Iridium Medical Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Iridium Medical Practice on 19 May 2015. We have rated this practice overall as good.

Specifically, we found the to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances, and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- The practice had a system for reporting, recording and monitoring significant events over time to keep patients, staff and visitors safe. However, we found an emergency medicine that was out of date.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice was clean and hygienic with good facilities and was well equipped to treat patients and meet their needs.
- The practice had appropriate skill mix of staff with expertise and experience in a range of health conditions.
- The practice was proactive in helping people with long term conditions to manage their health and had arrangements in place to make sure their health was monitored regularly.
- Information about how to complain was available and easy to understand.
- We found that the service was well led with policies and procedures in place to support the running of the practice.

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

The provider should:

Summary of findings

- Ensure all emergency medicines are in date and safe to use.
- Ensure infection prevention and control policy reflects the lead staff member.
- Ensure systems are in place to monitor if cleaning is being done by cleaners according to the practices cleaning schedules.
- Obtain details of legionella testing from the landlord and ensure any actions identified are followed.
- Consider if the Automated External Defibrillator (AED) shared within the building by other services would be immediately available in the event of an emergency. An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.
- Ensure all staff are fully aware of the Mental Capacity Act.
- Ensure an adequate business continuity plan is in place.

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?

Good

The service is rated as good in respect to safe. There were systems in place to ensure patients received a safe service. Lessons were learned from incidents and communicated widely to support improvement. There were enough staff to keep patients safe. Equipment required to manage foreseeable emergencies was available and was regularly serviced and maintained.

Are services effective?

Good

The service is rated good for effective. Clinical staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. We saw evidence where NICE guidance was discussed in clinical meetings. There was evidence that the practice had joint working arrangements with other health care professionals and services to enable an integrated approach to care. Effective arrangements were in place to identify, review and monitor patients with long term conditions and those in high risk groups. Staff had received training appropriate to their roles. Where staff had required training this was arranged.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients told us they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We saw that staff treated patients with kindness and respect and maintained confidentiality. Many of the staff were multilingual and translation services were available to people whose first language was not English.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was aware of the needs of their local population and engaged with the Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients we spoke with during our inspection reported good access to the practice and said that urgent appointments were available on the same day. On the day of the inspection we saw appointments were still available in the afternoon. The practice had good facilities and was well equipped to treat patients and meet their needs. The practice had a positive approach to using complaints and concerns to improve the quality of the service.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy and had aspirations to become a teaching practice. 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 meetings. There were systems in place to monitor and improve quality and identify risk. The practice did not have a patient participation group (PPG) but was looking to set up a virtual group. However, other mechanisms were in place to collect patient feedback. It was clear from our discussion with the GP partners and staff that they were aware of the issues patients wanted addressed. We saw evidence that the practice was addressing them.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Practice staff held a register of patients who had long term conditions and carried out regular reviews. There was a recall system in place when patients failed to attend for their reviews. For patients with the most complex needs, GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Practice staff liaised with local health visitors to offer a full health surveillance programme for children. Checks were also made to ensure maximum uptake of childhood immunisations. The practice nurse offered immunisations to children in line with the national immunisation programme. Alerts and protection plans were in place to identify and protect vulnerable children.

Working age people (including those recently retired and students)

Good

This practice is rated as good for the care of working age patients, recently retired people and students. The practice provided extended opening hours twice a week from 6.30pm to 8.30pm for patients who were unable to visit the practice during normal working hours. The practice also had arrangements for patients to have telephone consultations with a GP. The practice was proactive in offering a full range of health promotion and screening that reflected the needs of this age group. This included health checks for patients aged 40 to 70 years of age. Many of the staff were multilingual which helped reduce language barriers. The practice also had access to interpreters and staff were aware of how to book an interpreter.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for patients with a learning disability and most of these patients had received a follow-up. It offered longer appointments for these patients. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. GPs carried out home visits to patients who were housebound and to other patients on the day they had been requested. Staff were aware of their responsibilities about sharing information, documenting safeguarding concerns and how to contact the necessary agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. The practice had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Annual health checks were offered to patients with long term mental health conditions.

Summary of findings

What people who use the service say

As part of the inspection we sent the practice comment cards so that patients had the opportunity to give us feedback. We received 31 completed cards, the feedback we received was overall positive, and patients described the quality of the service and staff as 'excellent' and 'very good'. Three comment cards we reviewed stated that patients found it difficult to get an appointment at times. Three other comment cards also stated that some staff members were rude and unhelpful at times.

On the day of the inspection we spoke with nine patients. All of the patents we spoke with were positive about their experience. Patients were positive about the service and staff.

