

Church Lane - Khan

Quality Report

113 Church Lane
Stechford
Birmingham
B33 9EJ
Tel: 0121 783 2861
Website: not applicable

Date of inspection visit: 4 February 2015
Date of publication: 30/04/2015

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	3
The six population groups and what we found	5
What people who use the service say	7
Areas for improvement	7

Detailed findings from this inspection

Our inspection team	8
Background to Church Lane - Khan	8
Why we carried out this inspection	8
How we carried out this inspection	8
Detailed findings	10

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection at Dr Khan, Church Lane practice on 4 February 2015.

We have rated each section of our findings for each key area. We found that the practice provided a safe, effective, caring, responsive and well led service for the population it served. The overall rating was good and this was because practice staff were caring and motivated.

Our key findings were as follows:

- We found evidence that practice staff worked together to make on-going improvements for the benefit of patients.
- We found that patients were treated with respect and their privacy was maintained. Patients informed us they were satisfied with the standards of care they received.

- The practice was visibly clean and tidy. Annual in depth audits were carried out and resultant actions taken to protect patients from unnecessary infections when they visited the practice.
- The practice was able to demonstrate a good track record for safety. Effective systems were in place for reporting safety incidents. Untoward incidents were investigated and where possible improvements made to prevent similar occurrences.

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

In addition the provider should:

- Record that verbal consent has been given prior to intimate examinations of patients and fully record the annual health checks carried out for patients with a learning disability.

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?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learnt and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. Recruitment practices were robust and there were enough staff employed to provide a safe service. There was a designated lead to oversee the hygiene standards within the practice to prevent infections.

Good



Are services effective?

The practice is rated as good for providing effective services. Clinicians were up-to-date with both the National Institute for Care and Health Excellence (NICE) guidelines and other locally agreed guidelines. Practice staff were using innovative and proactive methods to improve patient outcomes and it linked with other professionals to ensure patients received effective care that was tailored to their needs. Practice staff carried out clinical audits and as a result made changes where necessary to promote effective care for patients. Systems were in place for regular reviews of patients who had long term conditions and housebound patients.

Good



Are services caring?

The practice is rated as good for providing caring services. We saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. Patients said they were treated with compassion, dignity and respect and we observed examples of this. Consideration was given to ensure patient confidentiality was maintained. Accessible information was provided to help patients understand the care available to them. Patients told us they were satisfied with the care they received and that their individual health needs had been addressed.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. Patients were given opportunities to comment on the way care and treatment was delivered by GPs. Practice staff demonstrated how they listened to and responded to their patient group. Patients with mobility difficulties were able to access the practice. There was a system in place which supported patients to raise concerns and complaints. Complaints received were recorded, investigated and responded to appropriately.

Good



Summary of findings

Are services well-led?

The practice is rated as good for being well-led. The arrangements and processes ensured risks to patients were identified and mitigated before they became issues which adversely impacted on quality of care. Analysis of incidents and resultant actions taken by practice staff further reduced the likelihood of similar occurrences. There were clear structures and lines of accountability in place to support and manage the staff team. There was an initiative in place to ensure appropriate standards of care were provided to patients who had long term conditions.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people. Patients over the age of 75 years old had a named GP to help co-ordinate their care. Older patients were offered annual health checks at the practice. There were arrangements to review patients in their own home if they were unable to attend the practice. Care plans were in place to monitor and review their health needs. Those with complex care and at high risk of admission had been identified so that they could be appropriately supported to live at home and avoid admission to hospital. Practice staff worked with the palliative care team through quarterly meetings to provide support to patients receiving end of life care.

Good



People with long term conditions

The practice is rated as good for the population group of people with long term conditions. Practice staff supported patients to receive co-ordinated, multidisciplinary care whilst retaining an oversight of their care. Patients with long term conditions were regularly reviewed and any changes in their care needs were cascaded to other involved professionals to ensure joined up care at all times. Staff kept a register of patients with long term conditions and those who had carers so that they could be offered support. The practice had a higher than average number of patients who had diabetes.

