the national average of 12.7% meaning more patients had been included.
- Seventy-four per cent of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months. This was below the CCG average of 86% and the national average of 84%.
- The percentage of patients with chronic obstructive pulmonary disease (COPD) who had had a review in the preceding 12 months was 93%. This was above the CCG and the national averages, both 90%.

Attendances for ambulatory care sensitive conditions were higher than the local and national averages and the practice felt that this was due to close proximity of the nearest A&E department (three miles from the practice). The practice had carried out audits of A&E attendances and had shared their findings with the local CCG to inform the development of future services.

There was evidence of some quality improvement including clinical audit.

- The practice showed us two clinical audits that had been completed in the last year, both off these were cycle audits (repeated to monitor any changes in outcome). One audit looked at the treatment of eczema patients and the use of creams. Changes were made and all GPs followed a new pathway to try alternative creams before prescribing steroid creams. A second cycle evidenced that this pathway was being followed.
- A second audit looked at appropriate prescribing of antibiotics. A second cycle showed no improvement had been made. As a result, the practice planned to introduce a laminated copy of the local formulary (guidelines) for the prescription of antibiotics into every clinical room and monitor prescribing.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

Good

Are services effective?

(for example, treatment is effective)

- The practice had a training policy in place in addition to training and induction programme for all newly appointed staff. This covered such topics as safeguarding, information governance and fire safety.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. The practice was in the process of converting this to electronic records to provide an oversight of the training staff had completed and needed to complete. Role specific training had been identified for some staff, for example, the healthcare assistant had completed initial and refresher training for performing spirometry. However there were a number of areas in relation to infection prevention control and health and safety, where role specific training requirements had not been identified and staff were not fully aware of the legal requirements. The practice had engaged with a human resource professional to address this shortfall.
- Staff administering vaccines had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example formal training updates and discussion at practice meetings.
- We were told that not all staff had received a regular appraisal. These were being planned with the support of a human resource professional. The learning needs of some staff were identified through a system of appraisals, meetings and reviews of practice development needs.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice team met regularly with other professionals, including palliative care and community nurses. They discussed the care and treatment needs of patients approaching the end of their life and those at increased risk of unplanned admission to hospital.
- The practice had shared 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.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. The GP was trained in the assessment of deprivation of liberty safeguards (DOLS). These safeguards ensure that important decisions are made in people's best interests.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GPs assessed the patient's capacity and, recorded the outcome of the assessment.
- There was an up to date consent policy for staff to refer to for guidance.
- The practice had performed an audit on patients who had consented to minor surgery. The audit showed that not all patients had given written consent for surgical procedures. The practice modified their form to give more information to the patient and planned a second cycle audit to evidence improvement. The practice performed acupuncture through an accredited clinician but consent was not recorded from patients.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition, those requiring advice on their diet and smoking cessation. Patients were signposted to the relevant services.
- Patients over 75 years of age were invited for an over 75 health check. We saw that only 18 out of 372 patients (5%) had received a health check in the last 12 months. The practice attributed this to a coding problem and told us that more reviews had been completed.

Good

Are services effective?

(for example, treatment is effective)

The practice's uptake for the cervical screening programme was 77%, which was comparable to the CCG average of 80% and the national average of 82%. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Data from NHS England for the time period 1 April 2015– 31 March 2016 showed that childhood immunisation rates for the vaccinations given were similar to national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 93% to 96% (national rate was 73% - 95%) and 78% to 96% for all five year old immunisation rates (national rate of 81% - 95%).

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. The practice had carried out 359 NHS health checks in the previous 12 months. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations. Conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Most of the 34 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients told us staff were helpful, caring, treated them with dignity and respect and they felt listened to. They told us responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey, published in July 2016, showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 90% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 93% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 100% of patients said they had confidence and trust in the last GP they saw compared to the CCG average and the national averages, both 95%.
- 88% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 85%.
- 94% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 88% and the national average of 91%.
- 96% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patient feedback from the comment cards we received was positive about their involvement in decision making about the care and treatment they received. They told us they felt listened to and supported by staff to make an informed decision about the choice of treatment available to them.

Results from the national GP patient survey published in July 2016 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were above local and national averages. For example:

- 88% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 86%.
- 89% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and the national average of 82%.
- 87% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care, for example, staff told us that translation services were available for patients who did not have English as a first language.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted staff if a patient was also a carer. A total of 77 patients who also acted as carers had been identified (1.2% of the practice population). The practice offered carers annual health checks and flu immunisations. However there was no patient call/recall system in place. Written information was available to direct carers to the various avenues of support available to them but this was not clearly displayed.

Staff told us that if relatives had suffered bereavement, the GP often contacted the patient and offered a patient

Good

Are services caring?

consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to access Cruse, a local bereavement support service.

Arrangements were in place to notify all staff about the death of a patient so that they were kept up to date and . a major alert was added to the patient notes to stop any further communication.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice held a register of patients living in vulnerable circumstances. For example, those with a learning disability and patients with alcohol related problems who received medication to help them.
- There were longer appointments available for patients with a learning disability. The practice had 35 patients on the learning disability register but there was no patient call/recall systems for this register. Although medication reviews had been carried out, no annual health checks had been completed on patients with a learning disability in the past 12 months.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS.
- There were disabled facilities, a hearing loop and translation services available.
- The practice provided care and treatment to approximately 70 patients living in care homes. These patients had received regular health and medication reviews.
- The practice provided weekly visits to two care homes with a high number of patients suffering with dementia. The practice carried out advance care planning for these patients.
- The practice regularly worked with the community healthcare staff, a team that included health and social care professionals, to provide effective care to patients nearing the end of their lives and other vulnerable patients.
- New mothers were offered post-natal checks and development checks for their babies.
- The practice had a policy to allow patients to book appointments with the doctor of their choice and advised that this could result in a delay in being seen.

