Hobs Moat 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?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 9 April 2015 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be good for providing safe, effective, caring, responsive and well-led services. The practice was good for providing services for older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances and people experiencing poor mental health.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. All opportunities for learning from incidents were maximised.
- Risks to patients were assessed and well managed.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said that there was continuity of care, with urgent appointments available the same day although routine appointments were not always easy to book. However, the practice had made some changes to try and improve access.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant event meetings.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on. For example, the practice implemented

Summary of findings

suggestions for improvements and made changes to the way it delivered services as a result of feedback from patients and from the Patient Participation Group (PPG).

We saw several areas of outstanding practice including:

- The practice had regularly produced a poster for patients in an easy to read format and user-friendly way with pictures and statistics. The information it gave patients included things such as: the amount of patients who had failed to arrive for an appointment together with the cost; the number of patients attending A & E; number of complaints received by the practice and the number of safety audits the practice had completed. Feedback from patients was consistently positive. It had helped to foster a more open relationship with patients as they now had a better understanding of how things were prioritised and the impact patients had on the practice.
- The practice had been awarded the Lesbian & Gay Foundation GOLD Pride in Practice award for delivering fully inclusive healthcare services to their patients. The practice had been required to meet strict criteria to be awarded the highest "Gold" level award. A number of changes at the practice had taken place to achieve this such as forging strong links with relevant support services to increase access and modifying the new patient questionnaire to capture data on sexuality. This resulted in doctors being aware when they saw patients and allowing targeted signposting to services where appropriate.
- The practice had previously reached out to patients at risk of falls by holding an event on falls prevention. The practice had now built on this area of interest and was collaborating with Warwick University on a falls research project for older people. Appropriate patients had been offered a one hour face-to-face assessment by nurses at the practice who had undergone further training. Patients had then been referred to either community physiotherapy, occupational health or to the GP as required. The project had allowed patients to become more educated about falls prevention and had been offered early interventions where relevant. A review of the collaboration project around the impact achieved had been scheduled for March 2016.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Risks to patients were assessed and well managed. There were safeguarding measures in place to help protect children and vulnerable adults. Reliable systems were in place that ensured the safe storage and use of medicines and vaccines within the practice. There was a designated lead to oversee the infection control within the practice. Enough staff were employed by the practice to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were near or below the average for the locality. The practice was aware of the areas where performance was not in line with national figures and we saw evidence of how some these were being addressed and updated data provided by the practice indicated improvements were being seen. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams internally and externally to deliver positive health outcomes for patients.

Are services caring?

Good

The practice is rated as good for providing caring services. Feedback from patients about their care and treatment was positive. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Staff were motivated and inspired to offer kind and compassionate care.

The practice supported patients to have a forum where they could learn and share ideas that promoted their health. There was an active patient participation group (PPG) at the practice that directed its own agenda and focused on topics that mattered to patients. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It 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. Patients said they found it easier to make an appointment since some changes had been introduced with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. The practice had been awarded the Lesbian & Gay Foundation GOLD Pride in Practice award for delivering fully inclusive healthcare services to their patients. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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 and had a range of enhanced services, for example, in end of life care. The practice maintained a register of patients in need of palliative care and held regular multidisciplinary integrated care meetings where all patients on the palliative care register were discussed. There was a designated lead for end of life care and systems in place to support the needs of patients at end of life. Home visits and same day appointments were available to those who needed them. Patients over 75 years of age were offered annual health reviews.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Clinical staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. Most of these patients had a named GP and a structured annual review to check that their health and medication needs were being met. Chronic disease management clinics were held, for example diabetes clinic and included reviews of medication to ensure conditions were being managed appropriately. For those people with the most complex needs, the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. Immunisation rates were comparable to national and CCG averages for all standard childhood immunisations. The practice website included sections with information for young carers to enable appropriate support to be provided in a targeted and engaging way. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives and health visitors.

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Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice had increased the number of online appointments offered as well as offering "worker" appointments slots and telephone consultations which enabled patients who had work commitments to have better access to the practice.

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. The practice held a register of patients living in vulnerable circumstances such as those with a learning disability and carers. Carer support and signposting to other support services was also being offered to those identified as carers. All people with a learning disability were offered annual health checks as well as longer appointments. Information in 'easy to read' format was available for those on the learning disability register.

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.

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). The practice had a lead GP for the management of patients with poor mental health and patients experiencing poor mental health were offered annual physical health check. However QOF data available for 2013/14 indicated that only 53% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plans compared to the national average of 84%. In addition 58% of these had their alcohol consumption recorded compared to the national average of 89%. The practice had recognised improvements were required and we were provided with evidence that current data demonstrated that higher outcomes had now been achieved.

