Balsall Common and Meriden Group 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

Key findings

Contents

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. (Previous inspection 5 November 2014 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

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

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

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

People whose circumstances may make them vulnerable – Good

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

We carried out an announced comprehensive inspection at Balsall Common and Meriden Group Practice on 20 February 2018 as part of our inspection programme

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. We saw that when incidents did happen, the practice discussed these at clinical meetings and learned from them and improved their processes as a result.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity, respect and in a timely manner. The National GP Patient survey results reflected this.
- In addition comment cards we received reported high levels of satisfaction with the services at the practice and patients we spoke with were also provided positive feedback.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it. However we did receive feedback that it was sometimes difficult to get through to the practice on the telephone and survey results reflected this.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. This is a training practice and the GP registrars (a GP Registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice) we spoke with felt well supported.

Summary of findings

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

- Continue to monitor patient satisfaction rates in particular in relation to access to the service.

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

Key findings

Areas for improvement

Action the service SHOULD take to improve
The areas where the provider **should** make improvements are:

- Continue to monitor patient satisfaction rates particularly in relation to access to the service.

Balsall Common and Meriden Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector supported by a GP specialist advisor and a Practice Manager specialist advisor.

Background to Balsall Common and Meriden Group Practice

Balsall Common and Meriden Group Practice is based in the Solihull Clinical Commissioning Group (CCG) area, which provides primary medical services under a General Medical Services (GMS) contract. (A GMS contract is a standard nationally agreed contract used for general medical services providers.) to a population of approximately 12,954 patients living in Balsall Common, Meriden and surrounding areas.

The practice's branch surgery, Meriden Surgery, is based at the Old School House, 200 Main Road, Meriden, Coventry, West Midlands. We did not visit the branch surgery as part of the inspection. This inspection focused on Balsall Common Health Centre based at, 1 Ashley Drive, Balsall Common. We reviewed the most recent data available to us which showed that the practice is located in one of the least deprived areas in Solihull. The patients are predominantly white British (95%) with small pockets of mixed race and Asian ethnicity (less than 5%). The practice has an above average patient population who are aged 65 years and over and a lower than average patient population aged 0 to 4 years in comparison to the average practice across England.

The practice is based in a two storey, purpose built health centre housing a number of consultation and treatment rooms some with specialist use. There is a main waiting area and several sub waiting areas. The reception area is situated on the ground floor opposite the entrance. Administration rooms are on both the ground and first floors which can be accessed either by lift or stairs.

The Meriden branch surgery is in a converted building with four consultation/treatment rooms, a main waiting area and reception and office space. Parking and facilities for disabled patients are available at both sites.

There are six permanent GPs (three male and four female) which includes five registered partners and one salaried GP. The practice employs an Advanced Nurse Practioners (female), three practice nurses (female) and one female health care assistant (HCA) with an additional HCA due to join the team in March 2018.The clinical team are supported by the practice manager and 17 administrative staff including secretaries and reception staff.

The practice is a training practice for GP Registrars (fully qualified doctors who wish to become general practitioners) and a teaching practice for medical students in their final year. The registered patient list size is 12458 patients.

The practice is open Mondays, Tuesdays, Wednesdays and Fridays from 8:30am to 6pm. However, the practice is closed every Thursday from 12pm until Friday morning 8:30am. When the practice is closed on Thursday

Detailed findings

afternoons patients requiring an appointment to see a GP can attend the branch surgery in Meriden until 6pm. A reciprocal arrangement is in place on Wednesday afternoons.

The practice has opted out of providing out-of-hours services to their own patients. If patients require a GP out of normal surgery hours a service is provided by Badger, who are an external out of hours service provider contracted by the CCG and can be accessed by the NHS 111 telephone service. Information regarding this is available in the practice waiting areas and on the website.

Good

Are services safe?

