

Newtown Health 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?

Good 

Are services well-led?

Good 

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	7
What people who use the service say	10
Areas for improvement	10
Outstanding practice	10

Detailed findings from this inspection

Our inspection team	11
Background to Newtown Health Centre	11
Why we carried out this inspection	11
How we carried out this inspection	11
Detailed findings	13

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Newtown Health Centre on 23 June 2016. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example the practice took part in a CCG funded project to offer individualised care plans to the practices top 50 patients who either attended accident and emergency (A&E) frequently or had high unplanned hospital admissions.
- The practice was trying to improve its dementia diagnosis through the use of an iPad with bespoke software for memory testing.

- Feedback from patients about their care was consistently positive.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example the appointment system was being reviewed after consultation with patients and staff. The proposals were being taken to the PPG for approval.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice actively reviewed complaints and how they were managed and responded to, and made improvements as a result.
- The practice had a clear vision which had quality and safety as its top priority.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.

We saw several areas of outstanding practice including:

- The practice took part in a CCG funded project to offer individualised care plans to the practices top 50

Summary of findings

high cost patients who either attended accident and emergency (A&E) frequently or had high unplanned hospital admissions. Data we looked at showed that the practice had significantly reduced admissions to secondary care for these patients.

However there were areas of practice where the provider should make improvements:

- Consider how to further identify the number of carers registered at the practice in order to offer further support and guidance.
- Continue to monitor patient survey results and patient feedback following implementation of new appointment systems.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services. There was an effective system in place for reporting and recording significant events. Lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again. The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. Risks to patients were assessed and well managed.

Good



Are services effective?

The practice is rated as good for providing effective services. The practice took part in a CCG funded project to offer individualised care plans to the practices top 50 patients who either attended accident and emergency (A&E) frequently or had high unplanned hospital admissions. The aim was to develop a care plan with the patient along with contact details of other services such as medical, social and voluntary who were involved with the care of the patient. The review of the project showed that significant reductions to A&E and unplanned admissions were made and patient feedback was positive. Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were in most areas above CCG and national averages. The nurse manager and healthcare assistant attended a diabetes education programme so they could advise patients what to expect when referred for the course. They also tailored the advice they gave to ensure it was consistent with what was delivered on the course. Staff assessed needs and delivered care in line with current evidence based guidance. Clinical audits demonstrated quality improvement. Staff had the skills, knowledge and experience to deliver effective care and treatment. There was evidence of appraisals and personal development plans in place for staff. Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Good



Are services caring?

The practice is rated as good for providing caring services. Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and

Good



Summary of findings

accessible. We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality. We were told that a staff representative often attended funerals of their patients.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services. The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs. The practice was trying to improve its dementia diagnosis through the use of an iPad with bespoke software for memory testing. The software could be used in 16 different languages and was useful for many patients registered at the practice who did not speak English. The practice had made available a leaflet in the practice entitled 'Ramadan and diabetes' (developed by Diabetes UK) which provided practical advice on how to keep good diabetes control during the fasting period. The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group (PPG). For example, patients were consulted on the appointment system and changes had been made based on their and staff feedback. The PPG were being further consulted to evaluate the changes. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Good



Are services well-led?

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as its priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. High standards were promoted and owned by all practice staff who worked well as a team across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice gathered feedback from patients, and engaged with patient participation group (PPG) which influenced practice development. For example, staff and patients were consulted on the proposed changes to the appointment system. The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place

Good



Summary of findings

for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken. There was a focus on continuous learning and improvement at all levels within the practice. Practice staff were well supported in their professional development. The practice was a training practice for qualified doctors training to be a GP and a teaching practice for medical students. Some of the practice nurses also mentored student nurses from a local university.

Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. Patients over the 75 years were allocated a named GP to support their needs and care plans were in place for those with complex care needs. The practice took part in a CCG funded project to offer individualised care plans to the practices top 50 patients who either attended accident and emergency (A&E) frequently or had high unplanned hospital admissions. A high percentage of these patients were over 75 years of age. The aim was to develop a care plan with the patient along with contact details of other services such as medical, social and voluntary who were involved with the care of the patient. Results showed that significant reductions were made to unplanned admissions and patient feedback was positive. The practice was responsive to the needs of older people, and offered home visits. The practice was accessible to patients with mobility difficulties and vaccinations appropriate for this age group were available for patients in this age group. The practice proactively offered vaccination to carers with 60% of registered carers receiving a flu vaccination last year. The practice regularly met as part of a multi-disciplinary team to discuss and review the care of those with end of life care needs.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Clinical staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority, this included patients with long term conditions. The practice took part in a CCG funded project to offer individualised care plans to the practices top 50 high cost patients who either attended accident and emergency (A&E) frequently or had high unplanned hospital admissions. The aim was to develop a care plan with the patient along with contact details of other services such as medical, social and voluntary who were involved with the care of the patient. Patients identified with a long term condition that would benefit from being receiving care under this project were also included in the project. Results showed that significant reduction to unplanned admissions was made. The practice operated specialist clinics to review and monitor patients with specific long term conditions such as diabetes, hypertension, asthma and COPD. Overall performance for diabetes related indicators (2014/15) was similar to the CCG and national average. The practice proactively referred patients to a diabetes education

Good



Summary of findings

programme. The nurse manager and a healthcare assistant had attended the programme themselves so that they could then advise patients on what they could expect when referred the course. Longer appointments and home visits were available when needed. For patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. The practice was working with the voluntary sector and was due to attend the launch event on the 'Family Fit' project with the Lord Mayor of Birmingham. The project aimed to work with local families to improve their health. The focus would be on families as opposed to the individuals with an aim to address obesity in school children. The practice nurses ran weekly clinics providing a programme of childhood immunisations. Immunisation rates were relatively high for all standard childhood immunisations. There was a GP led baby clinic for child surveillance. Post-natal checks, family planning and contraceptive advice were also available. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw positive examples of joint working with midwives and health visitors.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Extended hours were available. Online booking of appointments and ordering prescriptions were also available. The practice had also signed up to a service commissioned by the CCG which had a smart phone application giving patients an option to book appointments designated for online access. The practice offered a full range of health promotion and screening that reflected the needs for this age group.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice organised training for

Good



Summary of findings

staff to ensure they were aware of the needs of vulnerable groups such as travellers and asylum seekers enable them to receive easy access to primary care. This was identified as a training need due to the increase of these population groups in to the local area. The practice offered longer appointments for patients with a learning disability. The practice regularly worked with other health care professionals in the case management of vulnerable patients. The practice informed vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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). Sixty nine percent of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which was lower than the national average. The local CCG average was 84%. The national average was also 84%. However, the practice was also improving its dementia diagnosis through the use of an iPad with bespoke software for memory testing. The practice had purchased two iPads which were given to patients who went through series of questions after which the results and analysis were forwarded to the GP. The software could be used in 16 different languages. The practice had screened 34 patients over the last year. National reported data for (2014/15) showed 65% of patients with poor mental health had comprehensive, agreed care plan documented, in the preceding 12 months which was below to the CCG average 87% and national average 89%. The practice had a named GP responsible for mental health patients. The practice was able to signpost patients to support services.

Good



Summary of findings

What people who use the service say

The national GP patient survey results were published on July 2016. The results showed the practice was performing below local and national averages for the questions below. 374 survey forms were distributed and 90 were returned. This represented 0.8% of the practice's patient list.

- 56% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 74% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 61% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 61% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 21 comment cards which were all consistently positive about the standard of care received. However three patients commented on the lack of access to appointments via the telephone. Patients described the service as being of high standards and staff as polite and friendly. They told us that they were treated with dignity and respect by all staff. We saw examples where staff treated patients with compassion.

We spoke with seven patients during the inspection, including the chair of the patient participation group (PPG). All the patients were positive about the care they received, they told us that they were able to obtain appointments when they needed one and that staff were polite, caring and helpful. The also mentioned that the appointment system had been changed in October 2014 to allow better access but some patients were still getting used to the system. The appointment system had been reviewed to ensure it was suitable for all patients and the PPG were due to be consulted before implementation.

