Oakwood Surgery

Quality Report

Oakwood Surgery
856 Stratford Road
Sparkhill
Birmingham
B11 4BW
Tel: 0121 411 0346
Website: www.oakwoodsurgery.net

Date of inspection visit: 27 October 2015
Date of publication: 17/03/2016

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	9
Areas for improvement	9

Detailed findings from this inspection

Our inspection team	10
Background to Oakwood Surgery	10
Why we carried out this inspection	10
How we carried out this inspection	10
Detailed findings	12

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Oakwood Surgery on 27 October 2015. Overall the practice is rated as good.

- Our key findings across all the areas we inspected were as follows: The practice valued opportunities to learn and develop.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles. For example as there was a high prevalence of diabetes one of the GP partners had completed the Warwick certificate in diabetes care.
- Patients said they were treated with kindness and compassion. Many of the patients we spoke with had been with the practice for many years.
- Information about services and how to complain was available and easy to understand (including in different languages such as Arabic).
- Patients told us that there was continuity of care, with urgent appointments available the same day. Patient reviews were routinely carried out. The care home managers spoke very highly of the GPs at the practice.
- 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.

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

Action the provider must take to improve:

Summary of findings

- Ensure that all repeat prescriptions are only reauthorised by clinicians.
- Ensure that arrangements are in place to ensure the practice is able to deal with foreseeable emergencies that may impact on the running of the practice

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. The practice had a robust system for repeat prescribing with patients receiving regular reviews and most repeat prescriptions were signed by a GP before being issued to a patient. However administrative staff were able to re-authorise repeat prescriptions for one month in cases where medication was essential, pending the formal review with the GP. This did not reflect national guidance and this was highlighted at the time of the inspection. This was going to be changed immediately following the inspection.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff received training appropriate to their roles, for example one of the GP partners had undertaken the Warwick certificate in diabetes care, and this was due to the practices high prevalence of diabetes. There was evidence of appraisals and personal development plans for all staff. Staff worked in partnership with other professionals involved in providing care and treatment to patients.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with care and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with Birmingham South and Central Clinical Commissioning Group (CCG). Patients felt that there was continuity of care with urgent

Summary of findings

appointments available the same day. As a way of improving some of the survey results the practice had made appointments 15 minutes instead of 10 minutes. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Information was also available in different languages in response to the diverse population in this region.

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. All patients aged 75 and over had their own named GP. These patients also had the choice of seeing whichever GP they preferred. All patients over the age of 75 were offered health checks which included blood tests. They were able to discuss any problems they were experiencing during these appointments.

The practice arranged for flu vaccines to be administered in the community for patients who found it difficult to go to the practice.

The GPs and nurse consultant did home visits for older people and for patients who required a visit following discharge from hospital.

The practice held multi-disciplinary team (MDT) meetings for the planning and delivery of palliative care patients who were approaching end of life. These meetings were held quarterly and involved matrons, district nurses and palliative care nurses.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. The practice had well established clinics for asthma, diabetes and chronic obstructive pulmonary disease (COPD) which is a lung disease. The practice promoted independence and encouraged self-care for these patients. The practice identified patients who might be vulnerable or have specific complex or long term needs and ensured they were offered reviews where needed. Patients with long term conditions had personalised care plans in place. These patients had alerts that flagged up in their care records to enable priority access to GPs and the nurse consultant.

The practice was signed up to the unplanned admissions enhanced service where patients with long term conditions are monitored closely by community staff and GPs.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. All staff were trained in recognising potential child abuse. Computerised alerts had been put in the notes of those patients who had safeguarding concerns which enabled clinicians to consider issues for consultations with children who were known to be at risk of harm.

The practice was proactive in identifying ways of promoting good health within its younger population group. For example, the

practice offered a confidential service to young people who may be experiencing mental health issues, providing sexual health screening, the provision of contraception upon request and the availability of private facilities for self-testing for chlamydia.

The practice had a GP and nurse consultant led baby clinic which allowed mothers to have their post-natal checks and to have family planning and contraceptive advice. The nurse consultant ran weekly clinics providing a programme of childhood immunisations.

The practice had Citizens Advice Bureau clinics available for patients to book into.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The practice offered same day access to telephone call backs from a GP. These call backs were arranged at times to suit working patients as much as possible. The practice allowed patients to book up appointments up to one month in advance through online services or over the phone.