Good



Families, children and young people

The practice is rated as good for the population group of people with long term conditions. Practice staff supported patients to receive co-ordinated, multidisciplinary care whilst retaining an oversight of their care. Patients with long term conditions were regularly reviewed and any changes in their care needs were cascaded to other involved professionals to ensure joined up care at all times. Staff kept a register of patients with long term conditions and those who had carers so that they could be offered support. The practice had a higher than average number of patients who had diabetes.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the population group of the working-age people (including those recently retired and students). There were extended evening hours each Monday until 8pm. The practice was proactive in offering on-line services for making

Good



Summary of findings

appointments and ordering repeat prescriptions. Patients were offered a 'choose and book' service when they were referred to hospital outpatient services. This system gave them greater flexibility about when and where they were referred to.

People whose circumstances may make them vulnerable

The practice is rated as requires improvement for the population group of people whose circumstances may make them vulnerable. Practice staff discussed patients in vulnerable circumstances at joint meetings with relevant health and social care professionals to ensure they received appropriate care and support. The practice held a register of carers who cared for vulnerable patients to provide them with support.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Care was tailored to patients' individual needs and circumstances, including their physical health needs. Annual health checks were offered to patients with serious mental health illnesses. GPs had the necessary skills and information to assess and treat or refer patients with poor mental health.

Good



Summary of findings

What people who use the service say

We spoke with 10 patients during our inspection. Some had been registered with the practice for many years. They informed us that staff were polite, helpful and knowledgeable about their needs. Patients told us they were given enough explanations to enable them to understand about their health status and felt they were encouraged to make decisions about their care and treatment. They all gave us positive feedback about the standards of care they received.

Patients told us it was easy to obtain repeat prescriptions. They told us they were able to book an appointment on the same day but may need to ring again at lunch time to obtain an afternoon appointment. Patients told us they could make appointments in advance. All patients told us they were not kept waiting for their appointment before they were seen.

We collected two patient comment cards on the day of the inspection. Positive comments were made by both patients regarding the care they received and the helpfulness of staff.

The practice did not have a Patient Participation Group (PPG). They are an effective way for patients and practice staff to work together to improve services and promote quality care. The practice website requested patients to join a PPG.

Practice staff did not carry out annual patient surveys to gain an insight into patient's opinions and an opportunity to make improvements. The practice manager assured us they would introduce a system. Shortly after the inspection the practice manager informed us electronically they had developed a tool to commence a patient survey.

The National Patient Survey results from 2013 informed us that the results were average or below average. They were; 63.3% of respondents would recommend the practice, 70.24% for the last time patients wanted to speak with or see a GP or nurse and get an appointment. Also, 69.0% were satisfied with the opening times, 70.24% felt it was easy to get through by telephone, 65.9% had good or very good experience for making an appointment and 81.41% reported their overall experience was good or very good. Those of 70% or more were average and less than 70% were below the national average.

Areas for improvement

Action the service **SHOULD** take to improve

Record that verbal consent has been given prior to intimate examinations of patients and fully record the annual health checks carried out for patients with a learning disability.

Church Lane - Khan

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 specialist advisor who had experience in clinical practice.

Background to Church Lane - Khan

Church Lane - Khan served approximately 2900 patients within a three mile radius of the practice.

At the time of our inspection there was one full time and one part time GP partners who provided 13 sessions per week. There was a practice nurse who worked six hours per week who was on a temporary contract. Efforts to recruit a permanent practice nurse had been in place for some time. Practice staff had recently employed an experienced health care assistant who worked 20 hours per week. The practice manager leads a team of three receptionists and two administrators.

The practice offers a range of services including chronic disease management, diabetes, cervical smears, non-invasive contraception, minor surgery, injections and vaccinations. The practice also enables patients to access smoking cessation clinics.

The practice had opted out of providing out-of-hours services to their own patients. This service is provided by an external out of hours' service. Information of how to access the out-of-hours services was available in the patient leaflet, in the waiting area and via the telephone when the practice was closed.

Why we carried out this inspection

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

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired)

Detailed findings

- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced on 4 February 2015. During our visit we spoke with a range of

staff including two GPs, the practice nurse, practice manager and two receptionists. We also spoke with 10 patients who used the service and observed how patients were being cared for and staff interactions with them. We received two comment cards from patients. We looked at personal care and treatment records in relation to the care and treatment that patients received.