Areas for improvement

Action the service **SHOULD** take to improve

- Consider how to further identify the number of carers registered at the practice in order to offer further support and guidance.
- Continue to monitor patient survey results and patient feedback following implementation of new appointment systems.

Outstanding practice

- The practice took part in a CCG funded project to offer individualised care plans to the practices top 50 high cost patients who either attended accident and emergency (A&E) frequently or had high unplanned hospital admissions. Data we looked at showed that the practice had significantly reduced admissions to secondary care for these patients.

Newtown Health Centre

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 adviser, a practice nurse specialist adviser and a CQC Inspection Manager.

Background to Newtown Health Centre

Newtown Health Centre is part of the NHS Sandwell and West Birmingham Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

The practice is registered with the Care Quality Commission to provide primary medical services. The practice has a general medical service (GMS) contract with NHS England. Under this contract the practice is required to provide essential services to patients who are ill and includes chronic disease management and end of life care.

The practice is located in an inner city area of Birmingham with a list size of approximately 7,500 patients. The premises are purpose built for providing primary medical services.

Based on data available from Public Health England, the practice is located in the most deprived areas. Compared to the national average the practice had a higher proportion of patients between 0 and 50 and lower proportion of patients over 50 years of age.

Practice staff consist of two partners (both male), four nurses (including one nurse practitioner and a nurse manager), five health care assistants and a team of

administrative staff. The practice did not have a practice manager but the senior management team took on these responsibilities. For example, the performance manager was responsible for Human Resources (HR), Quality and Outcomes Framework (QOF) as well as IT. The finance manager took other responsibilities along with the nurse manager and reception manager.

The practice telephone was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.30am to 11am every morning and 3.30pm to 6pm daily. Extended hours appointments were offered from 6.30pm to 7.30pm on Mondays, Wednesdays and Fridays.

The practice is a training practice for qualified doctors training to become GPs. Nurse also mentored student nurse from local universities. The practice also planned to take on medical students from a local university which was opening a medical school from 2017.

The practice had been inspected previously under our current methodology but had not been rated.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We carried out an announced visit on 23 June 2016. During our visit we spoke with a range of staff including the GP partners, nurses, administrative staff and senior management staff. We spoke with patients who used the service including the chair of the patient participation group (PPG). We reviewed comment cards where patients and members of the public shared their views and experiences of the service

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

- Is it safe?
- Is it effective?
- Is it caring?

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

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

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

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

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events. The practice had an incident reporting book which was used to report events such as verbal abuse from patients. For more significant incidents the practice reported and shared this with the Clinical Commissioning Group (CCG) through the electronic reporting system. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. One of the GP partners chaired the quality and safety committee at the CCG. Following a recent medical emergency a table top review was held and the findings were shared with the CCG who shared this with other practices.

Staff members we spoke with told us that incidents were discussed in team meetings. Minutes of meetings we looked at showed that incidents discussion was a standing item on the agenda. For example, as a result of delays in referrals for cancer diagnosis the practice changed its administration process. A log was kept so that reviews would ensure no referrals were missed out.

We saw examples of memorandums that were sent to administration and reception staff to communicate learning from relevant incidents. The practice also carried out yearly reviews of significant events to identify further learning and spot any trends.

The practice received medical alerts via email which were then printed off and discussed in monthly meeting. Discussion of alerts was a standing item on the agenda and minutes of meetings we looked at confirmed this. We saw evidence that a recent medical alert had been responded to. Copies of relevant alerts actioned were also kept in the practice.

The practice also had a noticeboard in the staff area detailing alerts for missing persons and people trying to fraudulently obtain prescriptions. This allowed the practice to monitor any unusual medicine requests.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. This included arrangements to

safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults. We were told about an example where a reception staff recognised the need to review a patient after observing the body language of the carer of the patient. This resulted in a positive outcome for the patient. The practice had a child protection register with alerts in the notes. Currently the practice had 122 children on the list. The practice also had 18 adults on the safeguarding adults list. We saw many previous examples where referrals were made to appropriate organisations as a result of concerns. Training record looked at showed that staff had received relevant safeguarding training with GPs trained to child protection or child safeguarding level 3.

