Schoolacre Road Surgery

Quality Report

2 Schoolacre Road
Shard End
Birmingham
B34 6RB
Tel: 0121 747 2911
Website: www.schoolacresurgery.nhs.uk

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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 a comprehensive inspection of Schoolacre Road Surgery also known as Schoolacre Surgery on 5 February 2015.

We have rated each section of our findings for each key area. We found that the practice provided a safe, effective, caring, responsive and well led service for the population it served. We rated the practice as good overall.

Our key findings were as follows:

- There were systems in place to maintain the health and safety of the practice.
- The practice had effective procedures in place that ensured care and treatment was delivered in line with appropriate standards. The practice was proactive in promoting good health.
- Patients were treated with dignity and respect. Patients spoke very positively of their experiences and of the care and treatment provided by staff.
- The practice provided services that reflected the needs of the patients. There were dedicated areas in the waiting room that offered information about support systems and groups.
- We found that the service was well led with well-established leadership roles and responsibilities with clear lines of accountability.

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

The practice should:

- Record all incidents and share learning with all staff members.
- Confirm if legionella risk assessment had been conducted by the landlord of the building.
- Ensure staff members are aware of the lead(s) for safeguarding in the practice.
- The practice should consider conducting criminal record checks for existing clinical staff and those that carry out the role of a chaperone.

Professor Steve Field CBE FRCP FFPH FRCGP

Summary of findings

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The service is rated as good for safe. The services had a good track record for safety and there was effective recording and analysis of significant events to prevent unnecessary recurrences. There were safeguarding measures in place to help protect children and vulnerable adults.

Staff were suitably qualified, trained and competent to carry out their roles and a system was in place to enable sufficient staff numbers to meet service requirements. Equipment required to manage foreseeable emergencies was available and was regularly serviced and maintained.

Are services effective?

Good

The service is rated good for effective. Treatment was delivered in line with both the National Institution for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. Clinical audits were carried out and changes made to ensure patient care was appropriate for their needs. The findings from some audits resulted in changes to patients' prescribed medicines. There was evidence of multi-disciplinary working and the practice had developed a proactive system for ensuring patients received co-ordinated care.

Are services caring?

Good

The service is rated good for caring. We found and patients told us that practice staff were caring and helpful. Patients we spoke with told us they were satisfied with their care and they had confidence in the decisions made by clinical staff. The comment cards patients had completed prior to our inspection provided positive opinions about staff, their approach and the care provided to them. We observed that staff knew the patients well, interacted with them in a polite and helpful way and greeted patients in a friendly manner. The practice did not have a Patient Participation Group (PPG). A PPG can act as representatives for patients in assisting the practice staff in driving improvements to the services that patients received. However, we saw they were in the process of developing a PPG and a meeting had been scheduled.

Are services responsive to people's needs?

Good

The service is rated as good for responsive to the needs of people. The practice delivered core services to meet the needs of the main patient population they treated. Patients had access to screening services to detect and monitor certain long term conditions. There

were immunisation clinics for babies and children. If patients were unable to attend the practice a home visit from the practice nurse could be arranged. The practice had a system in place to respond to complaints and concerns.	
Are services well-led? The service is rated as good for well led. Patients were cared for by staff who were aware of their roles and responsibilities for managing risk and improving quality. There were clear governance structures and processes in place to keep staff informed and engaged in practice matters. There was evidence of improvements made as a result of audits and feedback from patients. We found that all staff were encouraged and involved with suggesting and implementing on-going improvements that benefitted patients.	**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

Good

Patients aged over the age of 75 years had been informed of their named and accountable GP. All older patients had annual health checks and where necessary, care, treatment and support arrangements were implemented. GPs provided care to patients registered with the practice who resided in care homes. The practice offered proactive, personalised care to meet the needs of older people and had a range of enhanced services. The practice was responsive to the needs of older people, including offering rapid access appointments or home visits for those with enhanced needs.