We looked at results of the national GP patient survey published in January 2015. There were 444 surveys sent out to patients as part of the national GP survey and 97 were returned constituting a 22% completion rate. The results of the national GP survey highlighted areas where the practice was above and below average in comparison to other practices in the local Clinical Commissioning Group (CCG) area. We saw that the survey did not highlight any areas that the practice was significantly better than local CCG area. We saw that 75% of respondents to the survey stated they were satisfied with the surgery's opening hours. This was fractionally better than the local average of 74%. We saw 83%of respondents to the survey stated they were able to get an appointment to see or speak to someone the last time they tried. This was the same as the local CCG average.

Areas where the practice was performing below the local CCG average were around telephone access. We saw 40% of respondents to the patient survey stated they found it find it easy to get through to the surgery by phone. This was significantly lower than compared to the local average of 63%. Forty six percent of respondents also described their experience of making an appointment as good compared to the local average of 68%. The lead GP partners were aware of this and had changed the appointment system. They were also trying to change and upgrade the telephone system but faced some challenges as they did not own the building. The GP partners also explained that three GP practices had merged to become a partnership of four GPs within the last 12 months. They had faced many challenges of integrating the different patient groups, staff, systems and ways of working to a single consistent way of working. They told us, and staff we spoke with confirmed, that this had been achieved successfully. Their focus was now to build on this and focus in areas they were aware needed improving. This included some of the access issues. We saw that this was being addressed.

The practice did not have a Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. Patients provided positive feedback regarding the staff and the service. One of the lead GP partners told us that they were in the process of developing a virtual PPG. We saw patients were being encouraged to join the group on the practice website. Although the practice did not have a PPG they had other mechanisms to collect patient feedback and demonstrated that they were aware of and had responded to some of the patient concerns.

Areas for improvement

Action the service SHOULD take to improve

- Ensure all emergency medicines are in date and safe to use.
- Ensure infection prevention and control policy reflects the lead staff member.
- Ensure systems are in place to monitor if cleaning is being done by cleaners according to the practices cleaning schedules.
- Obtain details of legionella testing from the landlord and ensure any actions identified are implemented.
- Consider if the Automated External Defibrillator (AED) shared within the building by other services would be immediately available in the event of an emergency. An AED is a portable electronic device that analyses life

threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.

- Ensure all staff are fully aware of the Mental Capacity Act.
- Ensure an adequate business continuity plan is in place.

Iridium Medical Practice

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 advisor and a nurse specialist advisor.

Background to Iridium Medical Practice

Iridium Medical Practice is a registered provider of primary medical services with the Care Quality Commission (CQC). The practice was a partnership of two GPs. However, during the last 12 months one of the GP partner had left and three other partners had joined. The practice manager who was the registered manager had recently left the practice. The practice was in the process of submitting appropriate forms so that the changes were reflected on CQC records.

The surgery served a population of approximately 13285 patients. The practice is open Monday to Friday 8am to 6.30pm. Extended opening was provided on Monday and Fridays from 6.30pm to 8.30pm. The practice has opted out of providing out-of-hours services to their own patients. This is provided by an external out-of-hours service contracted by the CCG.

Clinical staff included five GPs, this included four partners and one salaried GP (four male and one female). The nursing team included two advanced nurse practitioners who were qualified to diagnose medical problems, offer treatments, perform advanced procedures, prescribe medications, and make referrals for a wide range of acute and chronic medical conditions within their scope of practice. There were also two nurse practitioners and three healthcare assistants. The administration team included a business manager, clinical excellence manager, who had been recruited very recently, an operations manager and a team of reception staff.

The practice holds a General Medical Services contract with NHS England and has expanded its contracted obligations to provide enhanced services to patients. An enhanced service is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients.

Why we carried out this inspection

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

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?

Detailed findings

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

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

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

Before inspecting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 19 May 2015. During our visit we spoke with a range of clinical and non-clinical staff and spoke with patients who used the service. We observed how people were being cared for and talked with patients.

Good

Are services safe?

Our findings

Safe track record

We reviewed safety records and incident reports over the last year to show that the practice had managed them consistently over time. The practice used a range of information to identify risks and improve patient safety including reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we saw that an incident concerning repeat prescription was identified and immediate action was taken to contact the patient and then new systems were put in place to prevent reoccurrence.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these.

Staff we spoke with told us that they had access to the significant event policy which described the process for reporting incidents. They explained that they would speak with the management team and fill in a report. They told us, dependent on the incident, they usually received feedback with any learning identified in team meetings. Another staff member we spoke with gave us a specific example where they had reported an incident regarding an interaction with a patient in the incident book. They told us that learning was shared in regards to this incident in the practice meeting. We also saw an example where an audit was initiated partly as a result of a significant event.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Training records made available to us showed that all staff had received relevant role specific training on safeguarding. This was confirmed when we spoke with staff. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours and those details were easily accessible. We saw safeguarding contact details at the local authority were displayed in staff areas with advice on how to raise concerns.

