

Kirpal Medical Practice

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Kirpal Medical Practice on 26 September 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- Staff understood their responsibilities to raise concerns and to report incidents and near misses. The practice had a formal system in place for the ongoing monitoring of significant events, incidents and accidents.
- Arrangements were in place to ensure that risks to patients were assessed and managed. The exception was the process for managing patients on high risk medicines.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- The practice had a programme of continuous clinical and internal audit in order to monitor quality and make improvements.
- The practice invested in staff development and training.
- 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. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- 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.
- The provider was aware of and complied with the requirements of the duty of candour.

Summary of findings

There were areas of practice where the provider should make improvements:

- Implement a fully effective system to improve the management of patients on high risk medicines.
- Ensure clinical waste disposal procedures meet nationally recognised guidelines.
- Assess the risk of not having medicines to manage pain included in the emergency medicines box.

- Explore ways to improve communication with patients whose first language is not English.

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:

- There was an effective system in place for reporting and recording significant events.
- Records of clinical and significant event meetings demonstrated that incidents were fully discussed. Records showed that ongoing monitoring of events had taken place to ensure that systems put in place were appropriate.
- When there were unintended or unexpected safety incidents, patients received reasonable support, relevant information and an apology. Patients were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems and processes in place to keep patients safe and safeguarded from the risk of abuse.
- The practice's system for managing patients on high risk medicines was not fully effective
- There was an appointed lead for health and safety and risks to patients and staff were assessed and identified actions completed. For example, the practice had completed a legionella risk assessment.
- The premises and equipment were maintained to a high standard but bins and sharps boxes did not conform to nationally recognised guidelines.
- The practice was well equipped and had the appropriate medicines to respond to a medical emergency. The exception was medicines for pain management which were not included in the emergency medicines box.

Good



Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) for 2014/15 showed that the overall achievement of 96% of the available points which was above the locality average of 93% and the national average of 95%.
- The practice had lower than average overall clinical exception rates. The practice clinical exception rate of 5.1% was better than the local CCG average of 8.8% and better than the national

Good



Summary of findings

average of 9.2%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.)

- Staff were aware of current evidence based guidance to deliver care and there was a system in place to check they were being followed.
- The practice had completed clinical audits and the outcomes were used to monitor quality and make improvements.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. There was evidence of staff appraisals and personal development plans for all staff.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs. For example, the practice held meetings with the professionals involved in the care of patients receiving palliative care.
- Arrangements were in place to gain patients' informed consent to their care and treatment.
- Patients were supported to access services to promote them living healthier lives.

Are services caring?

The practice is rated as good for providing caring services.

- Data from the National GP Patient Survey results, published in July 2016, showed patients rated the practice above local and national averages for care provided by the GPs but below average for care provided by the nurse (the responses were received during a period of time when the practice was using locum nurses, permanent staff had since been recruited).
- Patients were treated with dignity and respect and they were involved in decisions about their care and treatment. Systems were in place to protect patient confidentiality.
- Arrangements were in place to ensure that patients and carers received appropriate and effective support.
- The practice held a carers' register and systems were in place, which identified patients who also acted as carers. This included young carers. Carers identified were supported and offered an annual health check and immunisation against flu.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



Summary of findings

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- Patients said they found it easy to make an appointment with a GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available in the waiting area and was easy to understand. The practice had responded quickly when issues were raised. Learning from complaints was shared with all staff.
- There was a translation service available but a lack of information translated into languages commonly spoken in the community.

Are services well-led?

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

- The practice had a vision to deliver high quality care and promote good outcomes for patients. Staff were aware of the vision and their responsibilities in relation to this.
- There was a clear leadership structure and staff felt supported by the management.
- The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There were arrangements for identifying, recording and managing risks and implementing mitigating actions to ensure that patients and staff were protected from the risk of harm. The exception was the procedure for the safe management of high risk medicines which was not fully effective.
- The provider was aware of and complied with the requirements of the Duty of Candour. The GP partners encouraged a culture of openness and honesty.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.

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.

Good



- The practice offered personalised care to meet the needs of the older people in its population.
- The practice offered GP home visits to older people who were housebound only. All home visit requests were assessed and prioritised by a GP.
- Flexible appointments and same day telephone consultations were available for older patients.
- All patients aged 65 and over were offered a health check including blood tests.
- Older patients identified at increased risk of hospital admission had written care plans that were reviewed with other healthcare professionals at bi-monthly multidisciplinary team meetings.
- All patients aged 75 and over had been contacted to inform them of their allocated GP.