The practice offered extended hours on a Wednesday evening until 7.30pm.

The practice referred patients to Health Exchange which provided help for patients with weight control and diet.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. Patients whose first language is not English were supported to understand their needs by involving interpreters in the discussion of their care and treatment.

The practice also took steps to ensure patients' cultural expectations were met when referring to different services. For example, requesting a female clinician.

Vulnerable patients were given alternative options to access the GPs and nurses and could walk in to make appointments or be seen by a GP. These patients were also discussed at the practice meetings.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as food for the care of people experiencing poor mental health (including people with dementia). Both lead GPs had experience in substance misuse services and prescribing for patients with substance misuse problems.

Summary of findings

Patients with poor mental health were invited for an annual review of their health, including their physical health, blood tests and their medications.

Patients with dementia (and their carers) were called for an annual review of their health, including their physical health and their medications.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was performing lower than local and national averages. There were 463 forms sent out and 93 responses received and a response rate of 20%. The survey results did not reflect what patients told us on the day of the inspection and patients comments in the CQC comment cards.

- 48.7% of patients found it easy to get through to this surgery by phone compared with a clinical commissioning group (CCG) a CCG is groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services average of 72.3% and a national average of 74.4%.
- 48.3% of patients with a preferred GP usually got to see or speak to that GP compared with a CCG average of 56.6% and a national average of 60.5%.
- 46.1% of patients described their experience of making an appointment as good compared with a CCG average of 70.6% and a national average of 73.8%.
- 42.8% of patients usually waited 15 minutes or less after their appointment time to be seen compared with a CCG average of 57.2% and a national average of 65.2%.
- 39.9% of patients feel they did not normally have to wait too long to be seen compared with a CCG average of 52.7% and a national average of 57.8%.

As a way of improving the services following the patient survey, the practice had recruited an additional receptionist to reduce the telephone waiting times. The practice also changed the telephone provider so that patients could dial a local number instead of the previous number which incurred premium rates for callers.

The practice was in line with local and national averages in the following areas:

- 75.7 % of patients were able to book an appointment to see or speak to someone the last time they tried compared with a CCG average of 80.2% and a national average of 85.4%.
- 85.1 % of patients found the receptionists at this surgery helpful compared with a CCG average of 85.1% and a national average of 86.9%.
- 80.9% of patients said the last appointment they got was convenient compared with a CCG average of 90.2 and a national average of 91.8%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 34 comment cards of which 33 were positive about the standard of care received. Patients referred to staff as being helpful and listening to them.

Areas for improvement

Action the service MUST take to improve

- Ensure that all repeat prescriptions are only reauthorised by clinicians.
- Ensure that arrangements are in place to ensure the practice is able to deal with foreseeable emergencies that may impact on the running of the practice.

Oakwood Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A Care Quality Commission (CQC) inspector and included a GP specialist advisor, a practice manager specialist advisor and an expert by experience who spoke with patients on the day.

Background to Oakwood Surgery

Oakwood Surgery is situated on the Stratford Road in South Birmingham in the Sparkhill Primary Care Centre. The practice has a list size of 6813 patients. The practice catchment area is ethnically diverse.

There is a public pay and display car park opposite to the practice which patients can use. The main entrance, reception and all disabled toilets are designed to allow easy wheelchair access.

The practice has two GP partners and one salaried GP (all male). The practice employs a long term locum GP (female) offering patients a choice of both male and female GPs. The practice has a nurse consultant and is actively looking to recruit two practice nurses. There is also a healthcare assistant (HCA).The clinical team are supported by a practice manager and a team of reception and administrative staff. A consultant gynaecologist (female) holds a weekly clinic at the practice. The pharmacist practitioner also attends the practice on a weekly basis to offer advice to patients. The practice has an in house counsellor, drug worker and also offers a phlebotomy (blood taking) service.

The practice has a patient participation group (PPG), a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

The practice holds a General Medical Services (GMS) contract with NHS England.

The practice is open Monday to Friday from 8am to 6.30pm. Appointments are available from 8:30am - 1.15pm and 3.30 – 6pm. The practice offers extended hours on Wednesdays until 7.30pm.