One of the GP partners was appointed as the lead for safeguarding vulnerable adults and children. All the GPs and practice staff had been trained to an appropriate level and demonstrated they had gained the necessary knowledge from this training to enable them to fulfil this role. We saw evidence that learning was shared through clinical meetings. For example, two of the GPs went on a GP update course and shared learning with all clinicians. Staff confirmed they knew who the safeguarding lead was and that they were able to access policies and procedures which we saw were available in the practice. Staff explained to us the processes they would follow in the event they became concerned that a patient may be at risk of harm. The lead safeguarding GP was aware of vulnerable children and adults registered with the practice and kept a record. There was a system to highlight vulnerable patients on the practice's electronic records. This included information so that staff were aware of any relevant issues when patients attended appointments. The lead GP we spoke with also explained how they had learned from a recent safeguarding incident involving an elderly patient living in a care home.

A chaperone policy was in place and information about the service was visible on the waiting room noticeboard and in consultation rooms. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during an intimate medical examination or procedure. Staff told us they offered a chaperone service if patients preferred. Staff records looked at and staff we spoke with confirmed they had received chaperone training from an external agency. They could explain the purpose of the role and how best to carry out the role. We saw information displayed in the reception area and consultation rooms informing patients that they could have a chaperone. Non clinical staff carried out chaperone training when clinical staff were not available. We saw that all relevant staff had undergone criminal records check carried out through the Disclosure and Barring Service (DBS) or were currently undergoing the checks. DBS checks help to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Good

Are services safe?

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked in the fridges were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw that there was a protocol for repeat prescribing which was in line with national guidance. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw PSDs for flu vaccinations; pneumonia and vitamin B12 injections signed off by one of the GP partners. We saw evidence of training that nurses and the health care assistant had received to ensure they were competent to administer the medicines referred to either under a PGD or in accordance with a PSD.

Cleanliness and infection control

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, the policy was comprehensive in outlining the method for taking precautions around spillages including bodily fluids. We saw spillage kits were available as well as personal protective equipment including disposable gloves, aprons and coverings. There was also needle stick injury protocol and staff knew the procedure to follow in the event of an injury. The infection control policy asked staff to refer to the protocol in the event of a needle stick injury. There was a lead for infection control and staff we spoke with were aware of the lead.

The practice was located in a new purpose built building and we observed the premises to be clean and tidy. The building was not owned by the GP partners and cleaners were organised by the buildings landlord. Management staff told us that the cleaners had a cleaning schedule but the practice did not keep a record. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with proximity sensor taps, hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Management staff were unsure if legionella testing had been undertaken at the practice. The building was not owned by them and they were trying to get confirmation from the landlord (NHS property services). Management staff told us that they were told legionella testing had been done but they could not get written evidence from the landlord to confirm this.

Equipment

We observed that staff had relevant equipment to enable them to carry out diagnostic examinations, assessments and treatments. Staff we spoke with explained all equipment was tested and maintained regularly. We also saw equipment maintenance logs and records to confirm this. Portable electrical equipment was regularly tested. We saw evidence of calibration of relevant equipment was carried out by an external organisation; for example spirometers, ear syringes, baby weighing scales and blood pressure measuring devices.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). DBS checks help to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. We saw that all clinical staff had undergone DBS checks and most administration staff had undergone DBS checks or were going through these checks.

The practice had appropriate measures in place to ensure there were sufficient numbers of suitably qualified, skilled and experienced staff on duty. We saw a weekly staff rota

displayed in the staff reception area. Staff we spoke with told us that the rota remained the same each week so they knew exactly what their roles and responsibilities were each week. We saw that the rota reflected busy periods where additional staffing requirements were needed. For example, more staff were made available at reception staff during mornings and specific days when there was more demand for services.

Monitoring safety and responding to risk

The partners did not own the building and the landlord (NHS business services authority) carried out some of the safety monitoring such as fire risk assessments. Management staff told us that they found it difficult to get confirmation or copies of safety checks that were carried out by the landlord. However, we saw that the practice was in the process of organising a fire safety risk assessment through an external agency. This was supported by a fire safety policy which outlined some of the risks in the building and actions to take in certain circumstances. Records looked at showed that staff had training in fire safety and there was a fire evacuation plan with designated fire marshals. We saw fire alarm testing was carried out and we were told that this was carried out by the landlord.

The practice also instructed an external agency to carry out a health and safety risk assessment. We saw other regular checks to protect patients were in place. They included checks for medicines management, dealing with emergencies and equipment.

