Bosworth Medical Centre

Quality Report

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

Ratings

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

Key findings

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Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. (Previous inspection 10 April 2015 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Requires improvement

Are services well-led? - Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) - Good

We carried out an announced comprehensive inspection Bosworth Medical Centre on 21 February 2018 as part of our inspection programme.

At this inspection we found:

- The practice had comprehensive systems to manage risk so that safety incidents were less likely to happen. We saw that when incidents did happen, the practice learned from them and improved their processes and that learning was shared with staff throughout the practice.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment were delivered according to evidence based guidelines.
- Patients reported that GPs and nurses treated patients with compassion, kindness, dignity and respect and involved them in decisions about their care.
- Most patients we spoke with expressed difficulty in gaining access to the practice by telephone, but reported that when they did they were able to get an appointment. Older patients and those who were vulnerable were provided with a specific number to gain immediate access if they needed to speak with a GP.
- The GPs were committed to improving patient outcomes and demonstrated a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider **should** make improvements are:

- Continue to explore ways of improving telephone access.

Summary of findings

- Introduce a formal system to monitor the quality of prescribing of non-medical prescribers.
- Improve computer read coding generally to remove the need for high exception reporting.
- Continue to increase the identification of carers on the register.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

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

Bosworth Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and included a GP specialist adviser.

Background to Bosworth Medical Centre

Bosworth Medical Centre is a GP practice located in the Chelmsley Wood Primary Care Centre. The practice provides primary medical services under a General Medical Services (GMS) contract to a population of approximately 9,000 patients living in the Chelmsley Wood and surrounding areas of Birmingham. A GMS contract is a standard nationally agreed contract used for general medical services providers.

The practice operates from a modern purpose built, two storey building with disabled access and parking. The reception area is spacious and allows easy access for patients using mobility aids. All consultations take place on the ground floor. The building is shared with a variety of other community services, for example, podiatry and physiotherapy.

The practice population has a higher than average number of patients aged under 18 years and a higher than average number of patients under 45 years. National data indicates that the area is one that experiences high levels of deprivation and high levels of obesity, teenage pregnancy and smoking. The practice population is predominantly made up of white British patients with a small but growing number of patients from ethnic minority groups.

There are three GP partners, who are all female and three salaried GPs, two female and one male. The practice employs three practice nurses, an advanced nurse practitioner, a clinical pharmacist, a health care assistant and practice manager who are supported by a team of administration and reception staff.

The practice offers a wide range of services including, minor surgery, long term condition monitoring, cervical cytology, child health services, family planning and weight management. The practice has a GP with additional training to provide hormonal contraceptive implants and family planning. Nursing staff are trained to provide enhanced diabetes services.

The practice is open on Monday, Tuesday and Friday from 8.30am until 6.30pm, Thursday from 8.30am until 1.30pm and Wednesdays from 8.30 until 7.30pm when the practice offers extended hours appointments from 6.30pm until 7.30pm. These are currently also available every second Saturday morning from 9am until 11am. The practice has opted out of providing out-of-hours services to their own patients. This service is provided by Birmingham and District General Practitioner Emergency Rooms (Badger) an external out of hours service contracted by the Clinical Commissioning Group (CCG). Badger also provide cover daily between 8am and 8.30am.

Good

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice carried out safety risk assessments and had a range of safety policies which were stored on a shared drive on the computer system and staff were all aware of how to access these. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance and staff we spoke with were all aware of the safeguarding lead GP and what to do if they had safeguarding concerns.
- We saw evidence of how the practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. The safeguarding lead GP attended regular safeguarding leads' networking meetings and undertook case audits and pathways reviews. Learning points were shared with staff at the practice.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control and we saw evidence of a recent audit where the practice had assessed and addressed identified risks.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions and we saw evidence of this. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for all staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety. For example, we noted that the practice had recently experienced issues with their computer system and had implemented measures to ensure the service continued unhindered.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. We saw a variety of templates on the computer system for specific conditions, such as asthma, diabetes and depression to facilitate comprehensive recording of all relevant information in the patient record. These care records showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The computer system the practice used allowed sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.
- The practice provided guidelines to administration staff to instruct them how to deal with all aspects of letters,

post and information received into the practice. We saw that this was comprehensive, clear and detailed covering a wide range of discharge summaries of specific conditions.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship. The practice had recently employed a part time clinical pharmacist to promote improved prescribing and medicines audit and review.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.
- The practice had recently employed an advanced nurse practitioner and had not yet identified a formal system of how they would monitor their consultations and prescribing. Discussions with the GPs confirmed they would address this.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, the practice changed their policy for prescribing during home visits in response to a significant event and generated all prescriptions electronically on their return to the practice.