People with long term conditions

Good

Practice staff recognised the long term condition needs of its practice populations. They held a register of patients who had long term conditions and carried out regular reviews. There were arrangements to review patients in their own home if they were unable to attend the practice. Patients on repeat prescriptions were reviewed to assess their progress and to ensure that their medicines remained relevant to their health need. GP's worked with other relevant healthcare professionals to deliver a multidisciplinary package of care. Only same day and urgent appointments were available with a GP. However, patients with long term conditions were able to book with the nurse and healthcare assistant in advance for regular reviews of their conditions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Appointments were available outside of school hours and the premises were suitable for children and babies. Practice staff liaised with local health visitors to offer a full health surveillance programme for children. Checks were also made to ensure maximum uptake of childhood immunisations. The clinical team offered immunisations to children in line with the national immunisation programme. A noticeboard in the reception area displayed information relevant to this population group including details of measles and vaccinations that were available. All consultation rooms were on the ground floor which made the practice accessible for pushchairs. There were policies, procedures and contact numbers to support and guide staff should they have any safeguarding concerns about children.

Summary of findings

Working age people (including those recently retired and students) The practice is rated as good for working age people (including those recently retired and students). Young adults had access to sexual health services and information, including lifestyle advice on healthy living. Information advertised on the practice notice board was relevant to this population group including the free condom service. Other information leaflets and posters in the patient waiting area and on the practice website were available. These drew people's attention to other support groups and organisations as well as providing information about self-management of minor illnesses. The practice nurse provided lifestyle advice and smoking cessation clinics. The practice offered extended opening hours to assist this patient group in accessing the practice. NHS health checks were available for people aged between 40 - 74 years. The practice offered a range of health promotion and screening services which reflected the needs for this age group.	Good
People whose circumstances may make them vulnerable The practice was rated as good for the care of people whose circumstances may make them vulnerable. Practice staff had identified patients with learning disabilities and treated them appropriately. Practice staff regularly worked with multi-disciplinary teams in the case management of vulnerable people. All patients within this group had received annual health checks. GPs carried out regular home visits to patients who were housebound and to other patients on the day that had required it. The practice nurse and the healthcare assistant also visited patients for regular reviews if required. The practice had access to interpreting service for patients whose first language was not English and the practice website could be read in many other languages.	Good
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). Care was tailored to patients' individual needs and circumstances including their physical health needs. The practice offered health checks to patients on the mental health register. Practice staff worked in conjunction with the local mental health team to ensure patients had the support they needed. Both GPs had attended training in the Mental Capacity Act 2005 to ensure all care provided was in patient's best interests.	Good

Summary of findings

What people who use the service say

We spoke with four patients during our inspection. Most of the patients we spoke with had been registered with the practice for many years. They informed us that staff were polite, helpful and knowledgeable about their needs. Patients told us they were given enough explanations so they understood about their health status. They told us they were encouraged to make decisions about their care and treatment. All the patients we spoke with gave us positive feedback about the standards of care they received. Patients told us it was easy to obtain repeat prescriptions and book appointments.

As part of the inspection we sent the practice comment cards so that patients had the opportunity to give us feedback. We collected 33 patient comment cards on the day of the inspection. Positive feedback was given by those patients who had made written comments. They included comments on standards of care, access to appointments and friendliness of staff.

We looked at results of the latest (January 2015) national GP patient survey. Out of the 325 surveys, 107 were completed and returned. Findings of the survey were compared to the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is a group of General Practices that work together to plan and design local health services in England.

The results of the national survey were above average. For example, 100% of respondents had confidence and trust in the last GP and nurse they saw or spoke to compared tothe local average of 97% and 95% respectively. 92% of respondents described their experience of making an appointment as good compared to the CCG average of 62%. Also, 96% of respondents would recommend this surgery to someone new to the area. This was also above the CCG average.

The practice did not have a Patient Participation Group (PPG) but was in the process of setting one up. PPGs are groups of patients registered with a practice who work with the practice to improve services and the quality of care. However, the practice conducted patient surveys and took on board other comments received through the comments box. Survey feedback revealed that patients were generally positive about the service.

Areas for improvement

Action the service SHOULD take to improve

- Record all incidents and share learning with all staff members.
- Confirm if legionella risk assessment had been conducted by the landlord of the building.
- Ensure staff members are aware of the lead(s) for safeguarding in the practice.
- The practice should consider conducting criminal record checks for existing clinical staff and those that carry out the role of a chaperone.