People with long term conditions

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

Good



- Patients with long-term conditions identified at increased risk of hospital admission had written care plans that were reviewed with other healthcare professionals at bi-monthly multidisciplinary team meetings.
- The practice Quality and Outcomes Framework (QOF) for the care of patients with long-term conditions was similar to or higher than the local and national average. For example, the practice performance for diabetes related clinical indicators was higher than the local Clinical Commissioning Group and England average (90% compared to the local average of 85% and England average of 89%).
- Longer appointments were available when needed and home visits made to patients who were housebound.
- The clinicians worked with relevant healthcare professionals to deliver a multidisciplinary package of care to patients with complex needs.

Families, children and young people

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

Summary of findings

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who did not attend hospital appointments.
- Immunisation uptake rates for standard childhood immunisations were similar to the local CCG and national averages. For example, childhood immunisation rates for the vaccination of children under two years of age ranged from 92% to 96%, children aged two to five 88% to 94% and five year olds from 85% to 95%.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies.
- Safeguarding children procedures identified those living in disadvantaged families and services offered included early identification of need and young carers were offered support.
- Children not attending the practice could be referred to the health visiting team using a 'hard to reach' form.
- The practice's uptake for the cervical screening programme was 76%, which was comparable to the national average of 82%.

Working age people (including those recently retired and students)

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 offered telephone consultations during working hours and the appointment telephone line was accessible to patients who worked during the day.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.
- The practice monitored appointment availability and offered appointments outside of core opening hours if required.

Good



People whose circumstances may make them vulnerable

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

Good



Summary of findings

- The practice held a register of 30 patients with a learning disability. In 2015/16, 24 had attended the practice for an annual health check and had written care plans in place.
- The practice had a high prevalence of young patients living in vulnerable circumstances. The practice assisted and supported these patients on an individual basis.
- Staff had been trained 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.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It told vulnerable patients about how to access various support groups and voluntary organisations.
- Flexible appointments were offered to patients with learning disabilities.

People experiencing poor mental health (including people with dementia)

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

- The practice regularly worked with multi-disciplinary teams in the case management of people who experienced poor mental health, including those with dementia.
- The practice held a register of patients who experienced poor mental health. Clinical data for the year 2016/17 showed that 16 of 25 patients on the practice register who experienced poor mental health had a comprehensive agreed care plan. The provider had planned to complete the remaining nine care plans before April 2017.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. For example, the child and adolescent mental health services (CAMHS).
- Data from 2015/16 showed the percentage of patients diagnosed with dementia, whose care had been reviewed in a face to face review in the preceding 12 months was 76%, which was lower than the national average of 84%.
- The practice maintained a register of patients diagnosed with dementia.

Good



Summary of findings

What people who use the service say

The national GP patient survey results published in July 2016 showed the practice was generally performing below national averages. A total of 364 surveys (8.5% of the patient list) were sent out and 90 responses were received giving a response rate of 25%, which is equivalent to 2.1% of the patient list. For example:

- 70% of the patients who responded said they found it easy to get through to this surgery by phone compared to the Clinical Commissioning Group (CCG) average of 60% and a national average of 73%.
- 70% of the patients who responded said they were able to get an appointment to see or speak to someone the last time they tried (CCG average 75%, national average 85%).
- 72% of the patients who responded described the overall experience of their GP surgery as fairly good or very good (CCG average 75%, national average 85%).
- 65% of the patients who responded said they would definitely or probably recommend their GP surgery to someone who had just moved to the local area (CCG average 64%, national average 78%).
- 77% of the patients who responded said they found the receptionists at this practice helpful (CCG average 81%, national average 87%)

As part of our inspection we also asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received 30 comment

cards which were mainly positive. Patients said the practice staff were professional, helpful and respectful and patients complimented the practice on having a clean environment. We spoke with one patient on the day of our inspection who chaired the patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. They told us that patients were satisfied with the care provided by the practice and there was no cause for complaint from the PPG.

The practice monitored the results of the friends and family test monthly. The results over a five month period (April 2016 to August 2016) showed that of the 139 responses received 71 were extremely likely to recommend the practice to friends and family if they needed similar care or treatment and 48 patients were likely to recommend the practice. The remaining results showed that 15 patients were neither likely nor unlikely to recommend the practice, and five patients were unlikely to recommend the practice. The comments made by patients in their responses were overall positive and aligned with the comments and responses received from comment cards, the patients spoken with and the GP survey results. We saw that the practice reviewed the comments received through the friends and family test and used these to make improvements.