The practice had a system in place to ensure regular monitoring of prescribing for patients with mental health issues. Patients requiring additional support were signposted to various support services

Summary of findings

including local counselling services. The practice had systems in place to support safer prescribing of patients on medicines for example shorter or non-repeat prescriptions for patients on antidepressants. Computer flags alerted staff if a patient requested a repeat prescription too early or did not request a repeat prescription.

Summary of findings

What people who use the service say

As part of the inspection we spoke with 11 patients who used the practice. This included a member of the patient participation group (PPG). PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We sent comment cards to the practice before the inspection inviting patients to tell us about the care they had received. We received 22 completed comment cards. Our discussions with patients and feedback from the comment cards told us that patients were happy with the service they received. Patients told us that they were treated with dignity and respect and felt listened to. Most patients said they could get appointments when they wanted one.

Data from the GP national patient survey for January 2015 showed that patients rated the practice near the CCG and national average in a number of areas including overall experience, access and quality of consultations. However, the practice was rated significantly lower in being able to get an appointment with a preferred GP (32% compared to CCG average of 56% and a national average of 60%). Nevertheless, 92% of respondents said that the last GP they saw or spoke to was good at giving them enough time compared to a local average of 87% and a national average of 87%.

The practice recognised where improvements could be made and had worked to develop the quality and access of service patients received. At the time of our inspection the practice was actively recruiting GPs in order to increase patient access to appointments.

Outstanding practice

We saw several areas of outstanding practice including:

- The practice had regularly produced a poster for patients in an easy to read format and user-friendly way with pictures and statistics. The information it gave patients included things such as: the amount of patients who had failed to arrive for an appointment together with the cost; the number of patients attending A & E; number of complaints received by the practice and the number of safety audits the practice had completed. Feedback from patients was consistently positive. It had helped to foster a more open relationship with patients as they now had a better understanding of how things were prioritised and the impact patients had on the practice.
- The practice had been awarded the Lesbian & Gay Foundation GOLD Pride in Practice award for delivering fully inclusive healthcare services to their patients. The practice had been required to meet strict criteria to be awarded the highest "Gold" level award. A number of changes at the practice had taken place to achieve this such as forging strong links with relevant support services to increase access and modifying the new patient questionnaire to capture data on sexuality. This resulted in doctors being aware when they saw patients and allowing targeted signposting to services where appropriate.
- The practice had previously reached out to patients at risk of falls by holding an event on falls prevention. The practice had now built on this area of interest and was collaborating with Warwick University on a falls research project for older people. Appropriate patients had been offered a one hour face-to-face assessment by nurses at the practice who had undergone further training. Patients had then been referred to either community physiotherapy, occupational health or to the GP as required. The project had allowed patients to become more educated about falls prevention and had been offered early interventions where relevant. A review of the collaboration project around the impact achieved had been scheduled for March 2016.

Hobs Moat Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, practice nurse and an expert by experience (a person who has experience of using this particular type of service, or caring for somebody who has).

Background to Hobs Moat Medical Centre

Hobs Moat Medical Centre is based in the Solihull Clinical Commissioning Group (CCG) area. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

The practice has five GP partners and four salaried GPs. Three of the partners GPs were female. Other practice staff comprised of a practice manager, an administrator, two secretaries, four practice nurses, four support staff and a large reception team. There were approximately 10,400 patients registered with the practice at the time of the inspection.

The practice has a general medical service (GMS) contract with NHS England. Based on data available from Public Health England, deprivation in the area served by the practice is lower than the national average.

The practice is open between 8am and 6.30pm Monday to Friday. During the out of hours period when the practice is closed (6.30pm to 8am) patients received primary medical services through an out of hours provider (Badger).

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

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

How we carried out this inspection

During our visit we spoke with a range of staff including GPs, a practice nurse, the practice manager and administration and reception staff. We also spent some time observing how staff interacted with patients. We spoke with 11 patients who used the service, one of whom was a member of the Patient Participation Group (PPG) who told us their experience not only as a patient of the service but also as a member of the PPG. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

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?

Detailed findings

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. This included reported incidents and national patient safety alerts as well as comments and complaints received from patients. Systems were in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred in the last 12 months. We saw that detailed information of significant events was recorded including how the event affected the patient, the practice or the practitioner. Identified learning points were recorded as well as the date discussed with staff at the practice. We saw that systems were in place to ensure that significant events were reviewed regularly.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. Staff told us they were actively encouraged and supported to raise any concerns they might have.

We saw that incident report forms contained detailed information including action points and identified learning. We looked at the minutes of meetings where these were discussed for the last three months. We saw that significant events were discussed at each meeting. Staff we spoke with confirmed that they were discussed at monthly practice meetings. Additionally the practice manager told us about a 'Weekly News' email that kept staff informed about significant events. Two reception staff and a practice nurse we spoke with were able to discuss recent significant events. We found staff were keen to learn from these incidents and improve systems and practices. Staff said that the practice was very open and all relevant information was shared.

