Dr Mohammad Salim

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.

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Overall summary

Dr Mohammad Salim's practice provides primary medical services to patients living within two miles of the surgery. The practice is small and has one GP, one nurse, a part time practice manager and two part time administration and reception staff.

We spoke with six patients on the day of our inspection and looked at nine Care Quality Commission (CQC) comments cards that had been left in our comments box. We spoke with the owner of a care home where four of the practice's patients lived. Patients told us that they found the practice welcoming and caring and were positive about the care and treatment they received. The comment cards also gave a positive view of patients' experiences of the practice.

The practice was caring, friendly and welcoming and, with fewer than 1800 patients. We found positive elements in all of the areas we looked at during our inspection and the patients we gained information from were all pleased with their care and treatment. The staff team were committed to the practice and wanted to develop and learn.

People confirmed that their privacy and dignity were protected and that the GP fully involved them in decisions about their care and treatment. Patients were able to get appointments easily. The GP and their team understood the needs of local people and were respectful of patients' diverse needs.

Whilst the practice had a friendly and inclusive atmosphere the leadership, management and governance arrangements lacked direction and structure. The practice did not have robust arrangements for monitoring the quality of the care and treatment it provides.

We found some aspects of the way the practice operated needed improvement and the provider was in breach of some regulations. These related to –

- Identifying, assessing and managing risks within the practice.
- Using incidents to identify changes and improvement that may be necessary.
- Having suitable arrangements to safeguard people from the risk of abuse.
- Staff recruitment.
- Supervision, training and staff appraisal.
- Dealing with complaints

The practice also needs to make improvements related to –

- Policies and procedures.
- Recording and safe keeping of information about multi-disciplinary meetings.
- Arrangements for checking equipment used at the practice.

Older patients were given priority for appointments and the GP and nurse visited them at home if necessary. The practice did not have effective systems for monitoring and recalling patients with long term conditions. The practice provided services for mothers, children and young people and worked with other services when appropriate. Evening appointments were available on some days for working age patients unable to go to the surgery during the day. The practice had some patients with learning disabilities but staff had not been trained about the Mental Capacity Act 2005 and so lacked understanding of their responsibilities in respect of gaining consent from patients who may not understand information about their care. There were no clear arrangements for the support and care that patients experiencing poor mental health might need.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

<Improvements were needed to make sure that the practice is safe. There were suitable arrangements in place to deal with medical emergencies at the practice. The practice was clean and there were suitable infection control arrangements to reduce the risk of cross infection. The practice was not keeping records about accidents, and significant events and there was no evidence of learning from these to enable the practice to monitor their track record on safety.

Are services effective?

Improvements were needed to make sure the practice provides effective care and treatment. The practice was aware of recognised guidance and good practice but did not have clear arrangements for monitoring and supporting the health of people with long term conditions. The practice did not have systems in place for best interest decision making when patients lacked capacity to provide informed consent. The staff team shared a commitment to put patients first and deliver high quality care. They showed willingness to develop and learn but the practice did not have learning and development or training plans in place to support them to develop their knowledge and skills, either as individuals, or as a team.

Are services caring?

We found that the practice needed to underpin their caring approach with better understanding of the law when making decisions about care and treatment when patients lacked capacity to do so themselves. All the patients we spoke with told us that that the practice was friendly and that the GP and staff were caring and respectful. People confirmed that their privacy and dignity were protected and that the GP fully involved them in decisions about their care and treatment.

Are services responsive to people's needs?

Improvements were needed to make sure that the practice is responsive. Patients were able to get appointments easily. The GP and staff understood the needs of local people and were respectful of patients' diverse needs. The practice did not have a suitable complaints process to help make sure that patients' concerns were responded to and investigated thoroughly and in a timely manner.

Are services well-led?

Improvements were needed to make sure that the practice is well led. Whilst there was a friendly and inclusive atmosphere, the

Summary of findings

leadership, management and governance arrangements lacked direction and structure. The practice did not have robust arrangements for monitoring the quality of the care and treatment provided.	