Our findings

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

Safety systems and processes

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

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training.
- The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse, harassment, discrimination and breaches of their dignity and respect and staff had a clear understanding of their responsibilities. We saw examples of where there had been concerns the relevant steps had been taken and agencies contacted.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Only clinical staff acted as chaperones, they were trained appropriately and were able to give a good explanation of their responsibilities in relation to this role. They had all received a DBS check.
- There was an effective system to manage infection prevention and control and we saw that a recent infection control audit had been undertaken in February 2017 with follow up actions. For example, faulty pedal bins were identified, noted in the action plan and had been replaced.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions and we saw records to demonstrate this. There were systems for safely managing healthcare waste.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. Rotas for administrative staff were managed by the supervisor and overseen by the practice manager. All of the staff we spoke with told us that there were enough staff to cover the needs of the service. Staff were able to cover for each other when absent.
- There was an effective induction system for temporary staff tailored to their role.
- We saw a comprehensive business continuity plan which included using the Meriden site as a base if the Balsall Common and Meriden Group Practice was not accessible and various contact details were included to enable staff to report issues. A copy of the plan was available electronically therefore enabling it to be accessed off site.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. The practice had a defibrillator (which provides an electric shock to stabilise a life threatening heart rhythm) available on the premises and oxygen with adult and children's masks. Non-clinical staff had received training on basic life support.
- Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. The practice had all necessary equipment in place to identify sepsis for example adult and paediatric pulse oximeters and all staff had undergone training and had easy access to guidelines and the sepsis toolkit.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

Good

Are services safe?

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. Regular meetings were held with community staff.
- Referral letters included all of the necessary information and were all completed by GPs.

Safe and appropriate use of medicines

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

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks.
- The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship. Staff had undertaken specific training in this and the guidelines were regularly reviewed by clinical staff.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines and we saw evidence of this.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues. For example, regarding fire and health and safety. We saw that equipment was calibrated and maintained appropriately in line with manufacturer's guidance.
- The practice monitored and reviewed activity which helped them to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. The GPs and practice manager supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. We saw evidence of an incident regarding a misunderstanding with an appointment. The incident was recorded, investigated and discussed at a practice meeting with actions to be followed up to ensure all staff were aware of the process to follow and how to communicate this to patients.
- The GPs, nurses and the practice manager demonstrated knowledge of recent alerts and there was a system for receiving and acting on safety alerts and we saw that searches had taken place in response to alerts. We saw evidence that these were discussed at practice meetings. The practice also learned from external safety events as well as patient and medicine safety alerts.

Good

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. The GP demonstrated comprehensive knowledge of the National Institute for Health and Care Excellence (NICE) guidelines and we saw evidence from patient records of how these had been applied in practice. For example, in asthma treatment, diabetes and primary prevention of coronary heart disease and hypertension. We also saw that the practice had discussed changes with GP trainees, this had been recorded in clinical meeting notes.

- We saw that patients' needs were fully assessed which included their clinical, mental and physical wellbeing.
- There was no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- The practice had a register of patients which was reviewed and updated at regular intervals. Patients with chronic disease problems were on appropriate registers and had annual recalls and reviews relating to their disease.
- Patients who may be at risk of admission were offered reviews to ensure that they could be managed safely at home. They had access to the GP through a dedicated telephone line.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- Carers' details were noted on the patients records so the practice could liaise with them to coordinate effective long-term care of the elderly. Housebound patients were flagged on the clinical system to identify those for whom domiciliary services were being provided for services such as monitoring anticoagulant medicine. (Anticoagulants are medicines used to prevent blood from clotting).
- To assist patients in this group who were prescribed a number of medicines to take their medicines correctly the practice offered online prescribing and blister packs. We also observed that the practice worked closely with the local pharmacies to provide a smooth and safe service to the patients.
- The practice carried out annual polypharmacy medicine reviews for patients who were prescribed more than eight medicines.
- At the time of our inspection, the practice had given flu vaccinations to 87% of all eligible patients aged over 65 during the current flu vaccination period, against the target of 75% for the whole vaccination season.
- The practice regularly monitored older patients who had been discharged from hospital or had received care form the out of hours or A&E service. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs and that additional support could be offered.
- The nominated GPs undertook weekly visits at the local care homes.