National patient safety alerts were received by the GP and circulated by the practice manager to practice staff depending on the nature of the alert. Staff we spoke with told us that when alerts relevant to the practice were received they were discussed at practice meetings to ensure all staff were aware, particularly where action needed to be taken. We were provided with an example of an alert that had been shared concerning Avian flu.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and adults living in circumstances which made them vulnerable. Training records made available to us demonstrated that all staff had received the level of safeguarding training relevant to their role. We asked members of medical, nursing and administrative staff about their training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were aware of their responsibilities and knew how to contact the relevant agencies in working hours and out of normal hours and properly document safeguarding concerns. We saw that contact details for relevant agencies were easily available to staff.

The practice had appointed one of the GPs as the safeguarding lead. They had been appropriately trained to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. The practice maintained a register of adults whose circumstances made them vulnerable. We saw that alerts had been setup on the system for children about whom safety concerns had been noted. There was evidence of active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority. We were told that every child with a child protection plan was discussed with health visitors at meetings.

We saw that the practice had chaperone policy (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). A chaperone leaflet alerting patients to this was seen in the waiting area. All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff who had undergone chaperone training would also act as chaperones when required. We found receptionist staff we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks.

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.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. This was being followed by practice staff. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol covered areas such as how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. We viewed audits carried out by the practice relating to antibiotic prescribing and saw evidence of change as a result of these.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance and kept securely at all times. We viewed a record book in use for when prescription pads were removed.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Infection prevention and control measures in place included the use of personal protective equipment (PPE) and clearly labelled sharps bins. Sharps is a term used to describe needles and other sharp medical instruments. An infection control policy and supporting procedures were available for staff to refer to which enabled them to plan and implement measures to control infection. We saw that the policy had been due to be reviewed in June 2014 but this had not been done.

We saw that PPE, including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how and when they would use these. Most equipment used was single use, further helping with infection control. Staff we spoke with were aware of when sharps bins should be disposed of.

The practice nurse was the for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that audits relating to infection control had been carried out and that any improvements identified for action were completed on time.

Notices about hand hygiene techniques were displayed in staff and patient toilets and patient waiting areas. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

We saw that the practice had a policy for management of clinical waste. Consignment notices demonstrated that clinical waste was being removed from the premises by an appropriate contractor. We saw that clinical waste was appropriately stored before being removed from the premises.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). The practice had undertaken a risk assessment for legionella and had decided that the risk was sufficiently low to make formal testing unnecessary.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. The practice manager told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place and the testing of portable electrical equipment was carried out by

the practice manager. We saw evidence that the practice manager was appropriately trained to carry this out. Evidence of calibration of relevant equipment was also seen; for example weighing scales, blood pressure measuring devices and the fridge thermometer.

We saw records to demonstrate that fire equipment such as smoke alarms and fire extinguishers had been subject to regular checks and routine maintenance. The practice had a fire risk assessment and an up-to-date health and safety policy. Fire extinguishers displayed stickers indicating the date of last testing. Fire drills with evacuation took place annually and staff undertook regular fire training.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that recruitment checks had been undertaken before being employed. For example, proof of identification, references, qualifications, registration with the appropriate professional body and DBS checks. We saw evidence that DBS checks had been carried out for all clinical staff and risk assessments were in place for non-clinical staff without DBS checks.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

We saw evidence to demonstrate that appropriate checks had been undertaken for locum GPs who worked at the practice. The practice manager told us they minimised the use locums to help maintain patient continuity of care and locums were never used to cover nursing duties. Staff we spoke with told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy and the practice manager had undertaken health and safety training and staff had received training in fire awareness.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. Staff explained how patients with long term medical conditions were monitored and appropriate alerts were placed on patients' medical records. For example there were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). All staff we asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. Back up paper copies of the business continuity plan were also located off site.

The practice had arrangements for identifying, recording and managing risks. We saw evidence where risk assessments had been carried out which identified key risks, with action plans in place to manage and minimise these risks. Risks identified included fire and health and safety at work. We saw from minutes of meetings that performance, quality and risks had been discussed and actions had been taken to address any improvements where they had been identified. The practice had carried

Good

Are services safe?

out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment and were familiar with current best practice guidance and with guidelines from the National Institute for Health and Care Excellence (NICE). These were available for staff to access on the practice computer system. They were aware of the need to stay updated regarding changes to guidelines. We were told that the practice manager also included any updates or changes to guidelines or recommendations as part of the 'Weekly News' email sent to all practice staff.

Patients had their needs assessed and care planned in accordance with best practice. We were told about the systems in place regarding long term conditions and that nursing staff had been trained in the management of long term conditions. The practice manager conducted monthly searches of patients who required review appointments.