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

Older people were one of several more vulnerable groups which the practice prioritised for appointments. The GP and practice nurse visited patients at home if they were unable to get to the surgery. There was not a systematic, robust process for reviewing older patients and providing health promotion advice. The practice communicated with the district nursing service to discuss and plan the care for older patients with chronic conditions who needed additional support from other services.

People with long-term conditions

The practice did not have a systematic, robust process for reviewing patients with long term conditions or for providing health promotion advice. Patients with these health needs were usually followed up when they contacted the practice for other reasons such as making a repeat prescription request. The practice nurse told us that since joining the practice a few weeks earlier they had begun to develop arrangements for working more closely with their patients with long-term conditions. They showed us some paperwork that showed they had made progress in identifying patients who would benefit from this.

Mothers, babies, children and young people

The practice provided services to women who are pregnant and had systems in place to inform the community midwifery team about new pregnancies. There was a community midwife allocated to the practice as the link for maternity care for patients at the practice. The reception staff told us that they had a contact number for the midwife should they need to speak with them regarding patients. Appointments were readily available for women who experienced any problems during pregnancy which required medical attention. The practice put parents with young children in touch with a health visitor for support, help and advice regarding children and parenthood. Patients at the practice were referred to a separate child health clinic available for patients in another part of the building. This was operated by a different healthcare provider. Childhood immunisations were provided at the practice and the doctor and nurse provided on-going support.

Contraception, sexual health advice and sexual health screening tools were available at the practice. Where necessary patients were informed about specialised sexual health clinics.

Summary of findings

The working-age population and those recently retired To meet the needs of people unable to attend during the main part of the day the practice offered evening appointments with the GP and with the practice nurse several days a week.	
People in vulnerable circumstances who may have poor access to primary care The practice was familiar with the challenges faced by patients in the community it served and were respectful and understanding of people's diverse needs. Staff made arrangements for people who did not speak English to be supported in discussions and decisions about their care. The practice provided care to a small number of people with learning disabilities. Staff were not familiar with the Mental Capacity Act 2005 and their responsibilities when people lacked capacity to make informed decisions.	
People experiencing poor mental health The practice did not have an organised way to monitor the numbers of patients with poor mental health or to proactively review their physical as well as their mental health.	

Summary of findings

What people who use the service say

We spoke with six patients on the day of our inspection and looked at nine Care Quality Commission (CQC) comments cards that had been left in our comments box by patients. Patients told us that they found the practice welcoming and caring and were positive about the practice and the care and treatment they received. The comment cards also gave a positive view of patients' experiences of the practice.

All patients we spoke with reported a positive experience regarding the caring nature of the GP and the rest of the team at the practice. Patients commented on the personalised service and said they felt reassured by the staff who knew them and their families well. Some patients reported that their anxieties were reduced by the welcome they received at reception. All patients we spoke with reported that their consultations with the GP and nurse were relaxed and unhurried. They told us that the GP always explained their condition and treatment to them and explained how to take their prescribed medication.

Patients said that they were treated with respect and that their dignity was always preserved.

Areas for improvement

Action the service MUST take to improve

The practice must introduce processes to identify, assess and manage risks within the practice.

The practice must introduce processes to ensure that any incidents, significant events or accidents are used to identify and learning and improvement that may be necessary.

The practice must introduce effective stock control measures to prevent out of date stock of medicines being available for use.

The practice must introduce an adult safeguarding policy and procedure which reflects the local multi-agency safeguarding board arrangements.

The practice must introduce robust staff recruitment and selection arrangements, including obtaining Disclosure and Barring Service (DBS) checks for staff unless the practice has assessed that a DBS check is not required for the post.

The practice must introduce processes to ensure that staff receive appropriate training, professional development, supervision and appraisal.

The practice must develop a complaints policy and procedure which meets NHS guidelines and provides patients and others with clear and accurate information about how to complain, who they should complain to, and what to expect regarding timescales and information.

Action the service SHOULD take to improve

The practice should review electronic and paper based documentation at the practice to make sure that it is current, tailored to the specific needs of the practice and readily available for staff to refer to.

The practice should introduce a system to ensure that all staff confirm that they have read the practice's policies and procedures and will abide by them.

The practice should improve the way multi-disciplinary meetings are recorded and also the arrangements to follow up matters discussed in these.