Are services safe?

Our findings

Safe Track Record

Practice staff demonstrated they had a good track record for safety. We saw records to show that performance had been consistent over time and where concerns had arisen they had been addressed in a timely way. There were effective arrangements in place that were in line with national and statutory guidance for reporting safety incidents. The practice manager took all safety incidents into account when assessing the overall safety record.

There were clear accountabilities for reporting safety concerns and significant events. Staff were able to describe their role in the reporting process and they told us they were encouraged to report incidents to senior staff. We saw how incidents were recorded and that systems were in place to ensure they were properly investigated and where relevant actions were taken to prevent recurrences.

Patients we spoke with during the inspection told us they felt comfortable and relaxed in the presence of practice staff.

Learning and improvement from safety incidents

There were processes in place for reporting, recording and monitoring significant events. Recordings of events were made as soon as they had occurred. The practice manager oversaw that they were dealt with effectively and relevant staff were informed of outcomes and any actions they needed to take.

We saw evidence that learning from incidents had been shared in a timely way. For example, a GP noted that a patient was still receiving a specific medicine. The patient was asked to attend for a medicine review and the medicine was discontinued. Practice staff also notified the local Clinical Commissioning Group (CCG) of individual events. The CCG is the NHS body responsible for commissioning local NHS services.

Reliable safety systems and processes including safeguarding

There were effective policies and procedures in place to ensure that patients were safeguarded against the risk of abuse and staff knew where to access them. Staff we spoke with demonstrated an understanding of the policies and procedures. There was a named GP lead for safeguarding

and we saw that all staff had received training appropriate to their role. Information about the local authority's safeguarding process was also available for staff to refer to. There were communications and co-operation with local health visitors which helped to identify children at risk and to keep them safe.

Patients of concern were discussed during regular meetings with external professionals and decisions made whether to refer the patient to the safeguarding authority.

There was a written chaperone policy within the practice. A poster on display in the waiting area informed patients of their right to request a chaperone to be present when clinical staff examined them or carried out a procedure. Where possible the practice nurse or health care assistant carried out this role but if not available non-clinical staff did. We asked the practice manager if staff had received training to chaperone patients. They informed us that staff had not been trained but they were in the process of sourcing a training course for staff to attend. Two patients who we spoke with told us they were aware of their right to request a chaperone during their consultations.

Medicines Management

We checked medicines stored in the consulting rooms and medicine refrigerators and found they were stored securely and were only accessible by authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. Staff were recording the refrigerator temperatures every day to ensure medicines remained at a safe temperature for administration.

Arrangements were in place to check medicines were within their expiry date and safe for use. Staff also used a rotation process so the most recently received medicines were used last. All the medicines we checked were within their expiry dates. The practice manager had purchased a thermometer to ensure the room temperature where medicines were stored remained below 25 degrees centigrade to ensure medicines remained safe for administration.

Vaccines were stored in a fridge in line with legal requirements and national guidance. We saw recordings that confirmed daily fridge temperatures were recorded to ensure the vaccines were stored at suitable temperatures and remained safe for administration.

Are services safe?

There was a protocol for repeat prescribing which was in line with national guidance and was followed by practice staff. Patients who had repeat prescriptions received regular reviews to check they were still appropriate and necessary.

Cleanliness & Infection Control

On the day of the inspection the practice was visibly clean and tidy and patients we spoke with told us it they were satisfied with hygiene within the practice. There were arrangements in place to reduce the risk and spread of infection. Staff told us that personal protective equipment (PPE) was in date and readily available. Patients confirmed that clinical staff wore PPE before they commenced procedures. There were hand washing instruction posters above each wash hand basin throughout the practice.

There was a cleaning schedule in place for cleaning staff to follow to ensure all areas of the practice were cleaned regularly. Cleaning materials were appropriately stored and there were hazard data sheets that provided staff guidance on how to use them safely. There was an infection control policy and staff understood the importance of ensuring the policy was followed. Staff had attended infection control training.