Staff described how they carried out comprehensive assessments which covered all health needs and were in line with national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, all 30 patients registered at the practice that had been identified as having learning disabilities all had care plans in place with regular health checks scheduled. We were provided with an example where a routine health check had revealed additional issues and about the appropriate follow-up which had been organised as a result of this.

We were told about the systems in place to avoid unplanned hospital admissions and action plans that had been put in place for all patients at a high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital.

We saw that the practice made use of Choose and Book referrals where possible (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

Patients who required palliative care (palliative care is a holistic approach to care for patients with incurable illnesses and their families) were regularly reviewed. Their details were passed to the out of hours service each weekend to ensure care would continue when the practice was closed. We were told that Macmillan nurses attended monthly multi-disciplinary practice meetings where each patient on the palliative care list was discussed.

We saw no evidence of discrimination by GPs when they made care and treatment decisions. Interviews with the GP showed that the culture in the practice was that they did not take age, sex and race into account in their decision-making.

Management, monitoring and improving outcomes for people

Information about patients' care and treatment, and the outcomes of this, was routinely collected and monitored and this information was used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. A 'Weekly News' email was sent out by the practice manager to all practice staff. This included information on various aspects practice performance.

We saw clinical audits that that had been undertaken in the last 12 months relating to infection control, antibiotic prescribing, minor surgery as well as audits linked to the Quality and Outcomes Framework (QOF is a voluntary incentive scheme for GP practices in the UK). We were told that in some cases audits were driven by significant events that had occurred or as a result of information from QOF. Other examples included an audit of cancer diagnoses in the past 10 years and an audit of the prevalence of diabetes due to lower than average practice prevalence. We saw evidence that learning from audits was shared with practice staff.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. However, QOF data for 2013/2014 indicated that there were a number of places where the practice did not perform as highly as the national average. The practice was aware of the areas where performance was not in line with national figures and we saw evidence of how these were being addressed. For example, at the start of the inspection the practice gave us a presentation on the services they provided. This practice presentation included information about how

Good

Are services effective?

(for example, treatment is effective)

patients with mental health issues were being offered care plans and being regularly reviewed and an action plan was being implemented to target all the areas of improvement. We were told that significant improvements had already been made in QOF outcomes for these patients when compared between 2013/2014 and 2014/2015 (although this data had not yet been formally published or validated). Examples of practice performance in the 2013/14 QOF (and non-validated practice supplied data for 2014/2015) for reviewing the care needs of patients included:

- Performance for diabetes related indicators were lower to the national average. For example, the percentage of patients with diabetes, on the register, with a record of a foot examination within the preceding 12 months was 73% for the practice compared to the national average of 88%. Non-validated practice data supplied showed that the 2014/15 performance had increased to 90%.
- The percentage of patients with mental health indicators who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was only 53% for the practice compared to an 86% national average. Additionally, those patients in this group who had a record of alcohol consumption documented in the preceding 12 months was 58% for the practice compared to a national average of 87%. Non-validated practice data provided showed that the 2014/15, care plan performance had increased to 97.5%. Additionally, those patients in this group who had a record of alcohol consumption documented had also increased and was now at 95.5%.
- Those patients at the practice with physical and/or mental health conditions whose notes record smoking status in the preceding 12 months was 90% for the practice compared to a national average of 95%. Non-validated practice data showed that the 2014/15 performance had slightly increased to 91%.
- The dementia diagnosis rate was comparable to the national average although the percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was again lower (76% for the practice compared to a national average of 84%). Non-validated practice data showed that the 2014/15 performance had increased to 84%.

The practice's prescribing rates were similar to national figures, for example antibiotic prescribing. There was a protocol for repeat prescribing. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP.

The practice used the gold standards framework for end of life care. It had a palliative care register and held regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, health and safety, infection control and safeguarding.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

We discussed training with the practice nurse and reception staff. We were told that the practice was proactive and encouraged staff to undertake training. We were told that spirometry (this is a test that can help diagnose various lung conditions) had recently been introduced. The practice nurse had undertaken spirometry training and then worked alongside other staff until they were competent to undertake this task. We saw that the practice nurse had defined duties that they were expected to perform and the training records we saw demonstrated that this staff member was trained to fulfil these duties. Practice nurses with extended roles (for example seeing patients with long-term conditions such as diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD) were also able to demonstrate that they had appropriate training to fulfil these roles.

We discussed the practice's appraisal systems and reviewed a random sample of appraisal records. We were told that all staff had annual appraisals and staff we spoke

with confirmed this. We saw that appraisal meetings were conducted by both the practice manager and GPs. We saw that learning needs were identified during the appraisal process.