There was a system for receiving and acting on safety alerts. These were received by the practice manager who disseminated to all clinicians for decisions on actions to be taken. We saw evidence from the minutes that alerts were discussed at practice meetings and actions required taken and recorded.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. For example, we saw examples where the GPs had applied the principles of the Mental Capacity Act (MCA) to enhance patient care.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice monitored and reviewed their Quality and Outcome Framework (QOF) achievement regularly to identify if there were areas which required more focus.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or may have been vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- All patients who were 75 and over were provided with a dedicated telephone number to allow them to access the practice without delay. We spoke with patients who confirmed this service had been offered to them.
- Non cancer patients with severe frailty were included in the Gold Standard Framework register to ensure they were discussed at meetings with the district nurses, practice nurse, Macmillan nurse and reception.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- Older patients who had experienced falls that had resulted in an ambulance attendance were offered a falls assessment and medicines review. Patients taking more than eight medicines were also offered reviews.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training. The nursing team had undertaken regular training in long term conditions and achieved diplomas in asthma, chronic obstructive pulmonary disease and diabetes.
- The practice had high achievement in most long term conditions although we noted that exception reporting was high. We discussed this at length with the practice and reviewed the practice exception reporting process. We found that exception reporting was appropriate but that there were some coding issues which may have affected the data. The practice told us that there was a high number of patients who did not attend their appointments. However, the practice had recruited a full time advanced nurse practitioner to focus on this group of patients and improve uptake. The practice was also planning to provide more visits to care home to review patients with dementia and mental health conditions. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.
- One of the nurses had completed a Cancer Care course to enable them to support patients with cancer and improve cancer care reviews.
- We noted that the practice had participated in a pilot scheme for diabetes care. This involved holding a monthly virtual clinic with multi-disciplinary specialists including the practice nurse, GP lead for diabetes, a consultant in diabetes, diabetes specialist nurse, and a pharmacist where patients with complex diabetes were reviewed and discussed. This had demonstrated an improvement in blood glucose levels and medication reviews. Staff had also improved their skills in diabetes management and were able to initiate insulin where appropriate.

Good

Are services effective?

(for example, treatment is effective)

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were 96% which was above the target percentage of 90% for children up to one year and the practice was at 89% for measles, mumps and rubella immunisation for children under 2 years.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. We noted the practice had made changes in their system as a result of audit regarding patients with high glucose levels in pregnancy to ensure they were correctly followed up and monitored.
- The midwife attended the practice and carried out antenatal clinics weekly.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 68%, which was comparable with the national average of 72% and clinical commissioning group (CCG) average of 74%. We looked at the practice exception reporting and found this to be in line with national guidance.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. The practice told us patients attended for a blood test relating to the assessment but many did not attend for the subsequent part of the assessment. Discussion with the practice indicated they were intending to review the process to carry out all aspects of the assessment at the same time. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- The practice offered learning disability health checks and sent health check letters in pictorial format to explain the assessment.
- The practice placed alerts on patient records to show that they were vulnerable.

People experiencing poor mental health (including people with dementia):

- 98% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is above the national average although exception reporting for this indicator was 28% compared to the national figure of 7%. The practice had planned to improve this by targeting more patients using home visits and liaising with local care homes to co-ordinate visits.
- 98% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is above the national average of 90% although exception reporting was 32% compared to the national figure of 13%. The practice had identified that some patients' diagnoses had been read coded again at their next consultation and had therefore needed to be exception reported. This coding error was being addressed.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption was 90% which was comparable with the CCG average of 90% and national average of 91%. Exception reporting was 27% compared to the national figure of 10%. The percentage of patients experiencing poor mental health who had received discussion and advice about smoking cessation was 93% which was comparable with the CCG and national average of 95%.
- We discussed exception reporting at length and identified some coding issues which the practice confirmed they would explore which would reduce the need for such high exception reporting in some cases.

Monitoring care and treatment

The practice demonstrated that they undertook regular quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care they provided. We saw evidence of a number of audits which

Good

Are services effective?

(for example, treatment is effective)

had identified where improvements could be made. For example, the practice had made recommendations regarding prescribing of prophylactic antibiotics involving more detailed recording of discussion with patients and improved communication with secondary care clinicians. Where appropriate, clinicians took part in local and national improvement initiatives. For example the practice had taken part in the National Cancer Care audit 2017.

The most recent published Quality Outcome Framework (QOF) results for 2016/17 showed the practice had achieved 94% of the total number of points available compared with the clinical commissioning group (CCG) average of 98% and national average of 96%. The overall exception reporting rate was 11% compared with a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. We saw evidence of a significant amount of training both online and from attendance at locally arranged training venues and in house training.
- The practice provided staff with ongoing support. This included an induction process, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity. The practice hosted the local Health Trainer and encouraged patients to attend.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that staff had received training in the Mental Capacity Act 2005 (MCA).
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately. We saw evidence of written consent forms used in the practice.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 18 patient Care Quality Commission comment cards we received were positive about the care they received from the GPs and nurses. Patients mentioned staff by name and commented on their caring nature and how staff were always efficient and took time to listen.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. There were 349 surveys sent out and 104 were returned. This represented about 1% of the practice population. The practice was slightly below average for some of its satisfaction scores on consultations with GPs although nurse consultations were in the main comparable with national and CCG averages.