Kirpal Medical Practice

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.

Background to Kirpal Medical Practice

Kirpal Medical Practice is registered with the Care Quality Commission (CQC) as a two GP partnership. The practice is located in Handsworth, a suburb of Birmingham with an above average number of people from ethnic minorities that includes Indian, West Indian and Eastern European communities. The practice has good transport links for patients travelling by public transport and parking facilities are available for patients travelling by car. The practice is situated within a single storey building containing six consulting/treatment rooms. There is level access to the building and doors to the building are automated. All areas within the practice are accessible by patients who use a wheelchair or parents with a pushchair.

The practice team consists of two GP partners, both male. The GP partners are supported by occasional locum GPs who cover holidays, one nurse practitioner (one day per week), a practice nurse (four days per week) and a healthcare assistant (three days per week). Clinical staff are supported by a practice manager, a medical secretary, a senior receptionist, a practice administrator and four administration/reception staff. In addition to the GP partners, there are a total of 11 staff employed either full or part time hours to meet the needs of patients.

The practice is open every week day between 8am and 6.30pm. Appointments are available from 8.30am to 1pm

and from 3pm to 6pm in the afternoon. The practice does not offer extended hours. The practice does not provide an out-of-hours service to its patients but has alternative arrangements for patients to be seen when the practice is closed. Patients are directed to the out of hours service, provided by Primecare, via the NHS 111 service.

The practice has a General Medical Services contract with NHS England to provide medical services to approximately 4,300 patients. It provides Directed Enhanced Services, such as the childhood immunisations, minor surgery (joint injections only) and asthma and diabetic reviews. The practice has a lower proportion of patients aged over 65 (10.5% compared to the England average of 17.1%) and a higher proportion of patients aged 18 and under when compared to the practice average across England (24% compared to the England average of 21%). The percentage of children affected by income deprivation is 32%, significantly higher than the national average of 20%. The level of income deprivation affecting older people is 41%, significantly higher than the national average of 16%.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 26 September 2016.

During our visit we:

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

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

- Is it safe?

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

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

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

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

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach to learning and a computerised system was in place for reporting and recording significant events. Staff told us they would inform the practice manager and/or the partners of any incidents to ensure appropriate action was taken. When appropriate to do so these were input onto a Datix system (a database used nationally to share events between providers). The practice manager was responsible for disseminating safety alerts and there were systems in place to ensure they were acted on. The practice manager was able to give an example of a medicine alert for a type of blood glucose testing strip. The provider evidenced that they had informed associated pharmacists, ran a search that found seven patients who required a change of testing strips, informed those patients affected and issued the approved strips. Alerts were shared with the wider practice team at practice meetings held bi-monthly, informal meetings were held each week.

We found that significant event records were maintained and systems put in place prevented further occurrence. Significant event records were clearly documented at the time they were reported. Action points recorded on the significant event forms (part of the Datix system) were used to inform staff of the event as a standing agenda item at practice meetings. Documentation available demonstrated that any lessons learnt and action taken had been shared with staff and remedial action had been taken. Ongoing monitoring was demonstrated by minutes of meetings where actions taken were reviewed. Staff completed an incident recording form which supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). We found that when there were unintended or unexpected safety incidents, patients received reasonable support, relevant information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Records we looked at showed that six significant events, both clinical and operational had occurred over the past 12 months. One of the events related to a delayed result from an MRI scan due to a backlog of scan results at the hospital.

The practice evidenced that the scan had been followed up and an urgent referral was made. The patient was given an appointment in which the GP explained the delayed results and the reasons for the urgent referral.

Overview of safety systems and processes

Arrangements were in place to safeguard adults and children from the risk of abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. One GP partner carried out the lead role for safeguarding adults and children. Staff we spoke with demonstrated that they understood their responsibilities and told us they had received training relevant to their role. The GP partners and nurses were trained to safeguarding level three and the non-clinical staff were trained to safeguarding level two. The GPs told us they provided reports where necessary for other agencies. The practice held registers for children at risk, and children with protection plans were identified on their individual computerised records. The practice followed up by telephone those children who did not attend practice or hospital appointments. The first appointment not attended was highlighted on the patient records, if a second appointment was not attended, the health visitor was informed and a 'hard to reach' form was completed and sent to the health visiting team. The practice discussed any concerns about children with a named health visitor and other relevant professionals.