The practice gave an example of managing poor performance in line with their disciplinary procedure. We saw evidence demonstrating that where poor performance had been identified, appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service electronically. Staff were clear about their individual responsibilities for passing on, reading and acting on any issues arising these communications. Staff told us they were usually seen and actioned every day. We were told that where a GP responsible for particular patients was on leave, a system had been set up on the computer to automatically alert another doctor to action on their behalf. This ensured that results, discharge letters and other information were not unnecessarily delayed.

Emergency hospital admission rates for the practice were slightly higher compared to the national average. Data available for the practice for 2014 showed 16 emergency admissions per 1,000 patients compared to the national average of 14 emergency admissions per 1000 patients. However, the emergency cancer admissions were significantly higher for the practice with a practice percentage of 49% compared to a national figure of 7%. The practice told us that they believed issues about how patients were being coded were thought to be impacting on the figures. The practice also provided evidenced which showed that patients had been incorrectly coded as emergency cancer admissions when patients had been attending scheduled chemotherapy sessions. Therefore, the practice was engaging with Solihull Clinical Commissioning Group (CCG) in the start of a project to properly identify and rectify these problems. The practice manager also told us that their current overall emergency admissions data for patients with a long term condition was lower with 25.9 per 1000 patients in comparison to local area average of 34.5 per 1000 patients.

The practice held monthly multidisciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term conditions, end of life care needs or safeguarding and children with a protection plan in place. These meetings were attended by district nurses, health visitors, palliative care nurses and community matrons as appropriate. Decisions relating to patient care were documented in patients' record and the minutes of these meetings were fed back to the wider practice team.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice used the Choose and Book system. Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency.

The practice worked collaboratively with other agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment. Special patient notes is information recorded about patients with complex health and social care needs used to alert or highlight any specific care requirements, long term care plans or any other useful information. For example all learning disability, deaf and visually impaired patients had special notes attached to their clinical record to alert all staff accessing their record.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act (MCA) 2005 (this provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves) and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. The practice nurse and GP had undertaken training regarding the Mental Capacity Act.

Good

Are services effective?

(for example, treatment is effective)

We discussed consent and were told that implied consent was obtained when appropriate. Codes were included on patient records to demonstrate the consent obtained. There was a practice policy for documenting consent for specific interventions.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the practice nurse. Where appropriate a follow up appointment for patients was booked so that they could be properly managed. A GP was informed of all health concerns detected and those patients requiring repeat prescriptions. These were followed-up as soon as a GP appointment was available and if possible at the time of the health check. Patients who required further support were signposted to various services such as smoking cessation and weight loss services as appropriate.

We saw that the practice website provided comprehensive information to patients regarding the benefits of stopping smoking, healthy eating, carers support and other information to promote a healthy lifestyle. This information could be translated into various languages which helped patients whose first language was not English have access to this information. We saw there were leaflets and posters signposting patients to support services in the reception area, for example carer support services and information to help support healthier lifestyles.

The practice's performance for the cervical screening programme was 75%, which was below the national average of 82%. The practice explained that this difference was due to them very rarely exception coding patients from their reported figures who had been invited three times to attend but failed to do so. Exception coding is the exclusion of patients from the list of reported figures who meet specific criteria. For example, patients who choose not to engage in screening processes. Practice figures were consistent with this, showing that the practice had exception reporting of only 1%, which was 3% below the local Clinical Commissioning Group (CCG) average. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test and persistent non-attenders were also sent a letter. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Performance for the majority of immunisations where comparative data was available was similar to the national or CCG average. For example:

- Flu vaccination rates for the over 65s were 72% which was similar to the national average. However, flu vaccinations for defined at risk groups were 44% which was below the national average of 52%.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 81% to 99% and five year olds from 89% to 96%. These were comparable to CCG averages.

The practice told us about the steps it had taken to try and drive up flu vaccination rates as well as to further increase vaccination rates overall. For example, the practice manager had asked to be a part of the Local Solihull Flu Steering Group (which includes representation from across Solihull such as Solihull CCG, local pharmacies, local hospital and Public Health England). Furthermore, the practice had been working with their Patient Participation Group (PPG) to try and find different strategies for increasing uptake and seeking patient views through surveys. As a result, the practice would now be offering a Friday evening and a Saturday morning flu clinics.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2015 and a survey of 100 patients undertaken by the practice's patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. Patients were generally satisfied with the service. Additionally, the 2015 national patient survey found that 88% said they found the receptionists at the practice helpful compared to the CCG average of 85% and national average of 87%.