The practice should introduce a robust system (including reliable records) for monitoring, calibrating and where necessary, replacing equipment used for patient care.

The practice should carry out complete and effective clinical audit cycles.

The practice should consider establishing a Patient Participation Group (PPG) and introducing other structured ways to gain patients views about the practice.

The practice should develop a strategy for the future development and leadership of the practice and provide suitable support and training for the new practice manager to assist them to understand and fulfil the responsibilities of the role.

Dr Mohammad Salim

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and included a second CQC inspector who is a nurse, a GP specialist advisor, and a practice manager specialist advisor.

Background to Dr Mohammad Salim

Dr Mohammad Salim's practice provides primary medical services to patients living within two miles of the surgery in the Winson Green area of Birmingham. The practice is small and has one GP, one nurse, a part time practice manager and two part time administration and reception staff.

The practice is situated in a large purpose built health centre that has been open for seven years. Other primary care and NHS services are located in the same building. The practice provides a service to just over 1700 people in a small geographical area which has high levels of social deprivation, is culturally diverse and densely populated. The practice does not provide an out-of-hours service. When the practice is closed patients can go to a GP 'walk-in' centre that is situated in the same building.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before our inspection, we reviewed a range of information we held about the practice and asked other organisations to share what they knew.

We carried out an announced inspection on 7 August 2014. During our inspection we spoke with the six patients, the owner of a care home where four people who were registered at the practice lived, the GP, the newly promoted acting practice manager, practice nurse and receptionist. We also spoke with the previous practice manager who was about to retire.

Before the inspection we had contact with Sandwell and Birmingham Clinical Commissioning Group, the NHS England local area team and also contacted the Local Medical Committees (LMCs) in the area. We attended listening events arranged by local community groups and looked at nine comment cards from patients describing their views and experiences of the practice.

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

- Is it safe?
- Is it effective?

Detailed findings

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before visiting, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share their information about the service.

We carried out an announced visit on 7 August 2014.

During our visit we spoke with a range of staff, including the GP, practice management staff and receptionist and the practice nurse.

We also spoke with patients who used the service.

Are services safe?

Our findings

Safe track record

The practice did not have any processes for recording and reporting significant events or accidents. They were not able to provide records of incidents or accidents at the practice apart from some old paperwork from 2010 and 2005. We saw a pad of accident reporting forms but this had never been used. The GP and staff told us that because they are such a small team they tended to deal with issues informally as they arose. We asked the team about how they would report a significant event and they said they would tell the practice manager and leave it to them to manage. The lack of records meant that the practice were unable to demonstrate or monitor their track record regarding safety.

Learning from incidents

The practice did not have any processes for learning, improving and ensuring openness and transparency when things go wrong. Because there were no records of significant events or accidents the practice was unable to show us how they had used these to help them learn from experiences and make improvements. We found from our discussions with the GP and staff that because the practice was small their meetings tended to be informal and were not recorded. The lack of structured information meant that there was no way for the GP to assure himself that all staff were fully aware of any issues.

Reliable safety systems and processes including safeguarding

There was a detailed Health and Safety policy but no system to enable the practice to be confident that all of the staff were familiar with the contents and their responsibilities.The management of the health centre building (not the practice) were responsible for arranging fire warden training and conducting weekly fire alarm tests. They also arranged unannounced fire drills, the most recent of which was in June 2014. We saw fire safety certificates confirming that appropriate fire safety checks, alarms and drills had been carried out. None of the staff at the practice had attended the fire warden training. We were told that this was being arranged but no dates had been confirmed.

We saw a number of policy documents which were all saved in one folder on the practice's computer system. The policies were generic documents which had not been tailored to meet the needs of the practice. The policies did not include details of nominated leads and there was no record to assure the practice that staff had read and understood them and had agreed to abide by them.

The practice had a policy for safeguarding children created in March 2014. This appropriately reflected local safeguarding arrangements detailed in the NHS Birmingham Organisations Guidance and Procedures for Safeguarding Children.