There was appropriate information about health and safety clearly displayed for all staff to see. For example, laminated sheets were displayed in staff notice boards for correct procedure for manual handling, what to do in the event of fire or first aid as well as procedures for dealing with spillages.

Arrangements to deal with emergencies and major incidents

We saw evidence that systems were in place to manage emergencies. We saw records held by the practice that showed all staff had received training in basic life support. There was emergency equipment available within the practice. This included oxygen and an automated external defibrillator (AED), which is used to attempt to restart a person's heart in an emergency. Staff we spoke with knew where this equipment was kept, records indicated it was checked regularly and we saw records to confirm staff had been trained to use it. The building was located in a health centre and was shared with other services such as the health visiting team. We saw that there was only one AED that was shared within the building, which may limit its availability.

Emergency medicines were kept securely in the reception area. Staff we spoke with were aware of the location they were kept in. We saw medicines which included those for the treatment of cardiac arrest and anaphylaxis (an allergic reaction). The practice had processes in place to check whether emergency medicines were within their expiry date and therefore suitable for use. We checked the dates of all the emergency medicines and found one medicine that had expired the previous month. We informed the practice management who made arrangements to replace the out of date medicine.

The practice did not have a business continuity plan (BCP) in place to deal with a range of emergencies that may impact on the daily operation of the practice. However, we were told that this was being written up. We were told that as part of the contingency planning a buddy GP site had been identified and would be incorporated within the BCP. We were told that discussions had taken place with the other practice and they were now waiting official confirmation.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE). NICE is responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment. We saw evidence where NICE guidance was discussed in clinical meetings. For example, minutes of a clinical meeting from February 2015 demonstrated that NICE guidance was discussed in relation to the management of patients with diabetes as well as cardiovascular disease. We saw evidence that an audit was conducted in line with NICE guidance which identified a number of patients that were not on a medication recommended by NICE. We saw that action had been taken and a full audit cycle was due so that the impact of the action could be assessed.

We reviewed medicine management data which showed that the practice was in line with local practices for prescribing of antibiotics. In some areas it was lower for the prescribing of some antibiotics. For other areas, the practice was overprescribing but the latest data we looked at showed that the practice was improving this to meet local Clinical Commissioning Group (CCG) targets. 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 GPs we spoke with demonstrated to us how they used computerised tools to identify patients with complex needs and who had multidisciplinary care needs documented in their case notes.

These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met. We saw that the A&E attendance for the practice was higher than the local average. We were told that the practice was close to the Heartlands Hospital which contributed to this. We saw actions were being taken to reduce the level of A&E attendance by following patients up where appropriate.

Discrimination was avoided when making care and treatment decisions. Our discussions with the GP partners showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. For example, the GP partners explained that 30% of the practice population were made up from Black Minority and Ethnic (BME) groups, and represented a disproportionately higher attendance at the A&E department of the nearby hospital. The practice was working collaboratively with the patients to change this. Other staff we spoke with also confirmed that discrimination was avoided when making care and treatment decisions.

Management, monitoring and improving outcomes for people

Staff throughout the practice had key roles in monitoring and improving outcomes for patients. These roles included infection control, scheduling clinical reviews, managing medicine alerts and medicines management. There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for patients with long-term conditions, such as diabetes and that the latest prescribing guidance was being used. The computer system flagged up relevant medicines alerts when the GP prescribed specific medicines.

Clinical staff actively participated in recognised clinical quality and effectiveness schemes such as the national Quality Outcomes Framework (QOF) and the local Clinical Commissioning Group (CCG) enhanced service schemes. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually. We saw evidence that QOF performance was reviewed monthly. One of the management staff showed us monthly printouts of the practice QOF performance which were reviewed in meetings. The practice had dedicated staff members to

Good

Are services effective?

(for example, treatment is effective)

follow up specific patient groups for flu vaccination. Data showed that 70% of patients over the age of 65 and 44% of at risk patients under 65 years had received a flu vaccination so far this year. We saw that other groups such as pregnant women, carers and children also received vaccination for this year, although the figures ranged from 20% to 30%. However, these were latest figures and the practice was working towards increasing the uptake.

The practice held regular clinical meetings to discuss clinical matters such as management of patients with diabetes, blood pressure and cholesterol. The practice meetings were used to discuss, significant events, flu targets, outcome of audits and any complaints received. This included GP partners and all other staff.

There was a system in place for carrying out clinical audits. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through systematic review of care and the implementation of change. It includes an assessment of clinical practice against best practice such as clinical guidance to measure whether agreed standards are being achieved. The process requires that recommendations and actions are taken where it is found that standards are not being met. For example, we saw learning from a recent warfarin audit was discussed at the team meeting.

We saw an example where an audit was initiated partly as a result of a significant event.