The evidence from all these sources showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. The practice was similar to the national and CCG average for its satisfaction scores on consultations with doctors and nurses. For example:

- 86% said the GP was good at listening to them compared to the CCG average of 88% and national average of 89%. For nurses, this was 94% compared to the CCG average of 91% and national average of 91%
- 92% said the GP gave them enough time compared to the CCG average of 87% and national average of 87%.
- 93% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 22 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with 11 patients on the day of our inspection, one of whom was also a member of the PPG. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. We saw that reception staff were respectful and treated patients in a friendly manner. The practice switchboard was located away from the reception desk and was shielded by partitions which helped keep patient information private.

There were both male and female GPs worked at the practice which ensured that same sex consultations could be provided if this was the patient's wish.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded in the main positively to questions about their involvement in planning and making decisions about their care. However, the practice was mostly rated lower by patients in these areas when compared to the CCG and national averages. For example:

- 80% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 86%. For nurses, this was 87% compared to the CCG average of 89% and national average of 90%.
- 70% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and national average of 81%. For nurses, this was 91% compared to the CCG average of 85% and national average of 85%.

Staff told us that translation services were available for patients who did not have English as a first language and that they knew how to access these services when needed. We also viewed the practice website and saw that it could be translated into a large number of different languages.

We saw examples of care plans that had been produced for patients with complex health needs. The GPs told us that patients and their families were involved in agreeing these.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were generally positive about the emotional support provided by the practice especially by nurses and rated it well in this area. For example:

- 79% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 85%. However, patients we spoke with and comment cards we collected all indicated a very positive view.
- 91% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 85%.

The patients we spoke with on the day of our inspection and the comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required.

Information in the patient waiting room told patients how to access a number of support groups and organisations. The practice also maintained a carers' register and we were told that practice's computer system alerted GPs if a patient was a carer. The practice manager told us that carers were offered annual flu vaccinations and support to ensure that they remained healthy and continued providing care. If appropriate, carers were also referred to the local Carers Centre with whom the practice had forged links with. We saw that there was a carers' page on the practice website with a links which signposted carers to further information about support available to them including a specific link for young carers.

The practice had a lead GP for end of life care and worked in partnership with Macmillan nurses. The practice told us how they supported families following a bereavement and also kept a list of patients who had died so that all staff were aware. We saw that information leaflets were available in the waiting area regarding local bereavement services. The practice provided families with a pack of helpful information which they could collect from the practice or be sent by post. Depending on the circumstances of death the GP would schedule a home visit one or two weeks later to offer support to the family.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice told us how it delivered services to meet the needs of its patient population. For example, for long term conditions such as asthma and diabetes a named GP lead was allocated for each disease area and practice nurses had acquired specialist qualifications.

There were nurse led services for vaccinations, cervical screening as well as disease management services which aimed to review patients with common illness and aliments. Patients over the age of 75 years had an accountable GP to ensure their care was co-ordinated.

The practice told us that they had an interest in falls prevention and had previously held an event on falls prevention for patients over 75's and those patients taking medication that increased the likelihood of falls. The practice was now also collaborating with Warwick University on a falls research project for older people. A questionnaire had been sent out to 959 patients in 2014 with 434 patients responding. 51 of these had been offered a one hour face-to-face assessment by nurses at the practice who had undergone further training. These had been completed in March 2015. Patients had then been referred to either community physiotherapy, occupational health or to the GP as appropriate. The project had allowed patients to become more educated about falls prevention and offer early interventions where required. A review of the collaboration project around the impact achieved had been scheduled for March 2016.

We were also told about a new weight management group that had been set-up at the practice in collaboration with the clinical commissioning group (CCG) to support relevant patients. We were informed that previous targeted work had focused on smoking cessation support services.

Tackling inequity and promoting equality

There were arrangements in place to ensure that care and treatment was provided to patients with regard to their disability. For example, saw that there was level access to the practice with entrance doors that were automatic which aided those with mobility issues and wide enough for patients in wheelchairs to gain access. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Although the practice was two storeys, patient facilities were restricted to the ground floor.

Accessible toilet facilities were available as well as two disabled parking spaces and two parent and child parking spaces. There was a hearing loop available to help patients with hearing aids and a screen which provided visual prompts for patients to be aware that they were being called for their appointment. Staff told us that longer appointments would be made for patients with hearing impairments. We saw that there was a dropped counter for patients in wheelchairs so they were able to access the reception counter. There were also facilities for baby changing and breastfeeding. The practice had increased the number of online appointments offered as well as offering "worker" appointments slots (for those patients who worked and therefore by booking an advance slot, could better plan when it would be most convenient to make to come to the practice). Telephone consultations also enabled patients who had work commitments to have better access to the practice.

As well as two male GP partners, the practice also had three female GP partners at the practice and were able to support patients who preferred to have a female doctor. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

The practice had recognised the needs of different groups in the planning of its services such as carers and vulnerable patients who were at risk of harm. The computer system used by the practice alerted GPs if patients had a learning disability, or if a patient was also a carer so that additional appointment time could be made available. Where patients were also identified as carers we saw that information was provided to ensure they understood the support that was available when needed.