We saw a Safeguarding Adults Policy dated June 2009 which had been due for review in June 2011. This was based on a policy from the Heart of Birmingham Teaching Primary Care Trust. Because this was five years old we were not assured that this would appropriately reflect current adult safeguarding arrangements in Birmingham.

Neither of these policies had been tailored to the needs of the practice and did not confirm who the practice's safeguarding lead was. There was no record that staff had read and understood their safeguarding responsibilities or that they had agreed to abide by the policy. Staff told us they would tell the GP if they were concerned for the safety of a child or adult. Staff told us they had done child safeguarding training but not adult safeguarding training. They said that from conversations with colleagues they thought there was a safeguarding procedure on the computer system but that they had not read it. They said that if they had a concern they would look into the policy for guidance.

The arrangements for recruiting and selecting new members of staff were not robust. The practice had not obtained Disclosure and Barring Service (DBS) checks for all staff. DBS checks help employers make safer recruitment decisions and reduce the risk of unsuitable people from working with vulnerable adults and children. DBS checks replaced the Criminal Records Bureau (CRB) check. There were no other records of other pre-employment checks in the staff files so we were unable to confirm that the practice had taken suitable steps to check the suitability of the people they appointed. We asked the staff if there were other records stored elsewhere but they confirmed that the DBS checks for the GP and two of the staff were the only staff pre-employment records the practice had. There were no other records of other pre-employment checks in the staff files so we were unable to confirm that the practice had taken suitable steps to

check the suitability of the people they appointed. The acting practice manager was not aware of any pre-employment checks being carried out for staff employed in recently. They could not explain why a nurse had been appointed to work at the practice without a DBS check being carried out. The practice had not carried out risk assessments to explain and support decisions to employ staff without obtaining an up to date DBS check.

The staff all undertook chaperone responsibilities when patients were having intimate examinations. They took this responsibility seriously but had not received specific training.

We saw that there was out of date paperwork in the administration areas of the practice and that information was not organised. For example, on one open shelf most of the files contained information from at least four years ago. The paperwork included blank photocopied 2010 'do not attempt resuscitation' (DNAR) forms and 2006 information about prescribing medicines for people receiving palliative care. Out of date information, particularly about care and treatment matters could place people at risk. In addition, the DNAR forms clearly stated that they must not be photocopied. One file on the shelf contained notes of multi-disciplinary meetings with sensitive information about patients including their identifying reference numbers.

Monitoring safety and responding to risk

Discussions about risks relating to individual patients were dealt with at multi-disciplinary meetings (MDTs). We saw notes of some MDTs between the GP, practice staff and external professionals such as district nurses. The notes described discussions about individual patients' care and treatment. There was no structured process for following up the agreed actions between meetings and the notes did not refer back to previous meetings to assure the practice about the outcomes for patients.

We saw certificates demonstrating that staff were trained in cardiopulmonary resuscitation. There were emergency drugs, a defibrillator, oxygen and airway maintenance equipment for adults and children available in the event of a patient being taken ill at the practice. The practice had arrangements to make sure emergency medicines and oxygen did not run out. There was also access to other medical practioners within the building. The GP confirmed that he carried adrenaline in his medical bag and penicillin for injection in suspected meningitis cases.

Medicines management

The practice had a prescribing policy and could demonstrate that they had appropriate arrangements for the prescribing of medicines. Prescriptions were filled in electronically and printed as they were given to patients. The GP used paper prescription pads when visiting people at home. The practice had a system for storing and monitoring these pads to prevent theft or misuse.

Vaccines and most medicines are temperature sensitive and must be stored, and in many cases refrigerated, according to the manufacturer's guidelines. We looked at the records of the medicines' fridge temperatures. These showed that staff were recording these appropriately and that the fridge had been maintained at the correct temperature.

When we checked the vaccination fridge we found that four different types of vaccine were out of date. The practice nurse removed these immediately. When we asked the staff about the procedure for receiving new vaccines and checking expiry dates we found that no process was in place and that no record was kept of any checks that they did. The practice nurse explained that all vaccines that were given in the practice were also checked before administering to the patients, however, out of date vaccines in the fridge left patients at risk harm from receiving expired medicines. Staff acknowledged that there were no existing stock control systems. The acting practice manager and the nurse said they would set a system up straight away.