Notices on the waiting room and consultation rooms advised patients that chaperones were available if required. Clinical staff normally acted as chaperones. However, administration staff who had undergone DBS checks also acted as a chaperone. There was a list of staff members who could act as chaperones displayed in the reception and other staff areas. The list was colour coded for priority. 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.

The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. One of the practice nurses was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. We saw an infection control audits was undertaken in May 2016 and we saw evidence that action was taken to address any improvements identified.

The practice also generated an annual infection control statement summarising any infection control incidents. It also summarised findings from audits and any actions that were required as well as detailing staff training needs, details of risk assessments and updates to policies and

Are services safe?

guidance. We saw that the last statement was generated in March 2016. There were no incidents reported that were related to infection control. Risk assessment carried out for the building by the lead nurse noted generally there were no issues. However, it noted that clinical rooms used by locum GP needed further attention to ensure correct standards were being maintained in regards to infection control. Deep cleaning of the waiting area floors were identified and had been arranged weekly. Training by an external lead was delivered and policies were reviewed.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. We saw evidence that the practice was meeting targets set by the CCG. Blank prescription forms and stationery were securely stored and there were systems in place to monitor their use. The practice employed an Advanced Nurse Practitioner (ANP) who could prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.

Monitoring risks to patients

Risks to patients were assessed and well managed. There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and

clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff was on duty. For example, the practice had a weekly reception rota with designated staff members that were responsible for covering the reception and those that were responsible for telephone and administration work in the back office. The practice also had a staff rota for GPs and another for nurses and healthcare assistants.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents. There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book was available.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. The plan was kept both on site and off site.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to keep all clinical staff up to date. The providers owned another practice nearby and joint clinical staff meetings were held. Record we looked at showed that NICE guidance was discussed. We saw NICE guidance's for cancer diagnosis was displayed in the consultation rooms we looked into. The practice monitored that these guidelines were followed through audits of referrals.

The practice had carried out an audit of patients who were housebound receiving home visits. This audit was triggered after a district nurse had informed the practice that a patient had not received a home visit for some time. To ensure needs of these patients were being met the audit identified that nine out of a total of 58 patients had not received a face to face home visit for over six months. These patients then received a visit to ensure any unmet needs were identified.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 95% of the total number of points available. Exception reporting was at 14% which was 5% above CCG and national averages. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.

Data from 2014/15 showed:

- Performance for diabetes related indicators was better than the national average. The practice achievement was 95% for the number of patients with diabetes, on

the register, in whom the last blood pressure reading had been measured in the preceding 12 months. This was above the local CCG average was 90 % and the national average was also 91%.

- Performance for mental health related indicators was lower than the local and national averages. The practice achievement was 72%, the local CCG average was 90% and the national average was also 93%.

The practice had processes in place to ensure patients with mental health were followed up and reviewed. However, the practice found it difficult to reach these patients.

There was evidence of quality improvement including clinical audit. There had been three clinical audits completed in the last two years, all of these were completed audits where the improvements made were implemented and monitored.

The practice took part in a CCG funded (PUSH) project to offer individualised care plans to the practices top 50 patients who either attended accident and emergency (A&E) frequently or had unplanned hospital admissions. The aim was to develop a care plan with the patient along with contact details of other services such as medical, social and voluntary who were involved with the care of the patient. There was a nominated care co-ordinator at the practice who regularly reviewed these patients. The aim was to reduce unnecessary access and thereby NHS costs for these patients.

As part of the evaluation of the project, patients taking part were asked to provide feedback. We saw the feedback provided by patients was overall positive, patients stated that they were happy with the project, had better access to their GP, they were empowered to manage their health and there was less a less need to rely on hospitals.