People with long-term conditions:

- The practice held registers of patients with long term health conditions which were regularly updated and assessed annually. All these patients were reviewed on a regular basis.
- Staff who were responsible for reviews of patients with long term conditions had received specific training, for example in chronic obstructive pulmonary disease (COPD) and diabetes.
- Each GP, supported by the nursing team, was allocated a number of registers to work on so that no patient missed their medication review, annual health assessment and annual blood tests.
- Patients were sent appointments by telephone, text message or letter whichever was appropriate. The blood test results were read and actioned by the GPs who then made any required changes to their management plan.
- The practice undertook post-discharge reviews. Staff monitored patients discharged from hospital to review their needs and if required would arrange a follow up

Good

Are services effective?

(for example, treatment is effective)

telephone triage or face to face appointment with the GP. The GPs reviewed discharge letters for palliative care patients and would contact the patients to see if any additional support was required.

- Data showed that patients with long term conditions such as high blood pressure, diabetes and COPD experienced care comparable to the Clinical Commissioning Group (CCG) and national averages. For example, the percentage of patients with diabetes, on the register, in whom the last blood pressure reading was within the recommended levels was 81% compared to the CCG average of 76% and national average of 78%.
- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP and nurses worked with other health and care professionals to deliver a coordinated package of care.
- Longer appointments and home visits were available if required.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90%: the practice achieved between 95% and 99% across all groups.
- There were appointments outside of school hours and any child who needed an appointment was seen on the same day.
- The practice building was suitable for children and babies with changing and feeding facilities.
- Full contraception services were offered including implants and intrauterine contraceptive devices (IUD).
- The practice held safeguarding meetings quarterly with midwifes and health visitors.
- We saw positive examples of joint working with midwives who held ante-natal appointments at the practice.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

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

- The practice's uptake for cervical screening was 81%, which was in line with the 80% coverage target for the national screening programme.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74 years. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Telephone consultations were available for patients who did not need a face to face appointment.

People whose circumstances make them vulnerable:

- The practice had a system of identifying carers either from the self-statement of the carer or identified by the social services. Also patients who had a carer were flagged on the clinical system
- Carer details were noted on the records so they could be liaised with to coordinate the long-term care of older or vulnerable patients.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

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

- 95% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is higher than the CCG and national averages of 84%.
- 93% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was the same as the CCG average of 93% and higher than the national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 98%; CCG 90%; national 91%); and the percentage of patients experiencing poor mental health who had received discussion and advice about smoking cessation (practice 98%; CCG 95%; national 95%).

Monitoring care and treatment

Good

Are services effective?

(for example, treatment is effective)

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example the practice had reviewed patients who had been prescribed a particular medicine and identified a number who did not have optimal management to ensure that patients get the best possible outcomes from their medicines.This group of patients were reviewed again 12 months later and all patients in this group now had their management optimised.

Where appropriate, clinicians took part in local and national improvement initiatives.

The most recent published Quality Outcome Framework (QOF) results were 100% of the total number of points available compared with the CCG average of 98% and national average of 96%. The overall exception reporting rate was 8% compared with a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example,

- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date. In addition some of the nursing staff had undertaken specialist training in COPD and diabetes.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. For example the practice had devised detailed timetables for trainee GPs to ensure that they had specific time located for seeing patients, mentoring support and administration time.
- The practice actively encouraged and supported the ongoing educational development of doctors, nurses and staff in long term conditions, with external education courses, in house meetings, eLearning and invitations for external speakers to attend the practice as required for example, the Alzheimer's Group, community respiratory nurses and hospital consultants from local hospitals.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The GP trainees told us that they felt well supported.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment and there was evidence in practice meeting minutes that demonstrated this.

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

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.

Good

Are services effective?

(for example, treatment is effective)

- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity and mental health issues.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately and we saw evidence of consent forms used and noted in the patient record.