Outstanding practice

Schoolacre Road Surgery

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 Schoolacre Road Surgery

Schoolacre Road Surgery also known as Schoolacre Surgery is a registered provider of primary medical services with the Care Quality Commission (CQC). The surgery is located at 2 Schoolacre Road, Birmingham B34 6RB. The surgery serves a population of approximately 3000 patients. The practice is open Monday to Friday 8am to 6:30pm. The practice provides extended hours on a Tuesday from 5:30pm to 7:30pm. The practice has opted out of providing out-of-hours services to their own patients. This is provided by an external out of hours service, Birmingham And District GP Emergency Rooms).

There are two GP partners (both female), a nurse prescriber, a healthcare assistant, a practice manager and a team of reception staff.

The practice takes on final year medical students for teaching purposes.

CQC has not received any information of concern about this practice.

Why we carried out this inspection

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

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people

Detailed findings

- 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)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 5 February 2015. During our inspection we spoke with a range of staff including two GPs, the nurse prescriber, the practice manager and three receptionists. We also spoke with four patients who used the service and received 33 comment cards from patients. We observed how patients were being cared for and staff interactions with them. Where necessary we looked at personal care and treatment records of patients. Relevant documentation was also checked.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. We saw that an audit was carried out as a result of a drug safety update with appropriate actions taken.

We saw that the practice had a system to review significant events annually. We saw there were three significant events that were recorded for 2012 and 13 which were discussed at the team meeting and learning shared where appropriate. A GP partner showed us an incident they had reported using an electronic system in the practice recently. From our discussion with the practice manager we were given example of an incident that they had responded to recently but had not documented this. Although there was inconsistency in the recording of some incidents the practice could demonstrate a safe track record over time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw that the practice had recorded three significant events for 2012 and13 and they were reviewed annually for any trends or themes. We saw minutes of meetings where significant events were discussed with some staff and learning shared. We saw one of the significant events recorded related to a patient who was diagnosed with cancer. The purpose of raising this as a significant event was to understand if the patient could have been diagnosed earlier by reviewing their notes.

We spoke with one of the GP partners who told us that significant events were recorded on an electronic system available commercially. This is a type of patient safety software for healthcare risk management, incident and adverse event reporting. One of the GP partner told us that any incidents reported on this system would be received by the Clinical Commissioning Group (CCG) who could use the system to analyse any trends. CCGs are groups of General Practices that work together to plan and design local health services in England. A GP partner we spoke with gave us an example of an incident they had reported using this system in the previous week. This involved a patient registered with the practice who had been admitted into hospital. The patient's family raised some concerns regarding their experience at the hospital with the GP. The GP raised this as a concern with the CCG so that other patients did not have the same experience. The GP partner told us that they had received a response via the electronic system from the CCG that this would be looked into.

Although a system was in place for reporting, recording and monitoring significant events they were usually clinical events. We spoke with the practice manager who told us that other incidents such as slips, trips or falls or violent and aggressive behaviour by patients were not recorded but were always actioned and learning discussed where relevant. The practice manager told us about a recent example that they had dealt with but had not recorded the event. The practice manager told us that this was sensitive information that could not be shared with other staff. However, there was scope to share learning without discussing the details of the incident as this could be relevant to other staff. The practice manager recognised this during out discussion and agreed to share this with staff. We also saw evidence of a significant event recorded in December 2013 where administration staff were not involved in any discussion and learning. This involved the loss of power supply to the practice and the resultant loss and disposal of vaccines that were stored in the fridges.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Staff members we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies. We saw a folder in the reception area for staff with relevant information and contact details so that they were easily accessible.

The practice manager and other staff we spoke with told us that one of the GP partners was dedicated as a lead in safeguarding vulnerable adults and children. They could demonstrate they had the necessary training to enable them to fulfil this role. One of the GP partners we spoke with told us that they both worked part time and shared this role of safeguarding lead. However, staff we spoke with told us that one of the GP partners was the lead, the arrangements therefore weren't clear to all.

Good

Are services safe?

There was a chaperone policy available and we saw notices visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff we spoke with told us that they did not act as chaperones but had been trained. A GP partner we spoke with told us that if a chaperone was not available then patients would be asked to attend another day.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There were two designated staff members responsible for ensuring medicines were kept at the required temperatures. One of the staff members we spoke with showed us guidance they were following to ensure medicines were being kept at required temperatures; this was in the nurses 'green book'. However, we saw that the guidance was not being followed completely. We saw that daily temperatures were being recorded.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Staff also used a rotation process so the most recently received medicines were used last. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were kept securely in a safe.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. The practice had a contract with an external cleaning company. We saw there were cleaning schedules in place detailing areas that needed to be cleaned daily, weekly and monthly. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

There was an infection control policy which stated that the practice nurse was the lead in this area. We spoke with the nurse prescriber who told they usually carried out spot checks to ensure cleaners were following schedules and to ensure sharps boxes were labelled appropriately and were not full.