Evaluation of the project also identified that there was greater continuity of care as there was a dedicated clinician to these patients. There was an in-depth understanding of identified patients with complex needs. This also allowed the identification of unmet needs. There was increased level of patient empowerment due to education of patients and there was an increased level of signposting to other agencies such as social care, mental health and substance misuse.

The project started in May 2015 and finished in March 2016. In addition to the positive outcomes for patients, evaluation of the project showed that the practice had

Are services effective?

(for example, treatment is effective)

reduced A&E attendance and cost. For example, the number of A&E attendances from the top 50 most attendees was 220 times between April 2014 and December 2014 (before the project). Evaluation of the project showed that the A&E attendances had dropped to 116 times for the top 50 attendees between April 2015 and December 2015. This was a reduction of 52%. The practice had also reduced its unplanned admission to hospital by 37%.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. The practice held induction review meetings after the initial two weeks induction to provide feedback and plan a strategy for moving forward. We saw an example of this which documented competencies and areas requiring further support. Based on this, a work plan was agreed with short term objectives.

The practice could demonstrate how they ensured role-specific training and updating for relevant staff such as for those reviewing patients with long-term conditions. We saw records of training for all staff based on their roles.

Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings. We saw that the staff had attended a half day screening update two years ago and were due again in 2017.

The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, and mentoring, clinical supervision and facilitation and support for revalidating GPs. There was a designated nurse manager who had been recruited recently. They were responsible for ensuring appropriate training was delivered to all nurses, recognised through appraisals. All staff had received an appraisal within the last 12 months. Nurses we spoke with told us that they received

one hour of clinical supervision every two months. They told us they had access to the GPs to discuss for example their complex diabetes patents. Staff also told us they received protected learning time to undertake training. The practice had training and development policy which laid out the process for staff to request study leave to ensure staff were competent.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and investigation and test results.

The practice shared relevant information with other services in a timely way, for example when referring patients to other services. We saw an example of a referral audit that had been carried out. We also saw that a significant event was raised as a result of delays to a referral which resulted in changes to the administration practices. All referrals were reviewed by the GP partners to ensure of it was appropriateness and quality. The GP partners would change the referral pathways if it was not appropriate.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment. One of the GPs carried out minor surgery and had a surgical background. They had been given a contract by the CCG to

Are services effective?

(for example, treatment is effective)

carry out minor surgery for other patients within the CCG. Formal consent was sought before the procedure and we saw evidence of the forms used. The practice was auditing outcomes and had a very low post-operative infection rate. Audit of this service also showed very positive feedback from patients.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example, patients receiving end of life care, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.

Staff was able to refer patients to health trainers who gave lifestyle support such as diet and exercise advice. For example, the practice held a prediabetes register. As risks are often preventable the purpose of this was to educate and support patients from progressing to diabetes and heart disease. To prevent progression, patients needed to make lifestyle changes in terms of healthier eating (losing weight) and increased physical activity.

The practice operated specialist clinics to review and monitor patients with specific long term conditions such as diabetes, heart failure and respiratory conditions. Patients we spoke with confirmed they received regular reviews of their condition.

Other services such as support workers from the citizen advice bureau were based at the practice at specific times. This was to help patients with any social issues which in turn was thought would lead to improved health outcomes.

Leaflets around the practice and information on the practice websites were available to help patients understand their care and treatment. The practice had a newsletter which also advised patients of some of the services that were available and some that had moved. For example, the dietetic service had moved to another site as well as the podiatry service.

The practice's uptake for the cervical screening programme was 79%, which was comparable to the CCG average of 80% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. One of the nurses had completed an assignment as part of their training on the barriers of cervical screening. To encourage uptake the nurse spoke with patients about some of the barriers and the importance on screening.

Data showed that the practices breast screening achievement for women aged 50 to 70 years in the last 36 months was similar to the local CCG average of 69% (CCG 68% and national 72%). However, this was lower the past six months. This was similar for bowel cancer screening for persons aged 60 to 69 years.

Childhood immunisation rates for the vaccinations given were slightly above the CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 69% (Infant Men C) to 99% and five year olds from 91% to 99%. The CCG averages for under two year olds was 41% (Men C) to 95%. For five year olds it ranged from 87% to 94%.