The practice does not provide out of hours services. Information for out of hours GP services is provided for patients at the practice, on the website and on the out of hours answerphone message. This service is provided by a GP out of hours Service called BADGER. The service is accessed by a designated telephone number which is provided on the practice website. There is a NHS walk-in-centre located on the ground floor of Sparkhill Primary Care Centre.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme 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 references to the Quality and Outcomes Framework data in this report relate to the most recent information available to the CQC at the time of the inspection.

Detailed findings

How we carried out this inspection

Before this inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. These organisations included Birmingham South and Central Clinical Commissioning Group (CCG); CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. NHS England Area Team and Healthwatch.

We carried out an announced visit on 27 October 2015. We sent CQC comment cards to the practice before the visit and received 34 completed cards giving us information about those patients' views of the practice.

During the inspection we spoke with 14 patients and a total of seven staff including the practice manager, GPs and the nurse consultant. We spoke with two members of the Patient Participation Group (PPG).

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

Are services safe?

Our findings

Safe track record and learning

The practice had a systematic approach for reporting and recording significant events. Staff informed the practice manager of all significant events and recorded these on the practice's computer system. We saw evidence that all significant events were discussed at the time of the event and following this at the monthly practice meeting.

The practice informed the Clinical Commissioning Group (CCG) of any significant events that might impact on other practices.

We reviewed six significant events during the inspection. Lessons were learned and improvements made to prevent similar events occurring again. We saw an example of a significant event which came to light after the practice support pharmacist carried out a review on all patients with atrial fibrillation (irregular heart rhythm). This identified a patient being prescribed two different medications when only one would have been necessary. As a result of this the first medication was stopped and the practice highlighted the importance of medication reviews and the need to improve communication between the community anti-coagulation clinic (clinics to monitor and manage medication that prevent blood clots) and the practice.

The practice used a range of sources such as National Institute for Health and Care Excellence (NICE) guidance to ensure they ran a safe service. Alerts about medicines and medicine devices were shared with all staff by the practice nurse. The practice did not have a practice nurse at the time of the inspection and national safety alerts were temporarily being shared with staff by the practice manager. For example, the practice was able to share an example of an alert they received about Ebola.

Significant events and safety alerts were regular items on the agenda at all practice meetings.

Overview of safety systems and processes

The practice had clear systems in place to ensure patients were safe such as:

- The practice had close links to the Birmingham Multi Agency Safeguarding Hub (MASH) website. Referral forms for child protection concerns and advice were on the front page of all the practice computers. Staff understood their roles and responsibilities regarding safeguarding including their duty to report abuse and neglect. The practice nurse, GPs, health visitors, reception team and school nurses attended bi-monthly safeguarding meetings. Social Services were invited to attend the MDT meetings to discuss vulnerable children and families. The practice computer system provided clear information for staff so that they were aware of any patients who may be vulnerable or at risk. The GP safeguarding lead had a list of children at risk and liaised closely with the health visiting team. The practice shared an example of a pregnant patient they were concerned about. This was reported through the appropriate multi agency safeguarding arrangements.
- The practice had a chaperone policy which staff were fully aware of. A chaperone is a person who acts as a witness to safeguard patients and health care professionals during medical examinations and procedures. Signs were displayed within the practice to inform patients that chaperones were available. All staff carrying out this role had a disclosure and barring check (DBS) - checks to 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. Staff we spoke with on the inspection confirmed they had been trained and understood what they were expected to do.
- The practice premise was owned by a third party who carried out relevant health and safety checks. Regular fire drills were carried out by the landlord. There was a fire safety lead for the whole building who was employed by the landlord. In addition to this the practice had two fire wardens who received training updates annually.
- Staff we spoke with confirmed that they had the equipment they needed to meet patients' needs safely. Each clinical room was appropriately equipped.We saw evidence that the equipment was maintained. The last Portable appliance testing (PAT) – is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use had been carried out in January 2015. We saw evidence of calibration of equipment used by staff including blood

pressure monitors, scales and fridges. This was last carried out in October 2015. Legionella checks had been carried out by a third party. Legionella is a bacterium which can contaminate water systems in buildings.