For example:

- 86% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) and national average of 89%.
- 79% of patients who responded said the GP gave them enough time compared with the clinical commissioning group (CCG) and national average of 86%.
- 96% of patients who responded said they had confidence and trust in the last GP they saw compared with the clinical commissioning group (CCG) and national average of 95%.
- 79% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared with the clinical commissioning group (CCG) and national average of 86%.
- 88% of patients who responded said the nurse was good at listening to them compared with the clinical commissioning group (CCG) and national average of 92% and 91% respectively.
- 87% of patients who responded said the nurse gave them enough time compared with the clinical commissioning group (CCG) and national average of 94% and 92% respectively.
- 96% of patients who responded said they had confidence and trust in the last nurse they saw compared with the clinical commissioning group (CCG) and national average of 99% and 97% respectively.
- 87% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared with the clinical commissioning group (CCG) and national average of 92% and 91% respectively.
- 64% of patients who responded said they found the receptionists at the practice helpful which was below the CCG and national average of 87%.

The practice had reviewed the patient survey results and made plans to address areas where they were below average. For example, they had organised additional training to take place for staff regarding customer service and discussed this in practice meetings.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language although this was not frequently required.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment. All clinical staff had a poster in their

room reminding them to enquire if patients were carers. This also showed contact numbers to local carers organisation as well as other support organisations such as the Alzheimer's Society, MIND and the Stroke Helpline.

The practice identified patients who were carers. They recorded at registration when patients were carers and the register was added to as carers were identified opportunistically. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 49 patients as carers which was less than 1% of the practice list size. Carers were offered flu vaccination and health checks.

Two GPs had completed alcohol champion training and were awaiting substance misuse training to provide advice and support to patients with problems in these areas.

Staff told us that if families had experienced bereavement, their usual GP contacted them if they felt it appropriate. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs or by giving them advice on how to find a support service.

Results from the national GP patient survey showed patients responses to questions about their involvement in planning and making decisions about their care and treatment were mixed. Most results were in line with local and national averages:

- 84% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 87% and the national average of 86%.
- 75% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared with the clinical commissioning group (CCG) average of 84% and the national average of 82%.
- 88% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 92% and the national average of 90%.
- 82% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared with the clinical commissioning group (CCG) average of 88% and the national average of 85%.

The practice manager reported any concerns and complaints regarding patients' experiences at practice meetings to alert all staff regarding issues and discuss ways of improving.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.

The practice complied with the Data Protection Act 1998.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as requires improvement for providing responsive services across all population groups.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example extended opening hours, and online services such as repeat prescription requests, telephone appointments, and provision of anti-coagulation clinics in the practice and leg ulcer clinics.
- The practice improved services where possible in response to unmet needs. For example, they had engaged in a project to provide virtual multi-disciplinary clinics providing reviews in the community of patients with diabetes to achieve better control and increase the skills of practice staff.
- The facilities and premises were appropriate for the services delivered. There were baby changing facilities, ample seating and space for patients using mobility aids and a hearing loop for patients who experienced hearing difficulties.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- The practice manager carried out a monthly search for patients reaching 75 years and contacted them to provide them with a direct telephone number to prevent any delay when seeking appointments.
- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs. Patients with multiple long term conditions were offered longer appointments of 20-30 minutes.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The practice hosted the local Health Trainer service which provided support and advice on healthy lifestyles. We saw that this was clearly advertised in the practice waiting area.
- The practice offered a comprehensive family planning and contraception service including intrauterine contraceptive device (IUCD) insertion and hormonal implants.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours on Wednesdays until 7.30pm and every second Saturday morning from 9am until 11am. The practice had also joined the North Solihull GP Collaborative project with ten other practices to provide additional extended hours appointments every evening from 6.30pm until 8pm, Saturdays from 9am until 12pm and Sundays from 9am until 11am. This was due to commence later in the year and was to be provided from Bosworth Medical Centre.
- Telephone and consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a

learning disability. They were offered annual health checks and the practice worked closely with the local learning disability care home. They also provided pictorial literature to help ensure an understanding of health checks offered.
- The practice told us they had invited a manager of the local learning disability care home to attend the patient participation group meeting to act as an advocate for patients.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. The GP mental health lead had additional training in mental health.
- The practice offered annual physical reviews for mental health and patients with dementia. The practice was considering liaising with the local care home to co-ordinate annual health checks as they had noted that patients were not taking up the invitations for these.