Notices displayed in the waiting room, treatment rooms and consultation rooms advised patients they could access a chaperone, if required. All staff who acted as chaperones were trained for the role. Staff files showed that criminal records checks had been carried out through the Disclosure and Barring Service (DBS) for staff who carried out chaperone duties. (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). Clinical staff normally acted as chaperones and some reception staff undertook this role when required. Staff clearly described their role to us and knew where to stand. A chaperone policy was available to support staff. The policy made appropriate reference to recording on the patient records that a chaperone was present and summarised the role of a chaperone.

Are services safe?

The practice maintained appropriate standards of cleanliness and hygiene and we observed the premises to be clean and tidy. There were cleaning schedules in place and cleaning records and standards were reviewed and problems reported to the cleaning supervisor. The practice nurse was the clinical lead for infection control. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

Treatment and consulting rooms in use had the necessary hand washing facilities and personal protective equipment which included disposable gloves and aprons. Hand gels for patients and staff were available. Clinical waste disposal contracts were in place through the landlord of the property. Reception staff were responsible for the disposal of the sharps bins and a protocol for needlestick injuries was in place. Not all boxes were seen to have been signed and dated with an assembly date and general waste bins were open in treatment rooms. The property maintenance was managed by the landlords and this included the cleaning. We were told that the cleaning contractor was responsible for emptying the clinical waste bins. Clinical staff had received occupational health checks for example, hepatitis B status and appropriate action taken to protect staff from the risk of harm when meeting patients' health needs. The practice had carried out recent audits on hand hygiene and fridge cleaning audits were carried out monthly.

There were some arrangements for managing medicines in the practice. The medicine prescribing practices we reviewed showed that the systems in place for patients to receive a formal review of their medicines were not fully effective.

- The arrangements for managing repeat prescriptions for high risk medicines that required monitoring were not consistently followed. For example, we saw that a medicine that required regular tests and monitoring of the dose to be taken was on an acute prescription so each medicine repeat request required approval from a GP. We found that of the nine patients on repeat prescriptions for a specific disease modifying medicine two had not had a blood test since September 2015 and November 2015 respectively.
- The practice had an effective process for making changes to prescribed medicines in patient's records following a visit to hospital. The reception staff were

responsible for adding and removing patient repeat medication items following their discharge from hospital. The process required GPs to check the changes and we saw evidence to confirm this was done.

- Formal arrangements for the review of patient medicines were in place. For example 74% of patients on four or more medications had been reviewed since April 2016.

We found that blank computer forms were securely stored and their use monitored. The practice no longer used prescription pads. The practice had systems for ensuring that medicines were stored in line with manufacturers' guidance and legislative requirements. This included daily checks to ensure medicines such as vaccines were kept within a temperature range that ensured they were effective for use. Specific medicine directions (Patient Group Directions for the practice nurses) were adopted by the practice to allow the practice nurses to administer specific medicines in line with legislation. Patient Specific Directions were not in place for the healthcare assistants because they did not administer any medication to patients.

We reviewed the staff files for three staff employed at the practice. We found that all files were thorough and contained appropriate recruitment checks which had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. Records showed that all permanent staff had criminal records checks carried out through the DBS. The practice occasionally employed locum GPs. Their records showed that a check was carried out to confirm the locum was registered to practice with their professional body, the General Medical Council (GMC) and information was held on employment history, qualifications, references and appropriate checks through the DBS to confirm the suitability of the GP to work with patients.

Monitoring risks to patients

The landlord of the property was responsible for the maintenance and management of the premises. The practice had procedures in place for monitoring and managing risks to patient and staff safety. Minutes of practice meetings showed that health and safety was discussed when required. The practice had a health and safety policy available and the mandatory poster was

Are services safe?

displayed in the reception area. The poster identified the named health and safety lead at the practice. This person had received additional training specific to this role. We saw that risk assessments relating to the premises, patients, visitors and staff working at the practice had been completed. For example, a risk assessment for the suitability and safety of work stations. There was a log of all risks identified. Records were available to demonstrate that a number of other risk assessments had been completed by the property landlord to monitor the safety of the premises. These included fire risk assessments, checking of fire alarms, emergency lighting and infection control. Control of Substances Hazardous to Health (COSHH) was managed by the landlord and safety data sheets for each product were kept where the practice could access them. The practice evidenced that the landlord had carried a legionella risk assessment and ongoing checks were carried out. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