We saw that the CCG had conducted an infection control audit in March 2014. We saw that the practice had acted on findings and made changes where appropriate. We saw that the audit recognised the need to only have children's toys that could be wiped clean in the reception area. We saw there was only toys that could be wiped clean so that they did not represented an infection control risk. All other toys had been removed.

The practice did not own the building and it wasn't clear if a risk assessment for Legionella had been carried out by the land lord. A Legionella risk assessment is a report by a competent person giving details as to how to reduce the risk of the legionella bacterium (that can grow in contaminated water and can cause harm) spreading through water and other systems in the work place. The practice manager informed us that they will follow this up with the landlord so that any actions identified from a Legionella risk assessment could be implemented.

Equipment

We saw that a contract was in place with Good Hope Hospital to carry out annual maintenance and calibration of equipment such as weighing scales, spirometers and blood pressure measuring devices. We saw equipment maintenance logs and other records that confirmed equipment was maintained. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date.

Staffing and recruitment

Most of the staff working at the practice had been employed for a very long time and the current rules regarding recruitment checks were not applicable at the time of recruitment. We looked at three staff files and saw that proof of identification, references and qualifications were checked at the time of recruitment. However, criminal records checks for nursing staff through the Disclosure and Barring Service (DBS) had not been carried out. DBS checks help 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. The practice manager showed us risk assessments that they had conducted. We saw that the risk assessment had taken account of the fact that staff had worked at the practice for a long time and staff were well

Good

Are services safe?

known to them and no issues had been raised by other staff or patients. The practice manager told us if they were to recruit any new staff members would carry out a DBS check.

One of the staff files we looked at was that of the nurse prescriber. We did not see their current registration status in the staff file with the Nursing and Midwifery council (NMC). The NMC is the body holding the licenses for all nurses and midwives. The practice manager had not updated the records but both the practice manager and nurse prescriber assured us of the registration status. After the inspection we were sent confirmation that the nurse prescriber was registered with the NMC.

We spoke with reception staff regarding the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. One staff member told us that most of them worked part time and there was always capacity to cover unplanned absences. We were told that one staff member was on sick leave on the day of the inspection. The practice manager gave staff members the option to work extra to cover the absence. If they were unable then agency staff would be used. The staff member told us that they were looking to increase the number of hours they worked and would always have capacity to cover unplanned absence.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included a fire risk assessment that was carried out in January 2014 by external professionals. Actions identified in the risk assessment were followed up. For example, all staff were given online fire training and fire evacuation procedures were displayed in the surgery. Annual checks were in place for lighting and smoke detectors as well as health and safety checks of the building. Monthly checks for medicines management, dealing with emergencies and equipment were also in place.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency medicines and equipment were available including access to oxygen and an automated external defibrillator (AED). An AED is 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. We saw emergency medicines and equipment were kept in the consultation room used by the nurse prescriber. A notice on the door stated that they were kept there and all staff members we asked knew the location. Records we looked at confirmed that it was checked regularly.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. However, when we spoke staff members they were not aware of the plan. The practice manager showed us a plan and told us that this would be discussed in staff meetings to ensure they were aware.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff we spoke with told us they were aware of current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The practice nurse prescriber led on long term conditions such as asthma and diabetes. They described how they followed local CCG guidance, NICE guidance and QOF guidance to help them effectively manage patients with long term conditions.

The practice was aware of the number of patients who had needs in regards to learning disability, dementia, mental health and palliative care. Patients' needs were discussed and where appropriate reviewed. For example, we saw quarterly meetings were held for patients on the palliative care register.

We saw evidence that both GP partners had attended Mental Capacity Act (MCA) 2005 training. The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

The practice had identified patients with complex needs who required multidisciplinary care planning. We saw examples of care plans for patients identified as having complex needs in order to support these in the primary care setting.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. For example, reception staff contacted patients who needed reviews of their medicines or long term conditions such as diabetes. The GPs conducted medicine reviews and the nurse prescriber ran chronic disease clinics.