- The practice was visibly clean and tidy. Patients we spoke with told us they were happy with the cleanliness of the practice. The nurse consultant was the lead for infection control. The practice clinical staff had received infection control training and all other staff had completed training including hand washing techniques. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. All staff had access to the infection control policy which was on all the computers. The practice was cleaned by an external agency. The cleaning staff had a cleaning schedule to follow to ensure all areas of the practice were cleaned as necessary. The cleaning equipment and products were kept securely.
- There was a sharps injury policy and staff knew what action to take if they accidentally injured themselves with a needle or other sharp medical device. The practice had written confirmation that all staff were protected against Hepatitis B. All instruments used for minor surgery were single use.
- We saw there were policies in place for the safe management of medicines, including emergency drugs and vaccines. Emergency drugs were stored securely in the treatment room and checked regularly by the nurse consultant and the healthcare assistant (HCA) in their absence.
- The practice had a system for repeat prescribing with patients receiving regular reviews and all repeat prescriptions were signed by a GP before being issued to a patient. However contrary to national guidance administrative staff were able to re-authorise a repeat prescription for a further month when a patient would otherwise run out of an important medication. The prescription would still be sent to the GP with the other authorised prescriptions for signing; however the risk was that a clinical decision to reauthorise the medication was being made by a member of the administrative staff. This was going to be changed immediately following the inspection so that only clinicians would make the decision to re-authorise prescriptions.
- We saw that appropriate recruitment checks were carried out. We saw the file of a new member of staff at the practice and saw that they had a DBS check in place, references were taken and checks carried out of their qualifications.
- The practice was actively recruiting for two practice nurses. The nurse consultant, who was employed via an agency, was able to carry out all these duties temporarily but there was pressure on them and the healthcare assistant. There was a rota system in place for other staffing groups to ensure that there was enough cover in place.

Arrangements to deal with emergencies and major incidents

The practice had a panic alert button for staff to use if they needed urgent help from other members of the team. All staff also had personal alarms. Staff were up to date with cardiopulmonary resuscitation (CPR) training and the practice had a system in place for monitoring when refresher training was due.

The practice had oxygen and an automated electronic defibrillator (AED – a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). During the inspection we noted that medicines which could be used in the event of a seizure were not present in the emergency box. The nurse consultant explained that she had forgotten to re-order this drug and was going to do so immediately.

Although the practice did not have a business continuity plan in place as the premises was owned by a third party, we saw during the inspection how they dealt with emergency situations. On the day of the inspection there were IT issues caused by the telephone provider. The practice worked well with another practice in the same building to ensure this did not impact on patients until it was resolved. During the inspection we highlighted the need for a business continuity plan. After the inspection the practice manager was going to ensure that contact details of all employees were kept off site so that they could be contacted in an emergency situation.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Our discussions with the GPs and the nurse consultant showed that they were aware of and worked to guidelines from the Clinical Commissioning Group (CCG) and the National Institute for Health and Care Excellence (NICE) about best practice in care and treatment. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment. Clinical staff had access to NICE guidelines on their computer systems and used these to ensure that their clinical decisions were in line with best practice.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF to monitor outcomes for patients. Current results were 90.5% of the total number of points available, with 4% exception reporting. Exception reporting relates to patients on a specific clinical register who can be excluded from individual QOF indicators. For example, if a patient is unsuitable for treatment, is newly registered with the practice or is newly diagnosed with a condition.

Data from 2014 to 2015 showed that the practice was below the CCG and national average for the following areas:

- Performance for diabetes related indicators was 65.1% which was below the CCG average by 25.3% and below the national average by 24.1%.
- The percentage of patients with hypertension having regular blood pressure tests was 96.2%, this was just below the CCG average by 2.9% and below the national average by 1.6%.

In order to improve the care for patients with diabetes one of the GP partners had completed the Warwick certificate in diabetes care. In the absence of a practice nurse this GP visited all housebound diabetic patients. The practice invited a consultant specialist to do a presentation at the practice followed by a virtual clinic to discuss different diabetic cases. As the practice benefited from the learning this now took place on a quarterly basis.

The practice was above the CCG and national average for the following areas:

- Performance for mental health related and hypertension related indicators was 86.2%. This was 0.4% above the CCG average and 4.7% above the national average.
- The dementia diagnosis rate was 100% which was above the CCG average by 2.6% and above the CCG average by 5.5%. The exception rate was 33%.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve patient care and treatment. There had been two clinical audits carried out in the last two years; one of these was a completed full cycle audit and the other one had not been re-audited.