All electrical and medical equipment had been checked annually to ensure the equipment was safe to use and working properly. Records showed equipment was maintained and calibrated in November 2015 and electrical safety checks had last been carried out in November 2015.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff and staff with appropriate skills were on duty. The practice used GP locums to support the clinicians and meet the needs of patients at the practice at times of absence.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents. There was an instant messaging system on the computers in all rooms and an emergency panic button in the reception, consultation rooms and treatment rooms which alerted staff to any emergency. The practice had a first aid box and an accident book and all staff knew where they were located. Staff training records showed that all staff had received recent update training in basic life support and staff spoken with confirmed this. The practice had no defibrillator (this provides an electric shock to stabilise a life threatening heart rhythm) on the premises after the landlord removed the previous one in June 2016. The practice evidenced that a replacement machine had been purchased and would be delivered soon. There was oxygen with adult and children's masks. Systems were in place to ensure emergency equipment and medicines were regularly checked. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date. The emergency medicines did not include anything for pain management. The provider explained that medicines could be obtained from the next door pharmacy but no formal risk assessment had been completed.

The practice had a comprehensive business continuity plan in place for responding to emergencies such as loss of premises, power failure or loss of access to medical records. The plan included emergency contact numbers and templates such as consultation sheets and blood test request forms in addition to information for staff of mitigating actions to reduce and manage the identified risks. There were hard copies kept off site that could be accessed remotely.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The GP we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and systems were in place to keep all clinical staff up to date. The practice discussed any new guidelines in a dedicated meeting held every month and these were tracked on a spread sheet. The practice monitored that guidelines were followed through risk assessments and audits or random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice collected information for the Quality and Outcomes Framework (QOF) to measure its performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results for 2014/15 showed that it had achieved 96% of the total number of points available, higher than the local Clinical Commissioning Group (CCG) average of 93% and the national average of 95%. The practice clinical exception rate of 5.1% was lower than the local CCG average of 8.8% and lower than the national average of 9.2%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.) Further practice QOF data from 2014/15 showed:

- Performance for the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was within target was above the local and national average (83% compared to the local average of 77% and national average of 78%). The practice exception reporting rate of 4.1% showed that it was lower than the local CCG average of 7.9% and the national rate of 8.7%.

- Performance for the percentage of patients with Chronic Obstructive Pulmonary Disease (COPD) who had been reviewed in the preceding 12 months was 92% which was above the local CCG average of 89% and national average of 90%. COPD is the name for a collection of lung diseases. The practice exception reporting rate of 9.8% was lower than the local average exception rate of 11.8% and national average of 11.1%.
- Performance for mental health related indicators was higher than the local CCG and national averages. For example, the percentage of patients experiencing mental health disorders who had a comprehensive, agreed care plan documented in their records in the preceding 12 months was 93% compared to the local CCG average of 86% and national average of 88%. The practice had exception reported seven of the 50 patients for this clinical area, equivalent to 14% (the local CCG average exception rate was 11.8% and England average was 12.6%).
- The percentage of patients diagnosed with dementia whose care had been reviewed in

a face-to-face review in the preceding 12 months was below the local CCG and national average (76% compared to the local CCG average and England average of 84%). The practice clinical exception rate of 12.5% for this clinical area was higher than the local CCG average of 8.4% and the England average of 8.3%. This represented three patients and the provider was aware of each individual and had invited them to attend a review.

Information received at this inspection demonstrated that the practice had achieved 96% of total QOF points available in 2015/16.

The practice had introduced and reviewed appropriate care plans where required for the ongoing management of patients identified at increased risk of hospital admission. Bi-monthly multi-disciplinary team meetings were held to monitor performance and an action plan was developed to identify the areas of patients' care that needed to be reviewed. Evidence was available to show that the practice had systems in place to follow up patients that had not attended reviews of their condition either at the practice or at the hospital.

Are services effective?

(for example, treatment is effective)

One of the GPs attended peer review meetings with other local GP practices where clinical issues, treatments and performance were discussed. For example, the practice had discussed the introduction of a preferred provider for minor surgery.

Clinical audits the practice had carried out demonstrated quality improvements to improve care, treatment and patients' outcomes. We saw that two clinical audits had been completed and repeated in the last year. One of the audits looked at atrial fibrillation (AF), a heart condition that causes an irregular and often abnormally fast heart rate. The audit was initiated following an update from NICE on best clinical practice in treating AF. The provider reviewed all patients on the AF register to test for risk of stroke. The first audit found four patients with AF at risk of stroke who were not on a medicine used to prevent blood clotting. The second cycle audit found that this had reduced to two patients and, both had made an informed decision to decline. The provider regularly audited consent records. Two audits had been undertaken in the preceding 12 months and recorded consent was 100% in both.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. This covered such topics as safeguarding, infection prevention and control, fire safety, confidentiality and health and safety. Staff had access to and made use of e-learning training modules, external and in-house training.