The practice manager showed us examples of clinical audits that had been undertaken during the last 12 months. This included an audit on a medicine shown to have an increased risk of side effects for patients in one of the population groups. We saw that the practice had conducted a search and advised appropriate patients of the risks related to regular use of the medicine. This was conducted in May 2014. Another search was conducted in December 2014 and found that only one patient was taking this medicine. However, the practice determined that this patient's risk for not taking the medicine was far greater than the risks of the side effects from the medicine. This demonstrated that improvements had been achieved to patient outcomes as a result of this audit. Other audits included non-attenders for cervical screening tests. Audits were also available for inadequate screening tests. We saw that 206 cervical screening tests were carried out between April 2013 and March 2014. We saw that there were six tests that were identified as inadequate and the practice sent patients communication to make further appointments.

The practice also used the information collected for the Quality Of Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually. For example, the practice had lists of patients that had learning disabilities, dementia, as well as patients with mental health issues. We saw that patients were being reviewed where appropriate. We saw that the practice had a list of 20 patients with a mental health issue and 14 had of them had been reviewed and others were planned.

There were systems in place to ensure patients who received repeat prescriptions were reviewed by a GP. There was a designated staff member responsible for repeat prescriptions and if there was a concern the GP would be informed to undertake a review. Reception staff could not issue prescriptions if the patients review date was due. Patients we spoke with told us that they received regular checks of their medicines and health.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. We were informed by the CCG that the practice had passed Aspiring to Clinical Excellence (ACE) foundation and was moving onto ACE Excellence. ACE is a programme offered to all Birmingham Cross City CCG practices. The ACE

programme aligns to the strategic objectives of the CCG and the NHS Outcomes Framework indicators, aiming to make improvements where the CCG has been identified as performing below national/local benchmarks.

Effective staffing

Practice staffing consisted of a range of medical, nursing and administrative staff. Staff told us that the practice was supportive in providing both mandatory training such as basic life support and other training in order to improve the service provided. We saw that the nurse was trained as a nurse prescriber which gave them a wider scope of practice. The practice also had a healthcare assistant (HCA). They had been trained to undertake tasks such as wound care and dressings, ear check and irrigation and dietary advice / weight management.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Staff members we spoke with told us that the practice manager had a system of undertaking appraisals on or near staff birthdays to ensure it was done annually. The GPs undertook appraisal of the nursing staff and the practice manager. Staff members we spoke with told us that they were encouraged to undertake training and told us that they had undertaken many eLearning courses including fire training.

There was a staff handbook with all policies and procedures including confidentiality statements. Staff files we looked at contained handbooks given to staff.

One of the GP records we looked at showed that they had a certificate in the management of alcohol problems in primary care. One of the GP partners told us that the practice was located in a deprived area and there were issues of alcohol abuse among the patient population. Such additional training helped in this area to help meet the need of patients.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, x-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically, by post and fax.

We saw evidence where discharge letters were received, they were reviewed and appropriate action was taken. Patients that had an unplanned admission to the hospital were reviewed within three days of discharge from hospital. If abnormal test results were received patients were contacted and appointments were offered based on the degree of the abnormality. For example, emergency appointments were offered to patients with very abnormal results.

The practice held quarterly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by district nurses, community matrons and palliative care nurses. The practice also worked with a prescribing support pharmacist from the CCG who visited the practice weekly to review prescribing patterns and provide advice around medicines. We saw an audit that was carried out by the practice which was supported by the pharmacist.

The practice also held unplanned hospital admissions meetings attended by the community matron. One of the partners and the practice manager also attended local clinical network meetings held monthly. This was a network of 21 practices meeting to discuss and implement CCG plans based on local needs.

A GP partner we spoke with told us that they worked closely with another local practice by sharing resources. We were told that the practice had one nurse prescriber and one HCA. If they were away on leave cover arrangements were made to ensured needs of patients were being met.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record system was used by all staff to coordinate, document and manage patients' care. All staff were trained to use the system and told us they found it easy to use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. The practice made referrals directly and through the Choose and Book system. (Choose and Book is a national

Good

Are services effective?