Annual infection control audits of the practice were carried out. They included all areas of the practice. The tool used to record the results included details of any actions that needed to be taken. We saw that actions had been addressed within a reasonable timeframe.

Clinical staff only used disposable instruments during minor surgical procedures. These and other clinical wastes were disposed of safely.

At the time of the inspection efforts were being made to employ a practice nurse who would be asked to take the lead role for infection control and prevention. In the meantime the practice manager told us they were carrying out this role.

The practice manager told us they were in the process of carrying out a legionella risk assessment of the water supply to the practice. Legionella is a germ found in the environment which can contaminate water systems in buildings.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment had been tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and appropriate recordings maintained.

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS). The DBS check is a criminal records check that helps identify people who are unsuitable to work with children and vulnerable adults.

Staffing levels were based on numbers and experience of each staff member and how the practice operated over the years. Consideration had also been given to the need for patient access to the practice. Staffing was monitored and reviewed as required. The practice manager told us they had been advertising for a practice nurse since August 2014.

We were told that reception and administration staff covered for each other by working extra shifts to ensure continuity during periods of annual leave. The GPs took on practice nurse duties when the practice nurse and health care assistant were not available. When the part time GP was absent the full time GP provided extra clinical sessions. When the full time GP was on annual leave locum GPs provided cover.

Monitoring Safety & Responding to Risk

We saw that the staff at the practice had received training in medical emergencies such as cardiopulmonary resuscitation (CPR). The practice had a defibrillator and oxygen on standby for dealing with medical emergencies. These were checked regularly to ensure they were fit for purpose.

There was a health and safety policy in place and staff knew where to access it.

Arrangements to deal with emergencies and major incidents

Are services safe?

We saw the business continuity plan. The document detailed the actions that should be taken in the event of a major failure and contact details of emergency service who could provide assistance. Copies of the document were held off site by the practice manager and the GPs. The document covered eventualities such as loss of computer and essential utilities. The plan was clear in providing staff guidance about how they should respond. It included the contact details of services that may be able to help at short notice.

A fire risk assessment had been undertaken that included actions required for maintaining fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

The patient leaflet and a recorded message on the telephone gave information about how to access urgent medical treatment when the practice was closed.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We discussed effective patient management with a GP. They explained how they ensured best practice by following published national and local guidelines. For example, National Institute for Care and Health Excellence (NICE). We saw that any revised NICE guidelines were identified and shared with all clinicians appropriately.

The clinicians we spoke with confidently described the processes to ensure that informed consent was obtained from patients whenever necessary. They were also aware of the requirements of the Mental Capacity Act (MCA) 2005 used for adults who lacked ability to make informed decisions.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with clinical staff showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Clinical staff actively participated in recognised clinical quality and effectiveness schemes such as the national Quality Outcomes Framework (QOF) and the local Clinical Commissioning Group (CCG) enhanced service schemes. QOF is a national performance measurement tool. We were shown the latest QOF achievements that told us practice staff were meeting all of the national standards. The CCG is the NHS body responsible for commissioning local NHS services.

There was a system in place for completing clinical audit cycles to provide assurances regarding quality of care and to improve outcomes for patients. We saw that timescales were identified for repeating audits to monitor if improvements made had been sustained. Staff told us the outcomes of audits were cascaded to relevant members of staff. Patients who had tablet controlled diabetes had been audited to check that they were receiving the correct medicine and dosage for their health condition. Where necessary changes had been made and a GP told us they intended to review the results of the audit at a later date. GPs carry out benchmarking by comparing their

prescribing practices against national data and local data. They also followed recommendations laid down by the local CCG for prescribing. For example antibiotics prescribed for treating infections.

Clinical staff told us they undertook lead roles to promote best practice within the team and to oversee the quality of care in order to drive improvements. For example, one GP was the lead for safeguarding and another for annual reviews of patients who had learning disabilities.

Clinicians were participating in the local CCG initiative where GPs in the area shared knowledge, information and the latest developments with each other. The aim of the scheme is to ensure that high quality care is delivered to patients and reducing the level of variation between practices. This had led to improvements at the practice in the prescribing of medicines for patients with type one (insulin dependent) diabetes and effective care and treatments for patients who had chronic obstructive pulmonary disease (COPD). COPD is the collective name for a range of lung diseases including chronic bronchitis, emphysema and asthma.