The practice had developed an effective appraisal system which included detailed appraisal documents. All staff had received a recent appraisal and records detailed development plans for each individual. The GPs and practice nurse had all completed clinical specific training updates to support annual appraisals and revalidation. The practice nurses received training and had attended regular updates for the care of patients with long-term conditions and administering vaccinations.

Coordinating patient care and information sharing

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

demonstrate that staff were aware of their responsibilities for processing, recording and acting on any information received. The practice tracked referrals such as urgent scan requests.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services. For example, when referring patients to secondary care such as hospital or to the out of hours service. Information was shared with the out of hours service so they were aware of patients' wishes and treatment choices when the practice was closed. The practice completed a weekly audit on patients who attended the out of hours service together with a review of the daily attendances. Records showed that there had been no concerns identified. Staff told us that they could discuss any concerns about children and families with a named health visitor. Multi-disciplinary team meetings were used to discuss patients on the practice palliative care register. Detailed minutes of the meetings were maintained and care plans were routinely reviewed and updated following the meetings. A copy of their care plan was kept in the patient's home.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. We found that staff understood and had an awareness of the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and where appropriate, recorded the outcome of the assessment. We saw that patients' consent had been recorded clearly using nationally recognised standards. For example, when consenting to certain tests and treatments such as vaccinations and in do not attempt cardio-pulmonary resuscitation (DNACPR) records. Audits were carried out to check that consent was obtained.

Supporting patients to live healthier lives

Are services effective?

(for example, treatment is effective)

The practice had identified patients who may be in need of extra support. This included patients with conditions that may progress and worsen without the additional support to monitor and maintain their wellbeing.

- Patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet and alcohol cessation.
- Patients were signposted to relevant health promotion services for example, dietary advice. Smoking cessation clinics were provided in house by the healthcare assistant.
- Patients had access to appropriate health assessments and checks. These included health checks for new patients, NHS health checks for patients aged 40-74 years and patients aged 75 years.

The practice had a comprehensive screening programme. A range of travel vaccines, childhood immunisations and influenza vaccinations were offered in line with current national guidance. Data collected by NHS England for 2014/15 showed that the performance for all childhood immunisations was comparable to the local CCG average. For example, childhood immunisation rates for the vaccination of children under two years of age ranged from 92% to 96%. Children aged two to five ranged from 88% to 94%, with the exception of the Infant Men C vaccination where the uptake rate was 9% of the 67 patients, and five

year olds from 86% to 93% with the exception of the Infant Men C, Infant PCV and PCV booster that were all 1.8% of the 55 eligible patients. The practice said this was due to the introduction of a catch up programme of vaccinations that commenced during the year in which the data related to. More recent figures provided by the practice evidenced that uptake rates for these immunisations were now in line with other immunisations (between 85% and 96%).

We saw that the uptake for cervical screening for women between the ages of 25 and 64 years for the 2014/15 QOF year was 76%, which was below the England average of 82%. The practice was proactive in following these patients up by telephone and sent reminder letters and figures had improved to 75% of eligible patients for the year to date starting April 2016. Public Health England national data showed that the number of females aged 50-70 years, screened for breast cancer in last 36 months was lower at 66% when compared to the average across England of 72%. Data for other cancer screening indicators such as bowel cancer were below local and national averages.

We saw that health promotion information was displayed in the waiting area and also made available and accessible to patients on the practice website. The health care assistant carried out health screening checks on all new patients registering at the practice.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- The area around the reception desk was open. To promote confidentiality, telephone calls could be responded to away from the front desk to support the privacy of patients when speaking to reception staff at the desk. If patients wanted to discuss something privately or appeared distressed a private area was available where they could not be overheard.

We spoke with one patient during the inspection and collected 30 Care Quality Commission comment cards completed by patients to tell us what they thought about the practice. Patients were positive about the service they received. Patients said that they received good care from all staff, the GPs were caring and staff were polite, considerate and helpful. There were a number of comments that complimented the provider on cleanliness. There was one comment that stated booking an appointment had been a problem but was satisfied after an explanation from the practice manager on how the appointment system worked.

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

- 91% of the patients who responded said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 83% and national average of 89%.
- 92% of the patients who responded said the GP gave them enough time (CCG average 82%, national average 87%).
- 95% of the patients who responded said they had confidence and trust in the last GP they saw (CCG average 93%, national average 95%).