Access to the service

The practice was open between 8am and 8pm Monday to Friday except Wednesday when it closed between 1.30pm and 5pm (during this time a telephone message directed patients to the NHS 111 service and out of hours GP cover was in place. It provided a mixture of pre-bookable and urgent appointments between 8am and 11.50am and 1.30pm to 8pm Monday to Friday. On a Saturday appointments were available between 8am and 2pm and on a Sunday between 10am and 2pm. The practice did not routinely provide an out-of-hours service to their own patients but patients were directed to the out of hours service, Badger when the practice was closed. The nearest A&E department was at the Queen Elizabeth Hospital in Birmingham and the nearest walk in centre was South Birmingham Walk In Centre in Selly Oak.

Results from the national GP patient survey published in July 2016 showed that patient's satisfaction with how they could access care and treatment was above local and national averages.

- 82% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and the national average of 76%.
- 83% of respondents described their experience of making an appointment as good compared to the CCG average of 70% and the national average of 73%.

The practice had invested in a telephone system that enabled patients to avoid the engaged tone when ringing the surgery and had installed an additional line in July 2016 that was dedicated to allowing patients to be contacted by the practice even at the busiest times. These measures helped the provider to achieve above average scores in the national patient survey on patient access by telephone:

- 82% of patients said they could get through easily to the practice by phone compared to the CCG average of 70% and the national average of 73%.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- We saw that information was available to help patients understand the complaints system in the complaints leaflet.

We looked at two complaints received in the last 12 months and found they were satisfactorily handled, dealt with in a timely manner with openness and transparency. Lessons were learnt from individual concerns and complaints and also from an analysis of trends. Action was taken as a result to improve the quality of care. For example, following a complaint received regarding the care administered, the practice felt the care was appropriate but still referred a patient to a consultant specialist to provide a second opinion.

The practice did not advise patients in their letters of response about how to escalate their complaint if they were not satisfied with the outcome or their complaint or how it had been managed. However, these details were included in the complaints leaflet and the practice told us that a leaflet was given out to each complainant.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a written set of aims which included the provision of high quality medical care, a commitment to educate employees on equality and diversity. They also had a set of objectives that included working with other local primary care providers to offer seven day services to a population of 23,000 patients. This strategy was coupled with an aim to provide more services in the community and through information technology.

Staff we spoke with felt engaged with the aims and objectives and understood their own roles and responsibilities as well as the role of colleagues. They told us how they related this to their practice of providing high quality care which mapped through to the positive patient feedback and higher than average satisfaction rates in the national GP patient survey published in July 2016. Staff felt that they were supported in their personal development and spoke of a good level of morale between colleagues.

The practice did have a supporting business plan that reflected this vision to ensure the future direction of the practice was monitored and evaluated. The management shared with us some of the future challenges such as succession planning and the development of the premises to increase the number of services that could be offered.

Governance arrangements

There was a clear staffing structure and staff were aware of their own roles and responsibilities. Practice specific policies were implemented and were available to all staff.

The practice had systems and processes in place to support an overarching governance framework that improved the quality and safety of their service. However. there were some gaps we identified. These included:

- Not all policies reflected current guidance, for example guidance relating to the safeguarding of vulnerable adults.
- The infection prevention control was managed and audited but there was no evidence of an action plan to address the issues raised from the most recent audit.
- Some recruitment checks had been completed but gaps meant that the risks to staff and patients had not always been assessed or mitigated.
- The health and safety measures did not always meet the mandatory requirements. For example, fire evacuation drills had not been carried out annually.
- There was no structured programme of staff appraisals.

Leadership and culture

The GP in the practice had the capability to run the practice and were able to demonstrate how they ensured high quality care was being provided by all staff. They aspired to provide safe, high quality care and the governance procedures supported them to monitor and evaluate this. Staff told us the management were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).The management encouraged a culture of openness and honesty and there were systems in place to ensure that when things went wrong with care and treatment:

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

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

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported. All staff were involved in discussions about how to run and develop the practice, and the management encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

Are services well-led?

Good

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

- The practice had gathered feedback from patients through an internal questionnaire, a questionnaire filled in for submission to the clinical commissioning group (CCG) and through the practice website. An ongoing questionnaire was available from the reception desk. Comments we saw were all positive.
- The practice had gathered feedback from staff through staff meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run and they had a suggestions box that was used to form the agenda for full practice meetings.

Continuous improvement

There was a strong focus on continuous learning and improvement within the practice. The practice was both a teaching practice for medical students and a training practice for newly qualified GPs. They played an active role in a number of ongoing research projects. The strategy linked into the 'community care first project' with a number of hosted services for patients to access closer to their home, reducing the need to attend a hospital. The provider explored how information technology could be used to improve the patient experience, for example, patient specific applications and providing a virtual pharmacist and GP access to patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** The provider had not ensured that all required recruitment checks had been carried out on staff employed. Checks on staff employed did not always include, employment history, references and a process to demonstrate that the physical and mental health of newly appointed staff had been considered to ensure they are suitable to carry out the requirements of the role. This was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.