(for example, treatment is effective)

electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff showed us how they used the system and told us that this system was easy to use.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act (2005) and the Children's and Families Act 2014 and their duties in fulfilling it. This legislation governs decision making when people at certain points in their lives may not have the capacity to make decisions affecting them. Both GP partners had undertaken Mental Capacity Act training.

The practice was registered with the Care Quality Commission (CQC) to carry out minor surgical procedures such as skin excisions and joint injections. However, the practice only carried out joint injections. We saw an audit on the accuracy of joint injections and no concerns were identified.

We reviewed care plans that were in place for patients with learning disabilities and dementia which showed how patients had been involved in decisions about their care. These care plans were reviewed annually.

Health promotion and prevention

The practice attended monthly clinical network meetings attended by 21 other practices to discuss CCG plans and local priorities.

It was practice policy to offer a health check with the HCA to all new patients registering with the practice. There was a protocol in place that was followed and this was developed by the CCG. The GP was informed of all health concerns detected and these were followed up in a timely way. The HCA also offered other services such as smoking cessation clinics and lifestyle advice. There were also nurse led clinics for long term conditions. Other clinics included ante-natal and warfarin clinics.

The practice had a wide range of health promotion leaflets and self-help guides in the surgery and on their website. The practice offered health checks to those patients aged between 40 - 74 years. These were led by the HCA and enabled the practice to identify any early indications of disease or health problems.

The practice also had six well laid out health promotion notice boards in the waiting area informing patients of other services such as mental health and sexual health that was available to them. The notice boards were generally specific to patient groups. For example, there was a notice board for women's health and another notice board for families and young people. Various health promotion leaflets were also available in the waiting area. For example, there was information displayed on the symptoms of asthma and advised patients to make appointment with the nurse if they identified some of the symptoms. The practice was proactive in promoting health and health screening services. We saw data which showed that the practice had carried out 206 cervical smear tests which was an uptake of 100%. This was above the 80% QOF target.

The practice offered childhood immunisations and flu vaccines. Patients were asked to make an appointment with the practice nurse prescriber for travel vaccinations and baby immunisation and check-ups were available with a GP.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent national GP patient survey most for the practice as well as speaking with four patients on the day of our inspection on patient satisfaction. Data from the national patient survey showed that the practice performed above average in all areas. For example, 96% of patients stated that they would recommend this surgery to someone new to the area. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 100% of respondents stating that they had confidence and trust in the last GP and nurse they saw or spoke with. 92% of respondents also described their experience of making an appointment as good which was better than local average of 68%. All the patients we spoke with were positive about their experience at surgery.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 33 completed cards and all were positive about the service experienced. Many of the patients stated that they had been patients for a very long time felt the practice always offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with four patients on the day of our inspection. All of the patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We saw all consultations and treatments were carried out in the privacy of a consultation room. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to maintain patient confidentiality when discussing patient information. The reception area was separated from the main waiting area and glass partitions helped reduce the risk of telephone and other conversations from being overheard. None of the patient feedback we received raised confidentiality at the practice as a concern. Reception staff we spoke with told us that they would use a spare room for confidential discussions if needed.

Care planning and involvement in decisions about care and treatment

The national GP patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. In total, 325 surveys were sent out with107 being completed and returned representing a completion rate of 33%. Patients generally rated the practice well in these areas. For example, data from the national GP patient survey showed 100% of respondants said the last GP they saw or spoke to was good at listening to them and 97% of respondants stated that the last GP they saw or spoke to was good at involving them in decisions about their care. While 99% stated that the last GP they saw or spoke to was good at explaining tests and treatments to them. Patients we spoke with were equally positive about the service and staff.

Feedback we received from patients during our inspection and through the comment cards told us that patients felt listened to and involved in decisions about their care and treatment. They also told us that information was given to them in a way they could understand so that they could make informed decisions. We saw evidence from care plans that patients were involved in decisions about their care.

The practice had conducted their own satisfaction survey and some of the comments made by patients showed that patients were given time during consultations and were listened to about their care and treatment.

Staff told us that translation services were available for patients who did not have English as a first language. Staff also told us they had the facility for patients with hearing difficulty to book appointments using text messages. Staff told us that this service was used by a patient registered with the practice.