- 89% of the patients who responded said the last GP they spoke to was good at treating them with care and concern (CCG average 80%, national average 85%).

The practice was below the average satisfaction scores on consultations with the nurse. For example:

- 77% of the patients who responded said the last nurse they spoke to was good at treating them with care and concern (CCG average 86%, national average 91%).
- 78% of the patients who responded said the last nurse they saw or spoke to was good at listening to them (CCG average 87%, national average 91%).
- 69% of the patients who responded said the last nurse they saw or spoke to was good at giving them enough time (CCG average 87%, national average 92%).

The patient satisfaction with reception staff was below local CCG and national average. Data showed that:

- 77% of the patients who responded said they found the receptionists at the practice helpful (CCG average 81%, national average 87%).

The practice were aware and said this was possibly due to the previous nurse situation where there was no continuity due to locum nurses (used during the period of recruitment for a new nurse) and a resistance by patients to see nurse prescribers. The provider attributed the receptionist scores to managing the expectations of new patients through education on the services available. This included the potential of patient leaflets being translated into different languages.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Results from the national GP patient survey published in July 2016 showed patients response to their involvement in care planning with a GP was above the local and national average. However the responses were below local and national averages when asked questions about their involvement in planning and making decisions about their care and treatment with the nurse. For example:

Are services caring?

- 91% of the patients who responded said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and national average of 86%.
- 85% of the patients who responded said the last GP they saw was good at involving them in decisions about their care (CCG average 76%, national average 82%).
- 78% of the patients who responded said the last nurse they saw or spoke to was good at explaining tests and treatments (CCG average 86%, national average 90%)
- 79% of the patients who responded said the last nurse they saw was good at involving them in decisions about their care (CCG average 82%, national average 85%).

Patient and carer support to cope emotionally with care and treatment

The practice had a carers' policy in place, which staff were aware of. Written information was available for carers to ensure they understood the various avenues of support

available to them. This included notices in the patient waiting room which told patients how to access a number of support groups and organisations. There were 73 carers on the practice carers register, which represented 1.7% of the practice population. The practice's computer system alerted the GPs and nurse if a patient was also a carer and patients were offered a flu vaccination and health checks. There was a recall system in place for carers to be invited for their flu vaccination and health check.

Staff told us that if families had suffered bereavement, patients were offered an appointment with a clinician to offer to the family. Leaflets and other written information on bereavement was available for patients in the waiting area and on the practice website. Families and carers were signposted to support services such as 'CRUSE' and 'Birmingham Healthy Minds', two local services that offered bereavement counselling.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local clinical commissioning group (CCG) to plan services and to improve outcomes for patients in the area. Services were planned and delivered to take into account the needs of different patient groups, flexibility, choice and continuity of care. For example:

- Patients with a learning disability were offered longer appointments at a time which was suitable to them and their carer.
- With administration support, the GPs followed up all patients on the admission avoidance register following their discharge from hospital. They met bi-monthly to review any admissions.
- The practice had access to appointments for patients who worked. We found that patients could book appointments online. However, repeat prescriptions, test results and summary care records could not be accessed due to information technology issues outside of the provider's control. An investigation was ongoing.
- Facilities for patients with mobility difficulties included a ramp for ease of access to the entrance of the practice. The front doors to the practice were automatic and patients with poor mobility. Adapted toilet facilities were available for patients with a physical disability.
- The practice referred patients experiencing memory loss to the local community memory loss clinic.
- Access was available to translation and interpretation services to ensure patients were involved in decisions about their care. However, there was a 24 hour wait and a new influx of Eastern European patients were not catered for. There was a self-check-in screen with a translation facility but this had been switched off due to removal of funding required to update the software to be compliant with the new computer system. The practice planned to re-introduce the self-check-in screen should funds be made available.
- Baby changing and breast feeding facilities were available.
- There were longer appointments available for older people and patients with long-term conditions.
- The practice made patients aware that home visits were available for patients who were housebound.

- Same day appointments were available for children as well as patients assessed as requiring an urgent appointment.

Access to the service

The practice was open every week day between 8am and 6.30pm. Appointments were available each week day from 8.30am to 1pm and from 3pm to 6pm. Extended hours were not offered at the practice although staff told us that clinicians would work additional hours when required. The practice did not provide an out-of-hours service to its patients but had alternative arrangements for patients to be seen when the practice was closed. Patients were directed to the out of hours service, provided by Primecare, via the NHS 111 service. The nearest hospital with an A&E unit and a walk in service was City Hospital, Birmingham. The nearest walk in centre was in Boots the Chemist situated in the city centre.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was below local and national averages for opening hours.