The practice was working with the voluntary sector on a scheme called the Family Fit' project. The project was due to be launched and aimed to work with local families to improve their health. The focus would be on families as opposed to the individuals with an aim to address obesity in school children.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. The practice also carried out health checks for the over 75 and 65% had undergone a review. For the 40-74 year old the current achievement was 8%.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed staff members who were courteous and very helpful to patients and treated them with dignity and respect at the reception desk. Staffs at all levels were approachable and courteous to patients for example, including the security, reception staff and clinical staff.

Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 21 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with seven patients including the chair of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required. They stated that staff were caring, listened to their needs and always responded.

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

- 90% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 83% and the national average of 89%.
- 89% of patients said the GP gave them enough time compared to the CCG average of 82% and the national average of 87%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and the national average of 95%.

- 84% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 87% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 80% of patients said they found the receptionists at the practice helpful compared to the CCG average of 81% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views.

We saw that personalised care plans were in place for the practice's most vulnerable patients with long term conditions and complex care needs. For example, 100% of care plans had been developed for patients on the unplanned avoidance register.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 89% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and the national average of 86%.
- 84% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 89% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care. Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. The practice also utilised a smart phone application which

Are services caring?

could be used to make appointments. This was useful for people who had difficulty with their hearing. The practice also offered online services for booking appointments and ordering repeat prescriptions.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. For example, there were information on bereavement as well as posters and information on female genital mutilation (FGM). One of the GP partners was also a CCG lead for FGM support, guidance and advice could be provided if necessary.

The practice's computer system alerted GPs if a patient was also a carer. The practice had a lower number of older patients than the national average and had identified 69 patients as carers (0.6% of the practice list). Written information was available to direct carers to the various avenues of support available to them. For example, the practice developed its own carers leaflet with helpful local contacts and advice on how to ask for carers assessment.

The practice website also had links to various information and supporting organisations. There was a comprehensive carers pack available at the practice developed by CarersUK. This also contained comprehensive information for carers.

The practice provided flu vaccines to carers and data showed 61% of carers registered with the practice had received a flu vaccination during the last flu season. One way the practice did this was to opportunistically administer vaccines to carers when clinicians carried out home visits.

The practice had a bereavement pack and staff members supported patients and attended funerals. The practice discussed an example of how the reception manager had supported a patient during end of life care giving practical and emotional support. The practice had a board in the staff area which was used to communicate information such as deaths. This allowed staff to be aware of any relatives who may attend surgery so that appropriate help and support could be offered. It also ensured that staff were not sending out any communication or calls for the deceased patient. We were told that a staff representative often attended funerals of their patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice was taking part in the primary care commissioning framework (PCCF) which is intended to help to develop general practice, encourage partnership working and deliver improvements in clinical outcomes for patients.

As part of the PCCF the practice offered extended hours Mondays, Wednesday and Fridays. There were longer appointments available for patients with a learning disability. Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. The current appointment system was based on a triage system where the GP would call back after request by patients for an appointment. If patients needed to be seen they were invited to attend the practice for a face to face consultation.

There were disabled facilities and patients using a wheel chair could access the practice, there was designated disabled parking and part of the reception desk was lowered. For patients who did not speak English, a translations service was available. Patients could request for appointments using a smart phone application and on the practice website. The practice website could be translated into various languages. There was a self-check in which avoided the need for patients to queue at reception and was available in various languages.

The practice was proactively trying to improve the number of patients it identified for possible referral for dementia testing through the use of iPads with bespoke software for memory testing. The practice purchased two iPads which were used by patients who went through series of questions after which the results and analysis were forwarded to the GP. The software could be used in 16 different languages and was useful for many patients registered at the practice who did not speak English as a first language. Since April 2015 the practice had carried out 34 successful dementia assessments using this software.

This inspection was carried out when Muslims were fasting during the month of Ramadan. We saw that the practice made available a leaflet produced by Diabetes UK entitled

'Ramadan and diabetes' which provided practical advice on how to keep good diabetes control during the fasting period. This was useful as this would be relevant to many patients registered at the practice.