Patient/carer support to cope emotionally with care and treatment

There were six notice boards in the waiting area of the practice with information about various other services available. One of the notice boards was dedicated to a new initiative called Complete Care. This was for adults aged 65 and above and led by Birmingham Community Healthcare NHS Trust (BCHC). The purpose of this initiative was to help reduce avoidable hospital admissions and link individuals into additional health and wellbeing services across the locality. We saw various services that were clearly

Good

Are services caring?

advertised to patients on the notice board. The GPs identified frail and elderly individuals who could benefit from more joined-up care and become better connected to the wide range of wellbeing services provided locally.

Other notice boards in the reception area had dedicated sections that provided information, advice and details of other services. It included details of services that could be requested. For example, chiropody, eye sight checks and a carers emergency response service.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. There was information for carers to ensure they understood the various avenues of support available to them.

Staff and the GP partners we spoke with told us that the practice did not provide direct support to families who had suffered bereavement. However, they contacted the family where necessary and provided information about other agencies that could help.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the nurse prescriber visited patients at their home if they were unable to attend the practice. This ensured any patients with long term conditions were reviewed and followed up where appropriate. The HCA would also visit patients such as those with diabetes at their home if they were unable to attend the practice. This enabled patients with diabetes to have their blood sugar levels reviewed appropriately.

The practice worked collaboratively with other services and professionals to ensure key patient information was shared. For example, the practice had implemented the gold standard framework (GSF) for patients with end of life care needs. Patients on the practice's palliative care register were discussed at regular multidisciplinary meetings.

We saw that the practice had referred a patient for help and support with their addiction to prescription drugs. This was raised as an incident after notification from a local pharmacy where the concern was raised.

There was a low turnover of staff at the practice which enabled a good continuity of care.

Longer appointments were available for patients who needed them and appointments were available at times that were more accommodating to patients who worked or were at school during the day.

The appointment system had been changed recently which meant that advanced appointments with the GPs were not routinely offered. We were told that the appointment system was changed due to high number of patients that were making appointments but were not then attending (DNAs). The practice managed to decrease the number of DNAs which meant that more appointments were available for patients on the day.

The practice was in the process of setting up a Patient Participation Group (PPG) and had scheduled a meeting for March 2015. PPGs are made of a group of patients registered with a practice who work with the practice to improve services and the quality of care. However, we saw that the practice invited feedback through a comments box. Staff told us that patients would provide feedback verbally to the staff and the practice manager. We were told that extended opening hours were introduced as a result of feedback from patients and their carers.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, patients registered as housebound could ask for home visits from the GPs as well as other clinical staff. The nurse visited patients at home for regular reviews. The HCA also visited patients at home to collect blood samples from patients with for example diabetes so that their condition could be monitored. GPs also provided care to patients registered with the practice who resided in a care home.

Vulnerable patients such as travellers or those without a fixed abode were able to see a GP. Reception staff showed us a form they used to register people temporarily so that they received the care they needed.

The practice had access to online and telephone translation services as well as a text message service for patients who had difficulty with their hearing.

All the consultation rooms were situated on the ground floor of the building which made access easier to patients who had difficulty with their mobility as well as parents with pushchairs.

Access to the service

Appointments were available from 9am to 12pm and 3.30pm to 5.30pm on a Monday.

Appointments were available until 6pm on a Thursday and Friday. The surgery also had extended opening hours on a Tuesday from 6.30pm to 7.30pm. The surgery was closed on a Wednesday afternoon when the out-of-hours service was available from an external provider.

The appointment system had been changed recently which meant that advanced appointments with the GPs were not routinely offered. We were told that the appointment system was changed due to high number of patients that were making appointments but were not then attending (DNAs). We were shown an audit which showed 127 DNAs for period the between 1 October 2013 to 27 January 2014. Another audit showed that this had come down to 65 DNAs

Good

Are services responsive to people's needs?

(for example, to feedback?)

for the same period the following year after the change in the appointment booking system. Also, staff members told us that this was only with the GPs and appointments for regular reviews, for example long term conditions were available with the nurse and HCA. We saw that the practice had conducted a survey to understand if patients were happy with this new system. Most patients were generally happy with the new system but some commented on not having the flexibility of being able to make advanced appointments. This was also reflected in couple of the comments cards we had received.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. For example, the website informed patients to call before 11am to arrange a home visit and that they could only have a home visit if they were too ill to visit the practice or were housebound.

There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients. The practice website provided details of the out-of-hours provider and their contact details. The website also had details of the nearest walk centre as well as NHS 111.