Patients were invited to contact the practice to receive their test results. However, if a test result was abnormal, patients would be contacted and asked to make an appointment to discuss the results with a GP.

Effective staffing

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

There were clear policies and procedures in place in regard to staff induction, training and appraisals that were commensurate with staff roles. This ensured staff received appropriate training and support to equip them to carry out their roles effectively.

Staff we spoke with told us they worked well together as a team and felt well supported. They were given opportunities and encouragement to develop their knowledge and skills to enhance their roles. The records we

Are services effective?

(for example, treatment is effective)

saw confirmed that staff had received the necessary support to for their required practices. The practice manager and GPs held meetings every morning to discuss operational matters that may need dealing with.

All staff had annual appraisals which identified learning needs from which action plans were documented. We saw that nurses' and health care assistant's appraisals were carried out by clinical staff so that their practices could be discussed and appropriately checked.

Working with colleagues and other services

Staff worked well with other professionals including community nurses and health visitors. Arrangements were in place for the shared care of patients. Shared care is where the prescribing responsibility for treatments which were initiated by hospital staff are transferred to the GP. The hospital consultant retains clinical responsibility for the patient and the GP acts on their advice. Shared care arrangements may be helpful to support the discharge of patients back into the community and help provide continuity of care. Attendance at multidisciplinary meetings assisted in patients receiving co-ordinated care.

Community nurses supported patients who were receiving end of life (palliative) care using the Gold Standards Framework (GSF). GSF is a national criteria for standards of care in respect of palliative care. Regular meetings were held with the community matron and community nurses present. We were told the matron of the local Marie Curie unit sometimes attended the meetings and they liaised well with clinical staff at the practice. This promoted a partnership for ensuring patients received appropriate and joined up care.

Practice staff worked with other service providers to meet people's needs and manage complex cases. Test results, X-ray results, letters from the local hospital including discharge summaries, out of hour's providers and the emergency service were received at the practice. The GP was responsible for taking any required action after reviewing these documents and any results.

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patient care. Staff were fully trained on the system, and commented positively about the system's security for

confidentiality and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The system included a facility to flag up patients who required closer monitoring such as children at risk.

For patients who had attended an out of hours service or following discharge from hospital we were told that the information provided to them was reviewed on a daily basis. A GP told us that if patient's required follow up they would send a request to the patient for them to make an appointment. If necessary a referral would be made to a hospital or physiotherapist.

Consent to care and treatment

The patients we spoke with told us they had been involved with decisions about their care and treatments. They told us they had been provided with sufficient information to make choices and were able to ask questions when they were unsure.

Patients who had minor surgery had the procedure explained to them and the potential complications and they were asked to sign a consent form to confirm this. One GP was not recording that they had received verbal consent from patients before they carried out intimate examinations. The GP was not following the guidance issued by the General Medical Council (GMC).

Clinicians were aware of the requirements within the Mental Capacity Act 2005. This was used for adults who lacked ability to make informed decisions. Staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity.

GPs knew how to assess the competency of children and young people about their capability to make decisions about their own treatments. They understood the key parts of legislation of the Children's and Families Act 2014 and were able to describe how they implemented it in their practice. GP's demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 years of age who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention

Are services effective?

(for example, treatment is effective)

We saw that all new patients were offered a health check. New patients who had received prescribed medicines from previous clinicians were given an appointment with a GP to review the medicine dosage and if it was still appropriate.

Patients who were due for health reviews were sent a reminder to make an appointment. Patients were asked about their social factors, such as occupation and lifestyles. These ensured doctors were aware of the wider context of their health needs.

Annual health checks were offered to all patients who were aged 65 years or more.

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. We saw

some health and welfare information displayed in the waiting area. For example, breast screening, shingles vaccinations for patients aged 70 years and safe alcohol consumption. Letters were sent to patients to encourage them to undergo breast screening; these were also available in pictorial format to assist patients with learning disabilities to understand the meaning of them. Contact details were on display for healthy lifestyle and weight loss advice.