The practice adapted its clinics to match the needs of patients. For example, the practice had increased its Asthma clinics in response to the number of patients with an asthma diagnosis registered with the practice

The practice also recognised that they had an increase in the number of migrants and asylum seekers into the area 18 months previously. As a response staff were given training (delivered by NHS England and the CCG) so that these patients could register at the practice without any issues. For example, the practice used its own address to register those that did not have a fixed address.

The nurse manager and healthcare assistant attended a diabetes education programme so they could advise patients what to expect when referred for the course. They also tailored the advice they gave to ensure it was consistent with what was delivered on the course. The practice also adapted the pictorial guide from 'Eatwell' for patients with diabetes and pre-diabetes. Eatwell Guide is a policy tool used to define government recommendations on eating healthily and achieving a balanced diet.

Access to the service

The practice telephone was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.30am to 11am every morning and 3.30pm to 6pm daily. Previously the practice closed on a Wednesday afternoon but as part of PCCF, it was now open. The practice offered a total of six hours extended opening. For example, on Mondays the practice offered extended hours with a GP and nurse. On Tuesdays it offered extended opening with a GP, an ANP and a nurse (for 30 minutes). On Fridays extended opening was available with a GP for 30 minutes. The practice hoped to offer seven day access as part of a scheme commissioned by CCG.

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

- 77% of patients were satisfied with the practice's opening hours compared to the national average of 76%.

Are services responsive to people's needs?

(for example, to feedback?)

- 56% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

The practice had changed its appointment system on 1 October 2014 to a patient access system. Under this system patients spoke with reception staff asking for call back from a GP. The GP would then determine if patients needed to be seen face to face. Almost all the patients we spoke with told us that they could get an appointment when needed. Many of the patients we spoke with told us that the new appointment system worked well. Appointments with nurses and Healthcare assistant could be pre-booked in advance.

The practice had conducted an audit of the before and after implementation of the new appointment system. It showed that the practice on average increased the number of patients treated each week. For example, results showed that on average 626 patients were treated before the new system was implemented. This was increased to 650 patients after the implementation of the appointment system. The number of average day waits to see a GP had decreased from 1.9 days before to 0.6 days.

The practice had also conducted a survey of a number of patients selected at random to get feedback on the system. Overall the feedback was positive. However, the practice also recognised that there were many patients that were unable to get through and the feedback was only from those patients that were able to get through on the phone. Furthermore the practice recognised that the new appointment system was not fully ideal for some patients such as those that did not speak English or those patients that had difficulty with their hearing. As a result the practice had carried out a review of the system involving staff and patients which identified a number of issues. For example, staff stated that as a result of the telephone appointment

system greater pressure were being put on healthcare assistant and nurses. As a result a new appointment system was being proposed which included a mixture of appointment types. They included on the day face to face appointments, home visits, emergency appointments, online appointments, appointments bookable in advance as well as a telephone triage system with a duty GP. This had been approved by staff and the GP partners and the practice was due to consult with the Patient Participation Group (PPG) at the next meeting for approval.

Listening and learning from concerns and complaints

The practice had an effective 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 information was available to help patients understand the complaints system.

The practice had received 14 complaints from April 2015 to March 2016. We found complaints were handled appropriately. Lessons were learnt from individual concerns and complaints and also from analysis of trends. An annual meeting was held to review complaints received and share any learning from them. For example, an action plan was developed from the annual analysis of complaints with three key areas for further improvement. One of the issues identified was the need to improve access. We saw that the practice was responding with the proposed new changes to the practice appointment system. Both staff and the patients were consulted as part of the change. Secondly, it was recognised that staff needed training in conflict resolution and this had been completed. The final issue was the maintenance/ renovation of the male toilets and the practice was working with the PPG to secure funding.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice summarised its mission, its delivery mode, the process it would use to deliver outcomes and the outcomes it was trying to achieve. For example, its mission statement was to put patient first, provide safe, high quality service delivered through excellent patient experience. Its delivery mode was through various mechanisms such as offering home visits, extended hours, working collaboratively with other providers as well as offering various enhanced services. To achieve these goals, the practice recognised the need to ensure quality and safety through following of appropriate pathways and effective significant even analysis. It also recognised that staff development was necessary for effective delivery as well as ensuring development of its infrastructure. The examples of outcomes it was trying to achieve included prevention of premature deaths, enhanced quality of life for patients with long term conditions and treating people in a safe environment and protecting them from avoidable harm. The summary was displayed in the practice for the benefit of staff. Staff understood the values of the practice and worked well as a team to ensure patients received safe and effective care.