- 59% of patients were satisfied with the practice's opening hours, which was below the CCG average of 71%, and national average of 76%.
- 70% patients said they could get through easily to the surgery by phone (CCG average 60%, national average 73%).

The practice had a system in place to assess whether a home visit was clinically necessary. The named GP had the responsibility for coordinating the patients care and made the decision on the urgency of the patients need for care and treatment and the most suitable place for this to be received. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits. Non-clinical staff would refer any calls which caused concern or they were unsure of to a clinician for advice. Information in the patient leaflet and on the practice website encouraged patients to contact the practice before 10:30am if they required a home visit. Further information informed patients that home visits would be made to patients who were housebound only.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with

Are services responsive to people's needs?

(for example, to feedback?)

recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints at the practice. We saw correspondence for five complaints received since April 2016 and found that all had been responded to, satisfactorily handled and dealt with in a timely way.

Records showed that complaints were discussed at practice meetings. We saw that lessons were learnt from concerns and complaints and action was taken to improve the service. For example, the practice recorded a negative review posted anonymously on the NHS Choice website as

a complaint. The complainant had experienced a problem with bad service and attitude from a member of the reception team. The practice responded to the complaint and provided an opportunity to meet and discuss their experience in more detail. The practice informed the staff of the complaint at the next practice meeting.

We saw that information available to help patients understand the complaints system included leaflets available in the reception area and patients but there was no information on how to make a complaint on the practice website.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a written vision and set of values laid down in a patient charter and a statement of purpose. Staff and patients felt that they were involved in the future plans for the practice. The practice produced annual summaries of strategy based on the CCG aims and objectives and NHS England plans and General Medical Services contract. The practice sought the views of patients and input of the patient participation group (PPG) on improvements that could be made at the practice. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services.

Governance arrangements

Governance within the practice was good. We saw examples of risks that had been well managed:

- There was a clear staffing structure and staff were aware of their own roles and responsibilities and all staff were supported to address their professional development needs.
- Practice specific policies and procedures were implemented and were available to all staff. An internal shared drive was used to advise staff when key policies were updated or of any new policies.
- We found that systems were supported by a strong management structure and clear leadership.
- Clinical and internal audits were carried out and the outcomes used to monitor quality and make improvements.
- Arrangements for identifying, recording and managing risks and implementing mitigating actions were in place to ensure that patients and staff were protected from the risk of harm. These included the arrangements for the safe management of medicines.

Leadership and culture

The GPs and practice manager were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff. There was a clear leadership structure in place and staff felt supported by the management. Staff we spoke with were positive about working at the practice. They told us they felt comfortable enough to raise any concerns when required and were confident these would be dealt with appropriately.

The provider was aware of and complied with the requirements of the Duty of Candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. When there was unexpected or unintended safety incidents the practice gave affected people reasonable support, relevant information and a verbal and written apology.

Staff told us that regular practice meetings which involved all staff were held and staff felt confident to raise any issues or concerns at these meetings. We reviewed minutes of meetings held and topics on the agenda included significant events, complaints, safeguarding, health and safety and other governance arrangements. There was a practice whistle blowing policy available for all staff to access on the practice's computer system. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected and this was confirmed in discussions we held with staff.

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

The practice encouraged and valued feedback from patients, the public and staff. The practice had an active patient participation group (PPG), formal meetings were held every three months and minutes were available to confirm this. The provider proactively sought patients' feedback and engaged patients in the delivery of the service. The practice had gathered feedback from patients through the friends and family test and complaints received. The provider was aware of and reviewed results from the GP national patient survey. Formal action plans were produced and displayed on the practice website. The patient participation group chairperson spoke of recent changes made in response to patient feedback. For example, access to a GP had been improved following the introduction of a GP led telephone triage system between 8am and 8.30am, each day. Parking at the practice was an issue that had been raised by patients. The provider did not own the property or surrounding land so had reported the problems to the local council and NHS Properties Ltd.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us

Are services well-led?

Good 

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

they would not hesitate to give feedback and discuss any concerns or issues with colleagues and the management team. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice

had completed reviews of significant events and other incidents and had ensured that lessons learned from these were used to make improvements and prevent further reoccurrence. Staff told us that they felt supported to develop. For example, a member of the administration team had been pledged support from the practice in achieving their nursing qualifications.