We saw that staff at the practice had had attended equality and diversity training. Staff we spoke with were able to provide examples of how they would ensure that the equality and diversity principles were applied. We were also told that the practice had been awarded the Lesbian & Gay Foundation GOLD Pride in Practice award for delivering fully inclusive healthcare services to their patients. The practice told us it was one of the first practices to be granted such an award and had been required to meet strict criteria to be awarded the highest "Gold" level award.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We were told that this had been initiated by practice manager who had made contact with the "Pride in Practice Foundation" to discover how being fully inclusive could be achieved. As a result of this, a number of changes at the practice had taken place. For example, strong links had been made with relevant support services to increase access, the new patient questionnaire at the practice had been modified to capture data on sexuality and it was ensured that this was information was coded onto the clinical system. This meant that the as doctors were aware when they saw the patient and links had been made with relevant services, signposting to targeted services was made where appropriate. We were provided with examples of how young patients in particular had been positively supported by the changes implemented at the practice.

Staff told us that translation services were available for patients who did not have English as a first language. This service could be arranged to take place either by telephone or in person. The practice website could also be translated into 90 different languages to ensure that patients had access to all information about the practice. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

Access to the service

The surgery was open from 8am to 6.30pm Monday to Friday although we saw that this was listed incorrectly on the practice website as 8am to 6pm Monday to Friday. Appointments were available on the day for patients that needed to be seen urgently. Patients were also able to book routine appointments two weeks in advance and would be able to see their preferred GP if willing to wait.

Information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for older patients, those with hearing or visual impairments, patients with learning disabilities and those with long-term conditions. Weekly visits were made to a local care home on a specific day each week, by a named GP and to those patients who needed one.

The patient survey information we reviewed showed patients gave a mixed response to questions about access to appointments and generally rated the practice lower in these areas. For example:

- 61% were satisfied with the practice's opening hours compared to the CCG average of 71% and national average of 75%.
- 70% described their experience of making an appointment as good compared to the CCG average of 68% and national average of 73%.
- 57% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 61% and national average of 65%.
- 67% said they could get through easily to the surgery by phone compared to the CCG average of 66% and national average of 73%.

We saw that priority had been given to telephone systems, appointments and the practice website during the last practice satisfaction survey in 2014. The main issue identified related to the telephone system and appointment access. An action plan had been developed which stated that the practice was to have further discussions regarding managing the telephone system, the limited resources of the practice and take advice from the Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We saw from the PPG notes that phone statistics from the telephone system and appointment booking for 2014 had been analysed and discussed and changes had taken place to improve patient experience.

We spoke with 11 patients on the day of the inspection, one of whom was also a member of the PPG. Two patients told us it could be difficult to get an appointment but confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. Other patients we spoke with were satisfied with the appointments system and said it was easy to use. Comments received from patients showed that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Home visits were available for patients who were too ill to attend the practice for appointments. There was also an online service which allowed patients to order repeat prescriptions, book and cancel appointments. Some of the feedback comments we received from patients told us that they found the online booking system and telephone consultations for patients helpful.

Listening and learning from concerns and complaints

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

We found that there was an open and transparent approach towards complaints. Accessible information was provided to help patients understand the complaints system on the practice's website and in a complaints leaflet available at the practice. Complaints information was also displayed in the waiting area display screen as well as being found within the practice leaflet. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

Staff told us that they were aware of the action they should take if a patient complained. Staff confirmed that complaints were discussed at practice meetings and they were made aware of any outcomes and action plans in place to address changes needed. We saw minutes that confirmed these discussions had taken place and that complaints were discussed in a way that ensured all staff were able to learn and contribute to determining any improvement action that might be required. For example we were told about how a particular complaint had been turned into a scenario with learning points attached.

We saw that the practice had recorded all complaints, including verbal and written complaints. We looked at the complaints for the period April 2014 to end of March 2015. The practice had received 10 complaints during this period and responses to and outcomes of complaints had been clearly recorded. Records were available showing that monitoring was undertaken to ensure that these issues had been appropriately addressed and were unlikely to re-occur.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

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

We found details of the vision and practice values were part of the practice's strategy. We saw evidence the strategy was regularly reviewed by the practice. The practice vision and values included providing high quality primary care services, ensuring patients were the first priority and treating patients with dignity and respect. The practice sent us a copy of their statement of purpose prior to the inspection of the service. Some of the practice aims in this document were to: provide a high standard of medical care; to involve patients in decisions regarding their treatment; encourage patient involvement and ensure all members of the team have the right skills and training to carry out their duties competently.

Members of staff we spoke with all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them. We looked at minutes of the most recent practice away day and saw that staff had discussed and agreed that the vision and values were still current.