This incident involved a patient who should have been diagnosed with diabetes. The audit result identified a further 27 out of a 128 patients who should have been diagnosed with diabetes. We saw that changes were made to clinical practice as a result of the findings of the audit.

A cancer diagnosis audit was conducted as a response to a patient being admitted to hospital for abdominal pain and a test to establish if they had cancer. The surgery wanted to establish if they were picking up on all red flag symptoms for this type of cancer. The audit identified 11 patients who were diagnosed with this type of cancer over the last two years. The findings showed that four of the patients should have been referred for confirmatory tests and this was discussed at clinical meetings so that all clinical staff could familiarise themselves with red flag symptoms.

We looked at a smoking cessation audit which showed that all patients who smoked and had a heart attack had not received any smoking cessation advice. An action plan was implemented and a second audit conducted showed that improvement had been achieved with 75% of patients who had a heart attack and were registered as smokers were given smoking cessation advice.

The practice had a palliative care register and had regular contact with multidisciplinary teams and attended relevant meetings to discuss the care and support needs of these patients and their families.

The GPs in the practice undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept their skills up to date. There was a consent policy and a form to gain consent for medical treatment, immunisation, investigation and operation. There was a section for parents if the patient was a child as well as a section for an interpreter to sign. There was also a section to withdraw consent.

Effective staffing

The practice staff included medical, nursing, managerial and administrative teams. During our inspection we looked at a range of staff training records. These showed staff were up to date with training, for example, in basic life support and safeguarding. We saw all GPs except one partner had been revalidated and they were due to go through revalidation in October 2015. Every GP is appraised annually and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

Staff also had annual appraisals but were now due appraisals for this year. Staff told us that these were used to identify training needs and action plans were formed. Staff we spoke with confirmed the practice provided training and funding for relevant courses. One staff member we spoke with told us that training was encouraged; they told us that they had received chaperone training from an external agency and they were given lead roles with appropriate training via external agencies. Management staff we spoke with told us that they intended to train all staff in different administrative roles so that the practice could be more flexible and offer a safe service during unplanned staff absences.

Working with colleagues and other services

Good

Are services effective?

(for example, treatment is effective)

Discussions with staff and records showed that the practice worked in partnership with other health and social care providers such as social services, end of life care teams and district nursing services to meet patients' needs. The health visiting team was based in the same building. We spoke with a member of the team who told us that the practice worked well with them. They told us that they had a good working relationship with the practice, they shared information and were invited to share information both informally and formally through multidisciplinary team meetings

Multidisciplinary team meetings were held quarterly to discuss patients with complex needs, for example those with end of life care needs or children who were considered to be at risk of harm. These meetings included health visitors and palliative care nurses. Decisions about care planning were documented in each patient's record.

Patients who had accessed the out-of-hours service were reviewed and followed up where necessary by the GP at the practice. Correspondence received from other services was dealt with by a GP on the day.

The practice worked with other service providers to meet patients' needs and support patients with complex needs. It received blood test results and x-ray results. These were assigned to an available (duty) GP for action on the same day. Letters received from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post scanned on to patient records and action taken within 48 hours.

Information sharing

We saw evidence where Special Patient Notes (SPNs) were provided by the GP to out-of-hours GP services to improve the care of patients. The practice had also signed up to the electronic Summary Care Record. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

The practice had systems in place to provide staff with the information they needed. An electronic patient record system was used (VISION online) by all staff to coordinate, document and manage patients' care. All staff were trained to use the system and told us they found it easy to use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The GP partners and staff told us that they were migrating to a newer system which they felt would enable them to offer a better service.

The practice staff including GP partners we spoke with told us they had good working relationships with community services, such as district nurses and the health visiting team. We spoke with the health visiting team who were located within the same building. The health visiting team confirmed that they had a good working relationship with the practice.

Consent to care and treatment

We spoke with six patients on the day of our inspection. All the patients told us they had been involved in decisions about their healthcare and treatments. They had been provided with sufficient information that enabled them to make choices and felt they had been able to ask questions when they had been unsure about anything.

We found that staff were aware of the Mental Capacity Act 2005, but two of the GPs were not aware of all aspects of the MCA act including the Children Act 2014 and Deprivation of Liberty Safeguards (DOLS). However, the GP demonstrated a clear understanding of the Gillick competencies. The Gillick competencies help clinicians to identify children under 16 years of age who have the legal capacity to consent to medical examination and treatment.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. Where appropriate we saw evidence carers of patients were involved in the treatment decisions.

The GPs in the practice undertook minor surgical procedures and there was a consent policy and a form to gain consent for medical treatment, immunisation, investigation and operation. There was a section for parents if the patient was a child as well as a section for an interpreter to sign. There was also a section to withdraw consent.