Timely access to the service

Patients were able to access care and treatment from the practice when they were able to get through on the telephone. However, most patients we spoke with, the national GP patient survey responses, and the comment cards we viewed highlighted difficulty in getting through on the telephone. Many patients told us they chose to walk to the practice rather than wait on the telephone.

- Patients were able to access initial assessment, test results, diagnosis and treatment once they had gained access to the reception.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The practice had changed their appointment system in response to patient feedback and in response to patient need. For example, they had reduced the number of appointments which could be booked in advance and most appointments were booked on the day. Patients called the practice and the GPs triaged patients and booked an appointment if they needed to be seen.
- Patients we spoke with were satisfied with this system but expressed the need for the practice to continue to address the telephone system.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was below local and national averages. We spoke with patients on the day of inspection and most stated that access to the practice by telephone was difficult and comment cards aligned with these views. However, two patients reported that they felt this was improving in recent months. Patients reported that although telephone access was difficult, once they had established a connection with the practice then they could get usually get an appointment. There were 349 surveys sent out and 104 returned. This represented approximately 1% of the practice population.

- 75% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 74% and the national average of 76%.
- 20% of patients who responded said they could get through easily to the practice by phone compared to the CCG average of 64% and national average of 71%.
- 72% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared to the CCG and national average of 84%.
- 70% of patients who responded said their last appointment was convenient compared to the CCG and national average of 81%.
- 41% of patients who responded described their experience of making an appointment as good compared to the CCG and national average of 69% and 73% respectively.
- 46% of patients who responded said they did not normally have to wait too long to be seen compared to the CCG and national average of 59% and 58%.

Discussions with the practice demonstrated that the practice had made changes to address telephone access by changing the telephone system but this had not had a significant impact and they had continued to monitor this. They had sought an alternative system which was to be installed in October 2018.

The GPs had also reviewed their use of locum GPs to address patient satisfaction. They had introduced their

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

own in house locum system to provide a rota system for the GPs to carry out extra sessions allowing them to provide afternoon appointments on Thursdays. They had also recruited an advanced nurse practitioner to add to and improve skill mix in the practice. They had promoted online access to appointments and we saw posters informing patients of this. We also noted they were encouraging patients to receive test results via text message and had introduced a system to allow patients to message the reception if they had queries which did not require an appointment to remove the need to call the practice.

The practice demonstrated that telephone access continued to be monitored and remained a priority.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do.
- The complaint policy and procedures were in line with recognised guidance. We reviewed the complaints received in the last year and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care and outcomes were discussed at practice meetings to share learning. For example, we saw that the practice had discussed the results of their annual complaints review with all staff and addressed areas where improvements could be made. They had arranged customer service training for reception staff and agreed specific clinical training for GPs. We saw evidence of a comprehensive complaints review report with detailed actions of all areas.

Are services well-led?

Good

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

Our findings

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

The partners demonstrated that they had the capacity and skills to deliver high-quality, sustainable care.

- They had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. For example, they had identified the increasing needs of the practice population and recruited an advanced nurse practitioner to increase capacity.

Vision and strategy

The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- The practice shared its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- We saw that the practice monitored progress against delivery of their strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff we spoke with stated they felt respected, supported and valued and demonstrated a commitment to provide services which focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values and we saw evidence of meetings where the practice had openly discussed ways of improving patient satisfaction, specifically regarding how staff could manage patient expectations and improve communication.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. We saw examples of where the GPs had contacted patients to discuss incidents. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff had received annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training and staff reported that they were treated equally.
- There were positive relationships between staff and teams.
- During our inspection we witnessed an incident and observed how staff had dealt appropriately with and supported a member of staff who had experienced unacceptable behaviour from a patient.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out,

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understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations and the practice had recently introduced regular peer review of referrals to secondary care. We noted that the practice had not yet set up a process to monitor the consultations and prescribing of the recently recruited nurse practitioner. However, the practice told us this would be implemented. The practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information were used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information. For example, the practice engaged in monthly peer review of referrals to secondary care which were recorded and discussed at practice meetings.
- The practice used performance information which was reported and monitored and management and staff discussed and addressed any issues.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- The practice encouraged patients to share their views and concerns and they engaged with the patient participation group to address these and make improvements.
- There was an active patient participation group with whom they met regularly who told us that they felt valued by the practice and that the practice always listened and responded to their comments.
- The service was transparent, collaborative and open with stakeholders about performance and staff and patients we spoke with confirmed this.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. Staff knew about improvement methods and had the skills to use them. The practice was introducing a new intranet system to improve access to learning and improve

Are services well-led?

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incident reporting and audit cycle reminders. They had also recently introduced an online training tool to allow staff to access a wide range of training as well as annual update training.

- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.