Good

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 12 patient Care Quality Commission comment cards we received were positive about the service experienced and patients comments included helpful, professional and caring attitudes of staff. Results from the NHS Friends and Family test results for the 6 months from September 2017 showed 94% of patients would recommend the practice to family. Comments we received from patients were aligned with the comments, survey and test results.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 233 surveys were sent out and 125 were returned. This represented a response rate of approximately 54% and represented approximately 1% of the total practice population. The practice was comparable for its satisfaction scores on consultations with GPs and higher for nurses. For example:

- 82% of patients who responded said the GP was good at listening to them compared to the CCG and national averages of 89%.
- 76% of patients who responded said the GP gave them enough time compared to the CCG average of 86% and the national average of 86%.
- 94% of patients who responded said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 96%.
- 80% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared to the CCG and national averages of 86%.
- 96% of patients who responded said the nurse was good at listening to them compared to the CCG average of 92% and the national average of 91%.
- 96% of patients who responded said the nurse gave them enough time compared to the CCG average of 94% and the national average of 92%.
- 98% of patients who responded said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and the national average of 97%.
- 95% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 87% of patients who responded said they found the receptionists at the practice helpful compared to the CCG and national averages of 87%.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Practice information was supported by large print for any patient who requires this for example, the practice leaflet and practice newsletter.
- Staff helped patients and their carers find further information and access community and advocacy services. There was a wide range of information available to advise patients in the waiting area. Practice staff demonstrated how they would help patients ask questions about their care and treatment.

The practice proactively identified patients who were carers and had involved the carers trust in particular to

Good

Are services caring?

identify young carers. Patients were reminded to inform the practice if they were or had become a carer. There was information on the practice website and in the practice directing patients to avenues of support.The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 180 patients as carers (just under 2% of the total practice list).

Staff told us that if families had experienced bereavement, their usual GP contacted them and sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. An information pack was available for patients which included organisations to contact for advice and support.

Results from the National GP Patient Survey of July 2017 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:

- 83% of patients who responded said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 84% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 82%.
- 93% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 92% and the national average of 90%.
- 87% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 88% and the national average of 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs. For example, telephone consultations, online services such as repeat prescription requests, advanced booking of appointments, advice services for common ailments.
- The facilities and premises were appropriate for the services delivered. All services were provided at ground floor level with easy access for patients with limited mobility.
- We saw from care records and minutes of meetings that care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- Patients newly diagnosed with cancer and dementia were contacted within six months of diagnosis to ascertain if any support was needed, either medical or personal.
- There were a number of day care centres within the practice area that were attended by their patients. GPs could refer to these centres and would see patients visiting the centres if required.
- The practice Gold Standard Framework (GSF) register included a large number of patients in this population group. Regular GSF meetings took place (including Doctors, Practice Manager, Practice Clerk, Macmillan Nurses and District Nurses) to review each patient's care, consider new patients appropriate to join the register, and to discuss any patient who had died since the previous meeting (to ascertain if lessons could be learnt from that specific episode of care). New cancer diagnoses were also discussed at the meeting in an attempt to identify if there was any delay in diagnosis of the cancer, and if there were lessons to be learnt from that diagnosis. The register was regularly reviewed with updates notified to all attendees of the meeting and relevant practice personnel. These updates included details of which patients had been added to the register, which had been moved to a higher category of need and which patients had died. The local out of hours service was kept up to date with all patients on the GSF register.

Older people:

- The practice screened patients who may be at risk of admission for the last two years and they were offered reviews to ensure that their care could be managed safely at home. These patients were given access to the GP via a dedicated telephone line.
- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The practice offered home visits for those who had difficulties getting to the practice.
- The practice offered online prescribing and blister packs were offered to patients who are on a number of medicines to help with compliance. They worked closely with the local pharmacies to provide a smooth and safe service to the patients.
- We saw from care records and minutes of meetings that care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

People with long-term conditions:

- The long term condition registers were regularly updated and assessed annually and patients were reviewed on a regular basis. Patients with multiple conditions could be reviewed at one appointment and consultation times were flexible to meet each patient's specific needs.
- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met.
- Patients could book telephone consultations with dedicated nurses for the management of their chronic disease for example asthma, COPD and diabetes.
- The practice held regular meetings with the community staff to discuss and manage the needs of patients with complex medical issues.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Patients were sent appointments by telephone, text message or letters whichever was appropriate. The blood results were reviewed and actioned by the GPs who made the required changes to the patient's care plan.
- The practice participated in post-discharge reviews where staff contact patients following discharge from hospital to review their needs and if required, a follow up telephone triage or face to face appointment could be arranged with the a GP. Reviews were carried out on a weekly basis where discharge summaries information was added to the patients' notes.
- A number of patients in this patient group had a priority marker on their records highlighting they may have specific urgent needs in relation to their health care. A priority GP was detailed on their computer records. Letters were sent to all priority patients informing them of their priority GP and of a dedicated telephone number to use in an urgent situation or query that took them straight through to the practice. Patients could see or make contact with any GP in the practice. A&E attendances and hospital discharges were regularly monitored in order to provide additional support to priority patients following A&E or out of hours attendances and on hospital discharge where appropriate.
- Regular meetings were held to ensure the proactive management of that specific chronic disease was in place. Regular reviews of patients were carried out to check which services were provided and if any additional support was required.
- The practice identified all acute exacerbations of conditions such as chronic obstructive pulmonary disease (COPD) and asthma, with a specific code and a template was used which alerted the practice COPD nurse, and lead GP, with a task informing them of the acute deterioration in the patient's condition. These patients were then followed up by the practice respiratory team who would invite the patient to attend clinic, or visit them at home to minimise the risk of future occurrences.
- The practice delivered prompt supplies of medicines to patients with a chronic disease, for example antibiotics and steroids were prescribed as 'Rescue Packs 'for patients with chronic obstructive pulmonary disease (COPD), and these could be delivered to a patient's home at short notice via the local community pharmacies.
- The practice offered near patient testing for patients prescribed specific medicines to treat rheumatoid arthritis, and other similar immunosuppressants, with a dedicated pathway of blood tests and results' management. Prescribing was monitored closely. Patients were offered joint injections at the practice, reducing the need for hospital treatment.
- The practice encouraged close contact with the community nursing team who were based in the same building.
- There were a number of day care centres within the practice area that were attended by patients. GPs referred patients to these centres and could see patients visiting the centres if required.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we reviewed confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- A midwife ran a regular antenatal clinic from the practice.
- Contraceptive services were available at the practice.
- Babies and young children were always seen as a priority.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice offered a range of services for patients unable to attend the practice for example, telephone consultations if a face to face appointment was not required. There was an email facility for patients to request repeat prescription or to cancel appointments.
- Students were offered vaccination and health checks for travel and applications for recruitment or university.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The practice actively screened patients for chlamydia, cardio vascular disease (CVD) chronic obstructive pulmonary disease (COPD) cervical screening and offered smoking cessation services.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- Patients were reviewed on an annual basis and were offered longer appointments if required.
- Patients received regular medication reviews and were often seen with their carers to enable them to raise any concerns regarding their health or medicine.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The GPs, together with practice nurses, administrative staff and dedicated community teams, fully supported the clinical management of residents in a local care home which was situated in the practice area.
- Patients were offered support from a variety of external agencies for example

- SIAS)

- Positive Mental Health Support Group,

- The Samaritans

- Solihull Mind

- Improving Access to Psychological Therapies (IAPT)

- John Black Centre who work in partnership with the emergency Arden Crisis Team.

- Queen Elizabeth Psychiatric Hospital including the Barberry Centre for postnatal depression (dedicated postnatal appointments were provided which include assessment for postnatal depression).

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was in the main, comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards. 233 surveys were sent out and 125 were returned. This represented a completion rate of 54% and a return rate of approximately 1% of the practice population of both locations.

- 62% of patients who responded were satisfied with the practice's opening hours compared to the CCG average of 74% and the national average of 76%.
- 64% of patients who responded said they could get through easily to the practice by telephone compared to the CCG average of 64% and the national average of 71%.

- 79% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared to the CCG and national averages of 84%.
- 73% of patients who responded said their last appointment was convenient compared to the CCG and national averages of 81%.
- 62% of patients who responded described their experience of making an appointment as good compared to the CCG average of 69% and the national average of 73%.
- 61% of patients who responded said they don't normally have to wait too long to be seen compared to the CCG average of 59% and the national average of 58%.