A range of tests were offered by practice staff including spirometry (breathing test) blood pressure monitoring and cervical smears to regularly monitor their health status.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We observed that reception staff greeted patients in a polite and courteous manner. When appointments were made by telephone we overheard receptionists offering patients choices. Reception staff respected when patients told them they were unable to attend on some days.

A receptionist told us they could ask a patient to speak with them privately in an unoccupied room to protect their confidentiality. Patients told us they had no concerns about staff ensuring their confidentiality.

We observed patients being treated with dignity and respect throughout the time we spent at the practice. We saw that clinical staff displayed a positive and friendly attitude towards patients. Patients we spoke with told us they had developed positive relationships with clinical staff who were familiar with their health needs.

Patients confirmed they knew their rights about requesting a chaperone. They told us this service was offered to them by clinical staff. Some people had used the chaperone service and reported to us they felt quite comfortable during the procedure. Intimate female examinations and cervical smears were carried out by the female GP to promote patient comfort during these procedures.

We saw that all clinical rooms had window blinds and privacy screening. Clinical staff told us the consulting room door was kept closed when patients were being seen. We observed staff knocking on doors and waiting to be called into the room before entering.

Care planning and involvement in decisions about care and treatment

Clinical staff supported patients to understand their care and treatment options including the risks and benefits to enable them to make informed decisions. Patients were given the time they needed and were encouraged to ask

questions until they understood about their health status and the range of treatments available to them. The patients we spoke with told us they were able to make informed decisions about their care and felt in control.

Patients we spoke with confirmed they had been given advice and choices about where they could be referred to assist them in making decisions for secondary assessment and care.

The Mental Capacity Act 2005 governs decision making on behalf of adults and applies when patients did not have mental capacity to make informed decisions. Where necessary patients had been assessed to determine their ability prior to best interest decisions being made. Staff we spoke with had an awareness of the Mental Capacity Act and had received training.

The practice nurse we spoke with told us they explained treatments and tests to patients before carrying out any procedure. They told us that patients were kept informed of what was going to happen at each step so that they knew what to expect.

Patient/carer support to cope emotionally with care and treatment

There was a dedicated section of notice board in the waiting area that provided information for carers. It included details of service that could be requested. For example, chiropody, eye sight checks and a carers emergency response service.

We saw a number of leaflets in the waiting areas for patients to pick up and take away with them. They informed patients of various support groups and their contact details.

Following bereavement the respective GP would contact the family by phone to offer them an appointment and information about the various bereavement counselling services available to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the local population and took appropriate steps to tailor the service to meet their needs. We were told about the measures the provider had taken to target patients with diabetes and chronic obstructive pulmonary disease (COPD). A GP had attended specialist training in these disorders.

We found that patients with a learning disability, mental health conditions and those considered to be at risk were offered an annual health review. Extra time was allowed for these sessions and GPs told us were willing to carry the health checks outside of the normal clinical sessions to assist them in attending. One GP was not always fully recording the annual health checks of patients who had a learning disability. Free health checks were available to patients between the ages of 40 and 74. Patients aged 85 and over were also offered annual health checks.

There was no active Patient Participation Group (PPG) but the practice was making efforts to develop one. PPGs are an effective way for patients and surgeries to work together to improve services and promote quality care.

We observed that senior staff were very accessible to patients and staff and were focussed on improving the service in any way they could.

Patients who were aged 75 years or over had been informed of who their accountable GP was so they could receive care from a GP who understood their needs.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services and had made arrangements for meeting their needs.

Staff told us that translation services were available for patients who did not speak English as a first language. This service could be arranged to take place either by telephone or face to face.

The premises were accessible by patients who had restricted mobility. There was a toilet for people who were disabled. The corridors and doorways to consulting rooms were wide enough to accommodate wheelchairs. All consulting rooms were located on the ground floor.

The practice had equality and diversity policy and staff were aware of it. Patients we spoke with did not express any concerns about their rights about how they were treated by staff.