Cleanliness and infection control

The practice was part of a seven year old purpose built health centre and cleaning was the responsibility of the health centre management team. The practice was well maintained, clean and tidy. The practice as a whole provided a clean environment for patients to be seen and procedures were in place to reduce the risk of infection but these were not supported by documentation.

We found that the practice had an infection control policy. However, the policy did not reflect what was expected in the practice, for example, there were references to additional documents which were not available. The nurse

told us she had her own copy of the policy and demonstrated appropriate knowledge and practice around infection control to help protect patients from the risk of infection. They told us that they had completed training in infection control in a previous job. All the other staff we spoke with were aware of the importance of infection control but there was no evidence of them being trained in this topic.

The nurse described appropriate processes for cleaning equipment after being used during a patient's appointment. We saw that there was hand wash available at all the hand basins as well as gel cleanser in clinical areas. The nurse told us they used personal protective equipment when necessary and that it was always available to them. We saw that this was available in the clinical rooms.

We found that all cleaning equipment, clinical waste and sharps containers were locked away safely and not accessible to the public. These were stored in the central part of the building and we saw documentation which showed that they were collected weekly by contractors.

We saw certificates showing that staff had been immunised against Hepatitis B and their immunity status was recorded in the staff records. There was a 'needle stick' injury policy with a good flow chart to guide staff in the event of them injuring themselves with a needle or other sharp equipment.

Overall responsibility for precautions against legionella bacteria was the responsibility of the health centre building management team. One of the reception staff was responsible for flushing the sluice taps each week as a precaution against legionella bacteria. We saw the records they kept of this and confirmed that they had done this every week since starting the checks in April 2014. They told us this was initiated on the instruction of the building management team.

Staffing and recruitment

The practice had a small staff team who, apart from the GP, were all part time. The acting practice manager and the receptionist were both part time and were flexible about providing cover when one of them was not at work. When the outgoing practice manager leaves in September 2014 the acting practice manager will step fully into that role on a full time basis and additional staff will be recruited for administration and reception duties. The GP told us that when they were away from work they used a locum to provide cover for them. The team were confident of maintaining a service to people during times of holidays or sickness and gave us examples of when they had done this.

Medical indemnity was in place for the GP and we confirmed that they were registered with their professional body, the GMC. They had had an appraisal in March and their revalidation was due on 13 August 2014. Revalidation is the process by which licensed doctors are required to demonstrate that they are up to date with current best practice and are fit to practise.

Dealing with Emergencies

There was no risk register or individual risk assessments to demonstrate that potential risks within the practice had been identified. The practice had not planned for and did not have any arrangements in place for dealing with emergencies or incidents which might have an impact of their ability to provide a service to patients such as power failures or fire.

Equipment

The practice did not have a reliable or robust process for making sure that all the equipment used there was safe to use and maintained in accordance with the manufacturer's instructions. There was a policy for the inspection, calibration and replacement of equipment. The policy referred to an equipment maintenance log. When we looked at the log we found that this had not been used. The nurse told us that she checked the equipment kept in her room herself. She showed us records that she kept of these checks. These showed that she checked and calibrated the nebuliser each week, checked the blood glucose monitor every day and the anaphylaxis emergency equipment every week.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

We found that the GP was aware of the importance of providing patients' care and treatment based on recognised guidance and best practice. The GP and the practice nurse had access to electronic versions of National Institute for Health and Care Excellence (NICE) guidance, which were kept on computer but did not have a process for auditing who looked at them and how often. The practice did not have a strategy for monitoring and supporting the health of people with long term conditions. The GP confirmed that that they provided this care in an unplanned and "opportunistic" way when people came to the practice for other reasons or requested a repeat prescription. However, the practice nurse who had joined the practice a few weeks before the inspection was working on ways to improve the arrangements for monitoring the health of people with long term conditions.

People may lose the capacity to make some decisions through illness or disability. In these circumstances health and care providers must work within the Code of Practice for the Mental Capacity Act 2005 (MCA). This helps to protect people and make sure that decisions are made in their best interests. The practice did not have a planned approach to providing care and treatment to people who lacked capacity to provide informed consent. None of the staff at the practice had received training about the MCA and the GP was not familiar with the expected processes for assessing people's capacity to make decisions.