The practice recognised low figures in some areas and had made changes to the appointment system from October 2017. The changes included adjustments to on the day bookings and telephone consultations and were well documented in the practice and on the website. Patients we spoke to on the day reported positively to the changes. An extended hours appointment service was being developed with other practices within the local alliance, with the support of the Clinical Commissioning Group.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice had received 29 complaints last year. We reviewed three of these and found that they were satisfactorily handled in a timely way.

The practice learned lessons from individual concerns and complaints and also from analysis of trends.

Are services well-led?

Good

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

Our findings

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

Leadership capacity and capability

The GP had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- The GPs and practice manager demonstrated knowledge of the local area and issues and priorities relating to the quality and future of services. They understood the challenges in providing effective health care in an area of high population.
- Staff told us that the GPs, nurses and practice manager were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

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

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. These included forward planning for the future when GP partners may retire.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs and support the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

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

- Staff stated they felt respected, supported and valued. They worked well together and enjoyed their work in the practice.
- Staff were able to demonstrate how they focused on the needs of patients and were empathetic.
- We saw that the practice addressed complaints and incidents with openness, honesty and transparency and engaged with patients and shared the outcomes with them. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. Staff felt supported by the managers and were encouraged to further their knowledge through training. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work. Trainee doctors told us that they felt well supported by the GPs and had a structured timetable in place to ensure that time was protected to complete specific tasks for example, tutorials, personal study time and breaks.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and the clinical team.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care which was a led by one of the GPs. This were structures and procedures that ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. The GP and nurses had lead roles in key areas. The practice held

Are services well-led?

Good

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

meetings with all staff to ensure learning was shared from significant events and all staff were aware of issues at all practices as well as how each practice was performing.

- The practice had a comprehensive suite of policies and procedures which were implemented and were available to all staff. We saw evidence that they were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained.
- Clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, we saw risk assessments for fire and legionella risks and appropriate actions had been taken.
- We saw evidence from the significant event and complaints log that lessons had been learnt and shared with staff. These were discussed at practice meetings and the minutes were available for staff to view.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control and were trained to an appropriate level according to their role.

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality. We noted that audit activity was recorded across both locations.
- The practice had plans in place and had trained staff for major incidents. A business continuity plan detailed what would happen in a range of emergency situations, including the sudden unavailability of the practice building. Copies of this were kept by key staff off-site for use in an emergency.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

- Quality and operational information was used to ensure and improve performance which was regularly reviewed in relevant meetings. Performance information was combined with the views of patients.
- The practice used performance information which was reported and monitored and management and staff were held to account. This was linked to staff appraisal and training.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care. The practice had introduced a number of alerts on the clinical computer system for example, if a high blood pressure was recorded the alert would prompt the clinician to arrange a retest, or an alert would appear on the screen if a medicine was no longer available.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- The practice had an active patient participation group (PPG) who met twice a year. A variety of topics were discussed for example, information to patients regarding repeat prescriptions. A meeting was held and

Are services well-led?

Good

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

local pharmacies were invited to attend. The PPG formed a working group to review the effect on patients and fed back to the practice. The practice fed back to the PPG about any changes within the practice by email.

- The service was transparent, collaborative and open with stakeholders about performance.
- The practice involved patients, the public, staff and external partners to support high-quality sustainable services.
- The practice had examined the results of the National Patient Survey of July 2017 which were in line with other practices in the area and nationally in most areas. They had also reviewed the patient comments on NHS Choices which were in the main positive and had taken measures to capture patient feedback in the waiting area using patient feedback forms.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement at all levels within the practice.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- The practice was supporting the local alliance with a patient survey on an extended access model under development
- The practice undertook external peer reviews as part of the local alliance.
- All practice staff were involved in the practice QOF achievements and nurses closely monitored their own areas for any changes or reduction in target achievement so that these could be addressed for example, extra nurses and support from the community teams to support the diabetes clinics.