Health promotion and prevention

Good

Are services effective?

(for example, treatment is effective)

It was practice policy to offer all new patients registering with the practice a health check with the healthcare assistant (HCA). The GP was informed of all health concerns detected and these were followed-up in a timely manner.

The practice also offered NHS Health Checks to all its patients between 40 and 75 years of age. The NHS Health Check programme was designed to identify patients at risk of developing diseases including heart and kidney disease, stroke and diabetes over the next 10 years. Data we looked at showed that 340 patients out of a total of 1482 eligible patients took up the offer of a health check for 2014-15.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice offered smoking cessation advice to those patients registered as smokers. The practice clinical system showed that 88% were offered advice.

Similar mechanisms of identifying 'at risk' groups were used for patients who were on multiple medication, at risk of flu, those who were deemed as obese and those receiving end of life care. These groups were offered further support in line with their needs.

Latest data we looked at showed that the practice performance in relation to health promotion activities such as e.g. cervical screening, diabetes checks, cardiovascular disease prevention as well as child health surveillance was in line with local and national rates.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. The practice offered flu vaccinations to patients over the age of 65 and to patients with chronic diseases such as asthma, diabetes, heart disease, and kidney disease.

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. We saw some health and welfare information displayed in the notice boards and television screens in the waiting area. We also saw evidence on the practices' Facebook page of various health promotion campaigns such as impact of smoking, management of conditions such as arthritis and stress.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with nine patients during our inspection and all the feedback we received was positive about the service and staff. We received 31 completed cards where patients shared their views and experiences of the service. The comment cards were mixed with mostly positive feedback. However, six comments cards while they were positive about the service commented on the difficulty of getting through on the telephone or the waiting time to be seen after their appointment time. Three of the comments cards also stated that some reception staff could be rude on occasions.

Before our inspection we noted some negative feedback on NHS choices regarding reception staff. The GP partners we spoke with were aware of this and told us that this was something that they were addressing through on-going training and through trying to improve access.

During our inspection we saw that staff treated patients with kindness and respect ensuring their confidentiality was maintained. Reception staff told us that a quiet room was available in the practice if a patient requested private discussions. We saw a notice in the waiting area informing patients of this. A comment card we received stated that reception staff offered them water in the waiting room and offered them a room on their own when they were in distress.

We reviewed the most recent data available for the practice on patient satisfaction from the national GP Patient Survey dated January 2015. The evidence showed that patients were satisfied with the consultations and felt they were treated with compassion, dignity and respect. Data showed that 31% of respondents said the last GP they saw was very good at treating them with care and concern. This was below the local Clinical Commissioning Group (CCG) average of 45%. However, 51% of patients also stated that GPs were good at treating them with care and concern. This was above the CCG average of 37%. We also looked at the same data for nurses and we noted a similar pattern. Data we looked at for waiting times showed that the practice performed lower than the local CCG average meaning that patients waited longer for their appointment compared to local practices. The GP partners told us they were aware and were taking action to address waiting times. We saw and staff confirmed that more telephone consultations were offered with a duty GP who could triage urgent cases. The practice had also employed two nurses and the patients we spoke with on the day told us that they had no issues with access.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The national GP Patient Survey information we looked at relating to questions about patients involvement in planning and making decisions about their care and treatment was mixed. For example 29% of patients rated the GPs as very good for explaining tests and treatments to them compared to the CCG average of 45%. However, 56% of patients rated the GPs as good for the same question compared to the CCG average of 38%. We saw a similar pattern in regards to question of GPs involving patients in decisions about their care.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in the decision making process 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 they wished to receive. Patient feedback on the comment cards we received WAS positive regarding the service and treatment.

Many of the staff members were able to speak some of the languages spoken by the patient population including Punjabi and Urdu. However, translation services were available for patients who did not have English as a first language and where staff members could not translate.

Patient/carer support to cope emotionally with care and treatment

We did not speak with or receive any comment cards from patients who were also carers. However, one comment card we reviewed highlighted that staff responded compassionately when they needed help and provided support when required.

The practice aspired to offer holistic support to patients with detailed psychological reviews to help them cope with

Good

Are services caring?

their condition. Notices in the patient waiting room, on the TV screen and patient website also informed patients how to access a number of support groups and organisations. For example, there was a link to patient.co.uk, a health site that patients could use to access information on various health related matters.

One GP partner we spoke with told us and evidence we looked at confirmed that they had called a family after a bereavement to offer support and counselling. We saw that the Cruse bereavement care number was given to families. Cruse supports people after the death of someone close to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had merged with four separate providers becoming partners within the last 12 months. The partners and management staff told us that they had worked very hard to integrate all staff together to work as part of one team while responding to any legacy issues.