The first completed audit was for medication prescribed for cholesterol. The audit related to the potential interaction of two drugs, one of which was a statin and this interaction which increased the risk of myopathy (muscle disease) was highlighted in a medicines alert. The audit identified patients listed as being prescribed both drugs and changes were subsequently made. The second audit was for atrial fibrillation (irregular heart rhythm) patients. This resulted in the practice contacting or inviting patients to make an appointment to see a GP to discuss the need and choice of anti-coagulant and led to a review of all patients with atrial fibrillation.

Effective staffing

The practice had an induction programme for all newly appointed staff. During the inspection we spoke with a member of staff who had recently joined the practice. They confirmed that they had completed training on topics such as infection control and safeguarding. They had been provided with role specific training about the practice's computer system. They were given the opportunity to shadow colleagues during their induction. They knew how to access all the practice policies and procedures.

The learning needs of staff were identified through annual appraisals and practice meetings. All staff we spoke with had an appraisal within the last 12 months. All staff had

protected time for learning and development. Staff attended learning events at the practice and days arranged by the CCG. We saw evidence of in house learning days that took place at the practice. One member of staff had begun administration duties at the start of her employment at the practice and now worked as a healthcare assistant. One of the GP partners was applying to become a GP trainer at the time of our inspection.

The practice participated in clinical research and one of the GP partners was taking part in three areas of research at the time of our inspection with the University of Birmingham. One was to look at whether a particular medication improved heart conditions. The second was to look at whether light therapy could help with a skin condition and the third was a study to see if a treatment could reduce the incidence of ulcer bleeding in patients who used aspirin.

The practice offered training to all staff on many topics including infection control, information governance, confidentiality, health and safety and customer service. The practice used an on-line training system which all staff had access to.

Coordinating patient care and information sharing

The practice had systems to provide staff with information they needed. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services. The GPs looked after patients who lived in two nearby care homes. Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred to, or after they were discharged from hospital. Information for out of hours GP services was provided for patients at the practice, on the website and on the out of hour's answerphone message. This service is provided by a GP Out of Hours Service called BADGER. OOH attendances from BADGER were updated to the practice's computer system on a daily basis. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated. Health visitors, district nurses and midwives attended the multi-disciplinary team meetings.

The practice had a register of patients with various long term conditions such as diabetes, asthma, heart disease, hypertension and chronic obstructive pulmonary disease (COPD). COPD is the name given for a collection of lung diseases, including chronic bronchitis and emphysema. All of these patients were invited for an annual examination carried out by GPs and the nurse consultant. Care plans were created for patients with a high risk of hospital admission such as those with COPD.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. 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 or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was monitored through records audits to ensure it met the practice's responsibilities within legislation and followed relevant national guidance.

Health promotion and prevention

The practice supported their patients to manage their health and well-being. The GPs, nurse consultant and HCA provided a range of health checks, smoking cessation, vaccination programmes, long term condition reviews and provided health promotion information to patients. Health promotion information as available on the practice's website and leaflets were accessible to patients in the waiting areas. The practice referred patients to Health Exchange which provided help for patients with weight control and diet.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 100% which was 3.1% above the CCG average and 2.4% above the national average. The exception reporting was 24.3% which was 13.1% above the CCG average and 18% above the national average.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example:

Good

Are services effective?

(for example, treatment is effective)

- Childhood immunisation rates for the vaccinations given to under two year olds ranged from 86% to 100% compared with the CCG average of 86% to 94%.
- Childhood immunisation rates for the vaccinations given to under five year olds ranged from 84% to 99% compared with the CCG average of 84% to 97%.
- Flu vaccination rates for the over 65s were 69% compared with the CCG average of 73%.
- Flu vaccination rates for the at risk groups were 50% compared with the CCG average of 52%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. Diabetic reviews were carried out by the long term locum GP who carried out insulin initiation.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During the inspection we observed that members of staff were professional and very helpful to patients both attending at the reception desk and on the telephone. We saw that people were treated with dignity and respect. Curtains were provided in the consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. This room was situated next to the reception desk so patients could use this discretely. Staff shared an example of a patient who was very distressed and grateful for the use of this facility. The practice took steps to ensure patients' cultural expectations were met when referring to different services, patients could also request to see the female locum GP.