Patients we spoke with and the comments cards we received showed that they were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. One patient we spoke with told us that the practice had met their needs during their pregnancy and could get an appointment on the same day on most occasions.

Listening and learning from concerns and complaints

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

We saw that a complaints leaflet was available to help patients understand the complaints system. Reception staff we spoke with told us that if a patient wanted to complain they would also hand out the complaints leaflet and explain the process to them. Patients we spoke with did not have a reason to complain but told us that they would not hesitate to discuss this with the practice manager or other staff.

We saw that there was one complaint that was currently being dealt with. This was received through NHS England and the practice had responded to the complaint, though investigations were still ongoing before final resolution.

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 provider had sent us a statement of purpose before our inspection which laid out the practices aims and objectives. One of the objectives was to provide a high standard of primary care treatment to the patient population. We saw that this was being done where possible through following appropriate guidance. Another aim of the practice was to be courteous, approachable, friendly and accommodating to patients. Our observations and discussions with staff members showed that staff displayed these aims.

We spoke with the practice manager about the plans for future development of the practice. The practice manager told us that there had been an underinvestment in the building previously. However, they were now intending to develop the practice further. We were told that the treatment rooms and the exterior of the building were refurbished recently. The plan next was to develop the reception area by changing the layout and the reception desk and changing the flooring from carpet to vinyl flooring. The practice manager told us that this would allow for better privacy at reception desk and ease of cleaning of the floors. The practice manager showed us a quote for the work they had obtained from a contractor that confirmed this.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. Staff members we spoke with were able to demonstrate to us how they accessed these polices on the computer system. All the polices we looked at had been reviewed regularly and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, the two partners were responsible for making major decisions regarding the practice. The practice manager was responsible for the day to day running of the practice. There was no deputy practice manager and the GP partners took on the responsibility of the practice manager when they were away on leave. There were specific identified lead roles for areas such as infection control, complaints and medicines management. Responsibilities were shared among GPs, the practice manager and the nurse prescriber.

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

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We saw that the practice had done an audit in response to NICE guidance for diabetes. It identified four patients that could benefit from another medicine recommended by NICE. Other audits included smear non-attenders as well as other medicine audits.

Leadership, openness and transparency

We saw regular team meetings were held. We saw minutes of meetings where various aspects of the practice were discussed such as unplanned admissions and QOF achievements. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Reception staff members we spoke with told us that they are asked on how the practice could be improved. They told us they were consulted to give feedback on the proposed changes to the reception desk and the reception area. Reception staff told us that they were kept in the ‘loop’ and we saw a communications book in the reception area so that they could update other staff on the day’s events. This was useful as many reception staff worked part time.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies including safeguarding, chaperone and complaints policy which were in place to support staff. We looked at three staff files and saw that they were provided a ‘staff handbook’ with relevant policies and procedures.

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

The practice did not have a PPG, but we saw that the practice was in the process of setting one up. We saw a notice in the reception area asking any patients interested becoming a member of the group to attend the first meeting scheduled for March 2015.

Are services well-led?

Good

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

The practice had a comments box and had gathered feedback to improve their service. Staff told us that they had received comments from carers for evening surgery appointments and this had been implemented. Staff also told us that they had received many positive comments and we saw many thank you cards that they had received regarding the service.

The practice manager told us that most of the patients had been registered with the surgery for a long time and would feedback any issues verbally. The practice manager told us they had received feedback from patients asking for more chairs with arms and they were looking to implement this. However, they were looking to renovate the reception area and had not decided on a colour scheme. Once they had finished in consultation with staff and appropriate contractors they would be purchasing the chairs.

We saw the practice had done a survey three months after altering the appointment system to book on the day only. This showed that most patients approved of the change to the appointment system. However, some patients had also commented that the appointment system was not as flexible. The practice manager told us that most patients found this useful as they had better access to the GPs and routine appointments with a nurse prescriber was available to book in advance. Therefore, there were currently were no plans change this.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Staff demonstrated to us how they accessed the policy on the computer system.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through regular training. We looked at three staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of any training needs.

The practice carried out clinical audits and we saw changes to patient's treatment were initiated as a result of audit findings.

The practice was a teaching practice and took on final year medical students from the University of Birmingham.

The practice had completed reviews of significant events and other incidents. However, it did not always share this with other administrative staff.