We found the GP partners and staff were aware of the needs of the patients and areas that needed to be improved. It was clear that the practice was working to implement systems to ensure it was responsive to patients' needs, to maintain and improve the level of service where appropriate. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, one of the lead GP partners discussed how they had integrated a consistent approach to the delivery of the service with staff coming from four separate practices with different ways of working. They were aware that access was an issue and had been working on increasing this through effective management of the appointment system with extra telephone consultations being offered. A new IT system was being installed, it was hoped that this would give greater flexibility in the way the surgery could manage its appointment system.

The practice did not have a Patient Participation Group (PPG) but was in the process of setting one up. PPGs are groups of patients registered with a practice who work with the practice to improve services and the quality of care. However, the GP partners were aware of some of the feedback from patients through collection of comments and carrying out patient surveys. The lead GP partner told us they monitored feedback on NHS choices website and aware of where the improvements were required. For example, they were aware that there some negative feedback in regards to some staff attitude as well access. We saw that the practice responded to some feedback and invited patents for further discussion in the practice. We saw that the training of staff focussed around customer service and patients we spoke with on the day were very positive about all staff.

The practice was part of the Birmingham Cross City CCG which was made up of 115 GP member practices which were divided into 10 Local Commissioning Networks (LCNs). One of the GP partners we spoke with told us that they were the lead for their LCN. The purpose of these networks was to develop key priorities and determine what action needed to be taken at a local level to enable delivery of the CCG's objectives. We saw evidence that the practice had taken part in a pilot research study with the University of Birmingham so the needs of the patient population could be better understood.

Tackling inequity and promoting equality

The practice proactively removed any barriers that some people faced in accessing or using the service. A female GP worked at the practice and was able to support patients who preferred to have a female doctor. Arrangements were also in place for temporary residents to register at the practice to ensure vulnerable patient groups had access to a GP when necessary.

There were arrangements in place to ensure that care and treatment was provided to patients with regard to their disability. For example, the practice was located in a new purpose built building with consultation rooms on one level and there were no steps to negotiate. Doors were wide enough for patients in wheelchairs to gain access. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

Many of the staff at the practice were multilingual and could collectively speak some of the languages spoken by patients. However, a translation service could be used if required.

Access to the service

The practice was open from 8am to 6.30pm Mondays to Fridays. The practice offered extended hours until 8.30pm every Monday and Friday. To improve access a new appointment system was introduced. For example, there was an on call GP who would be available to staff answering calls so that they were able to triage call where appropriate. Same day appointments were available as well as telephone consultations. The practice monitored the number of missed appointments (DNA, did not attend) and had taken action to increase number of appointments available. The practice had doubled its nursing staff from two to four, and two of the nurses were prescribers who were able to issue prescriptions. Staff told us that access to

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointments had been improved since last year. On the afternoon of our inspection we looked at the appointment system and saw that there were appointments still available which suggested that the practice was working towards meeting the needs of patients in regards to access. Some of the patients we spoke with on the day of the inspection told us that they were able to get an appointment on the day.

All the patients we spoke with and most of the comments cards we received showed that patients were satisfied with the appointments system. They confirmed that they could see a doctor on the same day if urgent.

Information was available to patients about appointments on the practice website. This included details on how to arrange home visits. The practice had alternative arrangements in place with an out-of-hours service provider for patients to be seen when the practice was closed. For example, the practice telephone answer machine and the website advised patients on what to do. Patients were advised to contact NHS 111 in the event they needed advice fast.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. There was a suggestion and complaints leaflet readily available in the practice reception area detailing the procedure. This detailed the procedure to provide feedback and to make a complaint. The leaflet also had a pro-forma that patients could complete to facilitate this process.

We saw that the practice had recorded the number of complaints over the last 12 months. We saw that the practice learned from complaints and responded by implementing changes to systems and processes where appropriate. For example, the practice received complaints regarding reception staff being abrupt. Before our inspection we noted this on the NHS choices website and some comments cards we had received also stated this. The practice responded by briefing staff in meetings on the importance of good customer care with tips on how to deal with difficult patients. Staff we spoke with confirmed this.

Some comments cards we had received also stated that patients found it difficult to get through on the telephone and at times found it difficult to get an appointment with a GP at a convenient time. The practice had also received complaints regarding this. The practice responded by contacting the telephone company to implement queuing, announcements or call redirection. However, because they did not own the building they were working with the CCG to resolve this. The practice also responded to complaints regarding access to a GP by making four extra sessions for emergency available for each GP. The practice noticed that they had received fewer complaints about access to appointments after the implementation of this.