33 out of the 34 patient CQC comment cards we received were positive about the service experienced. Patients referred to staff as being helpful and listening to them. Some patients we spoke with gave particularly positive accounts of the care and treatment they and their families received. They said that all their needs had been met and referred to staff as being superb. They felt involved in their care and were never rushed. We received one negative comment about the need for more nurses. This was a concern for the practice and they were actively recruiting for practice nurses at the time of our inspection. We spoke with two members of the patient participation group (PPG) on the day of our inspection. They also told us they were pleased with the care provided by the practice and felt very involved. They felt valued and respected by the practice team.

Results from the national GP patient survey published in July 2015, showed patients were happy with how they were treated and confirmed this was with compassion, dignity and respect. The practice was achieving higher than CCG and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 91.3% said the GP was good at listening to them compared to the CCG average of 87.6% and national average of 88.6%
- 90.6% said the GP gave them enough time compared to the CCG average of 85.1% and national average of 86.8%
- 95.4% said they had confidence and trust in the last GP they saw compared to the CCG average of 94.6% and national average of 95.3%
- 90.8% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 85.1%.
- 91.3% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 88.3% and national average of 90.4%.
- 85.1% patients said they found the receptionists at the practice helpful; this was the same as the CCG average and just below the national average of 86.9%.

We spoke with the managers of two local care homes where some of the practice's patients lived. One was an elderly care home and one was a residential home for patients with learning disabilities. The care managers at both homes spoke very highly of the GPs and receptionists at the practice. They said that the doctors were accessible and always responded to them. They both were able to contact the doctors in an emergency and obtain advice. They gave examples of how caring the doctors were and came and spent time with patients who were feeling lonely at holiday times such as Christmas. One of the GPs has been out to see patients as late as 9pm in the care home.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that their care and treatment was discussed with them and they felt involved in decision making. 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. Patient feedback on the comment cards we received was also positive.

Results from the national GP patient survey we reviewed showed patients responded quite positively to questions about their involvement in planning and making decisions about their care and treatment and results were slightly above local and national averages. For example:

Good

Are services caring?

- 89.3% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85.9% and national average of 86.3%
- 85.7% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81.6% and national average of 81.5%

During the inspection we saw evidence of good care plans for patients with dementia, learning disabilities and end of life.

Staff told us that translation services were available for patients who did not have English as a first language. Staff we spoke with said that most patients attended with family members. Most of the staff at the practice spoke additional languages including Arabic, Hindi, Urdu and Punjabi so were able to help with translating when required. We saw notices in the reception areas informing patients this service was available. Practice information leaflets were available in different languages.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice and rated it well in this area. Notices in the patient waiting room sign posted people to a number of support groups and organisations. Colleagues from the citizen's advice bureau attended the practice weekly to provide social advice to patients requiring this. There was also an in house counselling service available.

The practice had a register of carers. Carers known to the practice were coded on the computer system so that they could be identified and offered support. All carers were seen annually. 1% of the practice patient list were identified as carers.

Support was provided to patients during times of bereavement. Staff we spoke with recognised the importance of being sensitive to patients' wishes.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with Birmingham South and Central Clinical Commissioning Group (CCG) to plan services and to improve outcomes for patients in the area. The CCG commented that the practice engaged well with them.

Services were planned and delivered to take into account the needs of different patient groups and to help provide flexibility, choice and continuity of care. For example;

- A consultant gynaecologist (a specialist in women's health) attended the practice weekly so that patients could discuss their concerns with a specialist without needing to go to hospital. This included all family planning such as coil fitting.
- A pharmacist practitioner attended the practice weekly to provide medicines advice to the GPs.
- The practice had an in-house phlebotomy (blood taking) service.
- The practice had an in-house counsellor and drug worker to provide advice to patients in need.
- Colleagues from the citizen's advice bureau attended the practice weekly to provide social advice to patients.
- All patients over the age of 75 had a named GP.
- Patients with long-term conditions were reviewed annually. Twenty five percent of patients of the practice list had a long term condition. Patients with long term conditions had tailor-made care plans in place. These patients had alerts that flagged up in their records to enable priority access to GPs and the nurse consultant.
- The practice carried out a diabetic clinic every Friday morning.
- The practice had well established clinics for asthma and chronic obstructive pulmonary disease (COPD). COPD is the name given for a collection of lung diseases, including chronic bronchitis and emphysema.
- Baby clinics were held every Monday afternoon.
- The practice was signed up to the unplanned admissions enhanced service where patients with long term conditions were monitored closely by community staff and GP.
- The practice arranged for flu vaccines to be administered in the community for patients who found it difficult to go to the practice.