Staff shared more details of their aims for the practice during the inspection. This included a desire to provide safe, high quality and accessible services for all of their patients and those with an immediate medical need as well as reducing health inequalities. They discussed how the practice planned to deliver care with the future challenges that face them such as access to the service and resources. They had started to explore the staffing skill mix and explore new ways of working such as using system enhancements to improve access. The practice had been proactive in encouraging staff to undertake training, for example we were told that the nurses were undergoing further training to develop their careers, to further meet the needs of the practice population and provide additional support to the GP.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and paper copies of these were available to staff from the practice manager's office. We were told that these would soon be available on the practice computer system. We looked at some of these policies and procedures and found that they had been reviewed and were up to date. We were shown evidence to demonstrate that information had been sent to staff regarding information governance. Staff had signed to confirm that they had received and read a copy of the practice's confidentiality and data protection policy.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance and had identified where there were areas for improvement and action plans developed.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control, the practice manager was the lead for equality of access and one of the GP partners was the lead for safeguarding.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff, for example the induction policy and the bullying and harassment policy. Staff we spoke with knew where to find these policies if required.

We saw that regular practice meetings were held that enabled decisions to be made about issues affecting the general business of the practice. All staff were encouraged to attend these meetings. Records were made of the meetings and any actions required were clearly set out and reviewed to ensure changes were made.

Leadership, openness and transparency

At the start of the inspection the practice gave us a presentation on the services they provided. We observed the leadership roles in action and the team approach to the presentation. The practice supported the inspection in a friendly, open, supportive and welcoming way.

GPs confirmed there were positive relationships between the partners and the management to deliver patient centred quality care. There was a clear, visible leadership and management structure in place with responsibility for different areas shared amongst GP partners. For example, all the partners had various lead responsibilities such as safeguarding, mental health, Chronic Obstructive Pulmonary Disease (COPD) and diabetes. Clinical staff also had lead roles such as the lead nurse for infection control. Members of staff we spoke with were all clear about their own roles and responsibilities. Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Are services well-led?

Good

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

Staff we spoke with told us that the practice was well led and that decisions were not made in isolation but discussed so that perspectives of all staff were taken into account regarding any changes. All members of the management team were visible and accessible. The practice manager told us that they sent a 'Weekly News' email to all practice staff to update and share relevant information.

A poster titled "Open Care Statistics" had been produced by the practice for patients since 2013. We viewed the poster in its most recent format for March 2015 and saw that it was presented in an easy to read format and user-friendly way with pictures and statistics. The information it gave patients included things such as: the amount of patients who had failed to arrive for an appointment together with the cost; the number of patients attending A & E; number of complaints received by the practice and the number of safety audits the practice had completed. We were told that the practice manager had initiated the development of the poster following a complaint the practice received about not being able to get same-day repeat prescriptions. The practice told us that feedback from patients was consistently positive, with patients being surprised with the statistics. The practice told us that it had helped to foster a more open relationship with patients and that patients now had a better understanding and were appreciative of why things needed to be prioritised and how patients had an impact on the practice.

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG with 13 members although it was recognised that current membership did not represent the age range or ethnicity of the practice population A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

The PPG had carried out a face to face survey of patients in February 2014. The practice manager showed us the analysis of the last patient survey. We saw that this was discussed at the following PPG meeting. The results of the survey and minutes of PPG meetings were available on the practice website. An action plan had been generated to address issues raised. We spoke with a member of the PPG and they were very positive about the role the PPG played and told us they felt engaged with the practice. The PPG had also supported the practice with events such as patient education and annual flu clinics.

The practice had implemented other suggestions for improvements and made changes to the way it delivered services in response to feedback from the PPG. For example refurbishment of the waiting area which included the installation of an automatic door, increased appointments and setting up patient education events.

We saw evidence that the practice had reviewed its' results from the national GP survey and highlighted areas that needed addressing. The PPG had helped the practice to analyse these results and established an action plan to improve the patient perspective of the practice. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice. Actions to improvement patient experiences included the recruitment of an additional GP and releasing more online appointments to increase access and analysis of telephone access statistics to try and improve call handling and patient waiting times.

The practice had also gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Staff also told us they could make suggestions for improvements and that they were treated as equals by senior staff. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

Management lead through learning and improvement

We looked at a random sample of staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training, that regular protected time was provided for learning and that they had staff away days. Clinical staff said that they were supported to maintain their clinical professional development through training.

Are services well-led?

Good

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

The practice had responded to feedback on service delivery from the PPG as well as other patients through surveys and complaints. We saw that changes had been made to improve service as a result of feedback, for example a change was made to the practice's appointment system at the request of patients.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example, we were told of one incident which had been used as a learning scenario for staff at an away day.