Access to the service

We received positive feedback from patients on the availability of appointments. They were available from 9am until 11am Monday to Friday, 4:30pm until 6pm Tuesday, Wednesday and Friday and 4:30pm until 8pm Mondays. A GP told us that any emergency appointments not accommodated during the clinical sessions were seen at the end of these sessions. Patients were able to book appointments and order repeat prescriptions electronically. The practice had a high did not attend (DNA) rate. Patients would be phoned to raise their awareness and if it occurred three times patients were sent letters. DNAs result in less appointments being available for other patients.

Comprehensive information was available to patients about appointments in the patient leaflet. This included how to arrange urgent appointments, home visits and how to request urgent attention when the practice was closed.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handled all complaints in the practice. The practice leaflet informed patients about how to make a complaint if they needed to and reception staff told us they would arrange for patients to speak with the practice manager.

Practice staff offered patients who had concerns an advocacy service who would support patients during this process. We were shown a summary of the complaints received during the last 12 months. Two complaints had been received during the previous 12 months. We saw they had been investigated, responded to and there were instances where changes had been made to prevent recurrences. For example, a verbal complaint about the way a member staff had spoken with them. The complainant was invited to discuss their complaint with the practice manager who explained the circumstances

Are services responsive to people's needs? (for example, to feedback?)

and apologised. Staff told us that the outcome and any lessons learnt following a complaint were disseminated to relevant staff and discussed during meetings. We saw that complaints were discussed during clinical meetings.

Are services well-led?

Good 

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

Our findings

Vision and Strategy

The practice manager told us they did not have a business plan but did have a vision to provide high standards of patient care. We spoke with six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at recordings from meetings held by practice staff that demonstrated the vision and values were still current.

Governance Arrangements

The practice had a clear governance structure designed to provide assurance to patients and the local clinical Commissioning Group (CCG) that the service was operating safely and effectively. There were specific identified lead roles for areas such as safeguarding, cervical screening and checking vaccinations and emergency medicines and equipment. Responsibilities were shared among GPs, the health care assistant and the practice manager.

Leadership, openness and transparency

Staff we spoke with told us they were all clear about their own roles and responsibilities. They all told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw that practice staff held a range of regular meetings. They included clinical meetings, multidisciplinary meetings for long term conditions and daily non-clinical meetings. The practice manager also held regular meetings with all staff. The minutes told us that all aspects of the running of the practice were discussed as well as ways of taking corrective actions to meet patient's needs.

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

The practice did not have an active Patient Participation Group (PPG). PPGs act as a representative for patients and work with practice staff in an effective way to improve services and to promote quality care. The practice manager told us they were working towards developing a PPG.

The practice was participating in the 'Friends and Family' survey where patients were asked to record if they would

recommend the practice to others. The survey commenced 1 December 2014 and to date there were three completed forms. Two patients stated they were extremely likely to recommend the practice and one extremely unlikely.

The practice had a whistle blowing policy which was available to all staff to enable them to raise concerns. Staff we spoke with were aware of their rights and where to access it.

Management lead through learning & improvement

Aspiring to Clinical Excellence (ACE) is a programme offered to all Birmingham Cross City Clinical Commissioning Group (CCG) practices. The ACE programme is based on the strategic objectives of the CCG and the NHS Outcomes Framework indicators. ACE is a programme of improvement aimed at reducing the level of variation in general practice by bringing all CCG member practices up to the same standards and delivering improved health outcomes for patients. There are two levels, ACE Foundation and ACE Excellence. There are six components identified as priorities for the ACE Foundation level programme for the year 2014-2015. The two components of the ACE Excellence Pilot were holistic care and diagnosis of patients with long term conditions and integration of community teams into general practice. Achievement of ACE are verified by a practice appraisal process.

The lead GP told us they had completed the ACE Foundation course and had attended training courses towards achieving ACE Excellence for two types of long term conditions. Efforts were being made to provide high standards and consistent care and treatment to these patients. Performance against this programme were used to monitor practice improvements.

The practice was proactive towards staff training and staff told us they were encouraged and supported in attending various courses. For example, the health care assistant provided advice about healthy living and had received training.

The practice had completed reviews of significant events and other incidents and shared them with staff via meetings to ensure the practice improved outcomes for patients. For example, an incident had occurred concerning an out of date vaccine. To prevent recurrences a system was put in place for regular stock checks and rotation of dated medicines.