As part of its vision to deliver better infrastructure it was looking at moving to a new purpose built building and was currently in the planning stages.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that there was a clear staffing structure.

Staff were aware of their own roles and responsibilities. The practice had summaries of lead roles which were displayed in the consultation rooms. For example, some of the lead roles taken on by the GP partners included cancer care, safeguarding and palliative care. Other GPs in the practice took on lead roles for mental health, care planning, clinical governance and childhood surveillance. The nurses took on lead roles for various long term conditions as well as

infection control and cytology. The nurse manager was also the lead for ensuring education and development for the practice. The reception manager was responsible for complaints as well as management of administration team.

A programme of continuous clinical and internal audit was used to monitor quality and to make improvements with learning shared with clinicians.

There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. The practice was able to demonstrate that they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and took the time to listen to them. The practice was well organised and information was well documented.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment people received reasonable support, truthful information and an apology.

There was a clear leadership structure in place and staff felt supported by management. Staff told us the practice held regular practice meetings. Minutes of meetings we looked at showed that clinical meetings we held jointly with a nearby practice owned by the partners. This provided learning opportunities for all staff. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at practice meetings and felt confident and supported in doing so.

The practice held regular protected learning time (PLT) events for all staff in which the practice closed for half a day. This provided opportunities for training and team building. Staff said they felt respected, valued and supported, by the partners and senior staff in the practice.

Are services well-led?

Good 

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

For example, staff had been involved in discussions about the changes to the appointment system and had taken on board comments during evaluation. We found the practice to be well organised.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. The practice had a patient participation group (PPG) which met quarterly. We saw the next four PPG meeting dates had been displayed in the reception to inform and encourage patients to attend. We spoke with the chair of the PPG who told us that they were able to provide feedback on the new appointment system as well as other issues. For example, the PPG chair told us that members of the PPG consulted on the colour scheme as well as the selection of furniture for the waiting area in reception when it had been renovated.

The practice sought feedback from patients that had used the new appointment system. Patients were selected randomly and the feedback was used to help develop a system that would most suit the needs of patients. We saw evidence that the practice consulted staff members also on how the system worked and how it could be improved. The evaluation of the surveys and the proposed new appointment system was due to be discussed at the next PPG meeting for approval.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. Practice staff were well supported in their professional development.

Although the practice was located in a purpose built building there were plans to relocate and the discussions were ongoing with the local authority regards nearby vacant. We were shown architects impression of the proposed new practice building which it was thought would better help meet the needs of patients.

The practice was a training practice for qualified doctors training to be a GP and a teaching practice for medical students. The practice was planning to take on medical students from a local university which was opening a medical school in 2017. Some of the practice nurses also mentored student nurses from a local university.

The practice was forward thinking and had taken part in the CCG funded PUSH scheme to offer individualised care plans to the 50 high cost patients who either attend A&E frequently or have high unplanned hospital admission. The practice was looking at delivering integrated care in the community through the Multi-Speciality Community Provider (MCP) scheme it had been invited to join.

The practice was working with the voluntary sector (Legacy, West Midlands), a registered charity focussing on post-war migrant communities in Birmingham. It was due to attend the launching of the 'Family Fit' project with the Lord Mayor of Birmingham. The project aimed to work with local families, mainly ethnic minorities, to improve their health. The focus would be on families as opposed to the individuals with an aim to address obesity in school children.