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 aimed to provide a quality service for their patients by treating every patient as an individual and respecting their needs and views. The practice also aimed to offer patients a full range of appointments to meet their needs through telephone advice, pre-bookable and late evening appointments. Some of its values were to empower the staff team to do their best and to pursue excellence for the patients, the practice and the team. We saw evidence of these aims in practice. Staff told us that the appointment system had been changed to offer better access. A GP partner told us that access to clinicians had been increased in comparison to what was available 12 months previously. The practice planned to implement a new IT system that they hoped would allow them to become more effective with offering access. Staff told us that they had access to training and support. One staff member was being supported at attend a course as they had aspirations to become a nurse. One lead GP partner who was a GP trainer told us that they were working to become a teaching practice in the near future.

The GP partners we spoke with told us that they had resolved many issues such as increasing nursing staff, reorganised staff to utilise their strengths after the merging of the partnership. They also told us that they had worked to ensure staff coming from different practices were working as a team and were motivated to deliver an effective service.

According to staff, the practice had improved within the last year when three GP surgeries had merged to become a single partnership. They told us that they were working hard to maintain standards and spoke with us about the areas of service needing improvement. Staff members we spoke with told us that they worked well as a new team especially as they had come from different practices before the merger.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in hard copies and on the computer within the practice. We looked at a selection of these policies and procedures. We saw plans were in place to ensure these were reviewed annually or sooner if required. Some of the policies, at the time of our inspection, were being reviewed by the clinical excellence manager who had started work at the practice a few weeks previously. They explained that they had taken over some of the roles of the practice manager who had recently left. They were working towards ensuring policies and procedures reflected actual practice and were up to date.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a national performance measurement tool. We were told by the senior partner GP and the practice manager that QOF data was regularly discussed at their practice meetings. The lead GP told us that they had two staff members dedicated for long term conditions and the employment of two extra nurses helped to improve their QOF achievement. The practice QOF achievement for the year 2013-14 was 84% which was below the local Clinical Commission Group (CCG) average. 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. However, the practice confirmed that they had increased this to 94% for 2014-15. Administration staff members we spoke with told us that they were given specific areas of QOF so that they could contact patients for check-ups or recalls. They told us that each GP oversaw specific area of QOF so that targets could be met.

The practice also carried out clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, we saw an audit was conducted as a result of an incident involving a patient with diabetes. Evidence from other data from sources such as complaints were also used to improve the service. For example, the appointment system had been reviewed and changed as a result of complaints from patients regarding access.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead for infection control and the senior partner GP was the lead for safeguarding. There was a business manager, a clinical excellence manager who was responsible for providing leadership in administrative procedures. They were supported by other team members including the operations manager and head receptionists. Staff members we spoke with told us that they worked effectively as a

Are services well-led?

Good

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

team. They told us that they had come from three separate practices and did not expect to work so well as a team. They felt supported, valued and were clear about their own roles and responsibilities.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice. The partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. A healthcare assistant was being supported financially as they had aspirations to become a nurse.

We saw that practice staff held a range of regular meetings. They included practice meetings, multidisciplinary team meetings and clinical meetings. A staff member we spoke with told us that they were reviewing the meetings for reception staff to make them more specific to their role. This was as a result of feedback from staff.

The practice was taking part on the triumverate leadership program developed by Health Education West Midlands. The key aim of the programme is to provide a leadership approach adopted by three key roles within general practice; GP, Practice Nurse and Practice Manager that will allow the practice to shape and change the future.

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

The practice did not have a Patient Participation Group (PPG). PPG are groups of patients registered with a practice who work with the practice to improve services and the quality of care. The lead GP told us that they were in the process of setting one up and were considering a 'virtual' group with information and discussion circulated on-line. This was because they had difficulty attracting members. We saw that the practice encouraged patients to register for the PPG on their website.

Although the practice did not have a PPG, other mechanisms were in place to ensure they received feedback. They practice encouraged comments and complaints and we saw that they had responded where appropriate. The practice monitored patient feedback on websites such as NHS choices and the lead GP was aware of the issues facing patients registered at the practice. Staff we spoke with told us that they were encouraged to provide feedback on what worked and what didn't at the practice formally through appraisals or informally through meetings.

Staff told us that they could provide feedback in regards to the service and it would be listened and actioned where appropriate. A staff member we spoke with told us that reception meetings were being introduced so that issues being discussed were relevant to them.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training with one staff being supported to become a nurse. We saw that appraisals for most staff were due. One of the management staff told us that they had started their role recently and this was one of their priorities.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example, a diabetes audit was conducted partly as a result of an incident. We saw that the appointment system was reviewed and changed as a result of complaints.

The practice aspired to become a training practice and was working towards this. One of the lead GPs told us that they were taking part in various training courses to support their aim to be a training practice. .