The practice also provided the following:

- There were longer appointments available for people with a learning disability.
- Appointments could be booked online.
- Home visits were available on request for older patients and patients who would benefit from these.
- The practice had a family friendly waiting room with wipe clean toys available for children to play with.
- The practice had a hearing loop and translation services for patients

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were available up to four weeks in advance; urgent appointments could be booked on the day if the patient called the practice between 8.30am and 9am. Appointments were available from 8.30am to 1.15pm and 3.30 to 6pm. The practice offers extended hours on Wednesdays until 7.30pm. The practice closed for one hour at lunch times and the doctors carried out their home visits during this time.

Results from the national GP patient survey published in July 2015 showed that patients' satisfaction with how they could access care and treatment was lower than the local and national averages. Most of the patients we spoke with on the day of the inspection said they were able to get appointments when they needed them. The survey results were:

- 65.8% of patients were satisfied with the practice's opening hours compared to the CCG average of 73.6% and national average of 75.7%.
- 48.7% of patients said they could get through easily to the surgery by phone compared to the CCG average of 72.3% and national average of 74.4%.
- 46.1% of patients described their experience of making an appointment as good compared to the CCG average of 70.6% and the national average of 73.8%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 42.8% of patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 57.2% and national average of 65.2%.

The practice was continually looking to improve and as a result of the survey results and input from the patient participation group (PPG) had extended appointments to 15 minutes instead of 10 minutes. PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The above figures did not reflect the CQC comment cards or the patients we spoke with on the day of the inspection The practice had recruited an extra receptionist to reduce telephone waiting times. The practice also changed the telephone provider so that patients could dial a local number instead of the previous number which incurred premium rates. A.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager handled all complaints at the practice.

We saw that information was available to help patients understand the complaints system on the website and leaflets were available which set out how to complain and what would happen to the complaint and the options available to the patient.

We looked at three complaints received in the last year and found these had been dealt with according to their policy and procedure. Complaints were discussed at practice meetings and lessons were learned from these. For example, one of the complaints resulted in an update at the practice meeting about services available to patients within the community to prevent delays.

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 clear vision and strategy to deliver high quality care to a diverse community of patients. The GPs at the practice believed firmly in offering continuity of care and many patients we spoke with had been patients at the practice for years. The practice valued each patient as an individual. The practice worked closely with Birmingham South and Central Clinical Commissioning Group (CCG) to respond to the needs of the patients. One of the GPs had been an active member of the CCG for many years. All staff we spoke with were proud to be working at the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity.

- There was a clear leadership structure with named GPs in lead roles such as safeguarding and diabetes. Staff we spoke with told us there was an open door policy and they felt valued and supported.
- There were robust arrangements for identifying, recording and managing risk. For example there was a high prevalence of diabetes so the practice ran a diabetes clinic and offered pre diabetes advice to patients.
- The practice had a programme of continuous clinical and internal audit which was used to monitor quality and make improvements. For example, the practice had recently carried out an audit in the usage of a particular inhaler. This resulted in a reduction in the usage of the inhaler as recommended by national guidelines.
- The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing better than national standards. QOF was regularly discussed at practice meetings.

Leadership, openness and transparency

Meetings were held regularly and minutes kept and circulated to the team. Once a month the practice closed for teaching and this was advertised on the website and in the practice so that patients were aware. Staff told us there was an open culture and they were happy to raise issues at practice meetings. The partners were visible in the practice and staff told us they would take the time to listen to them. Staff we spoke with described the partners at the practice as caring and felt they always had time for them.

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

The importance of patient feedback was recognised and there was an active patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We met with a member of the PPG during the inspection. The PPG had seven members and met quarterly. The PPG were trying to recruit new members.

The practice listened to the recommendations of the PPG to make improvements to the service. For example in order to improve access the PPG made a number of recommendations which the practice implemented. The improvements included:

- The introduction of 15 minute appointments
- Online appointments

A local number for patients to call to make appointments

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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