Some patients at the practice did not speak English as a first language. The practice used various approaches to discuss patients' care with them and provide information about their care and treatment in a language they would understand. The patients we spoke with told us that the GP and nurse always asked for their permission before carrying out procedures and explained to them what they would be doing.

Management, monitoring and improving outcomes for people

Before the inspection we reviewed information from the General Practice Outcome Standards. This is a tool which local clinical commissioning groups use to help them monitor the performance of a GP practice. The tool compares practice results for certain conditions and illnesses against the average results for England. The information suggested that the practice results were lower than the England average. This information was reflected when we looked at information for the Quality and Outcomes (QOF) framework during the inspection.

QOF is a scheme which rewards practices for providing quality care and helps to fund further improvements. Whilst the practice did take part in this scheme they were not proactive in this. The summary for their QOF outcomes for 2013/14 showed low achievement levels for identifying and treating chronic heart disease, hypertension, diabetes, strokes, chronic obstructive pulmonary disease COPD, depression and mental health. The practice was not using the QOF data to provide a framework for recalling patients when needed but were relying on following patients up opportunistically.

The practice had no records to show that they analysed or reviewed significant events or 'near misses' to help identify improvements they could make. The GP and staff told us that because they were a small practice they usually talked about things as and when they happened. The practice was unable to provide us with information such as audits to show that they were monitoring their performance to help them manage and deliver improvements.

The practice was not routinely carrying out full clinical audit cycles. One clinical audit was done in February 2014 in respect of the blood monitoring and diagnosis of gout. However, the audit cycle was incomplete because the practice had not included arrangements to review the results and outcomes for patients.

Effective Staffing, equipment and facilities

The practice was situated in a modern health centre which is shared with several GP practices and NHS services but was self-contained with its own suite of consulting rooms and separate reception. The reception desk was set away from the waiting areas which gave a reasonable amount of privacy for patients when speaking to reception staff. Staff told us that they offered to take people to a separate room if they wanted to have greater privacy. The practice had good access for people with restricted mobility and there were disabled parking spaces immediately in front of the building. Door signs had Braille labelling for people who use this and a hearing loop to make communication easier for people with hearing aids.

Are services effective?

(for example, treatment is effective)

When we spoke with staff they showed that they wanted to learn and do things correctly. However, the practice did not have learning and development or training plans in place to support them to develop their knowledge and skills either as individuals or as a team. There was suitable documentation available at the practice to support effective appraisal systems for staff, however, this had never been used. In our discussions with some staff we found that there were no arrangements for them to receive one to one support and supervision or appraisal to monitor their performance and learning needs. With the exception of the GP and nurse staff told us that they had not had structured appraisals.

We saw evidence that staff had received training in safeguarding children and cardiopulmonary resuscitation. Some additional training was planned for the nurse to enable her to fulfil more of the potential duties of a practice nurse such as baby immunisations which the GP was currently doing. However, there was no process for identifying, planning and recording other training that staff may need to do or benefit from.

Revalidation is the process by which licensed doctors are required to demonstrate that they are up to date with current best practice and fit to practise. The GP was due for revalidation in August 2014 and had received appraisal as part of this process. The nurse's registration was also up to date and they were receiving support and external mentoring as part of their practice nurse training.

Working with other service

The practice was able to provide examples of working with other professionals to co-ordinate patients' care and treatment. For example, the GP said they met monthly with district nurses to co-ordinate care for people recently discharged from hospital and those nearing the end of life or receiving palliative care.

The practice had a system to inform the out of hours service about people who may need support in the evenings, overnight and at weekends. This included people who were terminally ill or at high risk due to their specific health needs. The practice confirmed that the out of hours service provided them with information by 8am the next working day about any patients they had seen.

A counsellor from Healthy Minds provided twice weekly counselling sessions at the practice for patients with mental health difficulties. This was a contracted service available to all GP practices in Birmingham.

The GP told us that he checked and followed up any test results received. Staff confirmed that they made sure the GP received the paper copies of any results promptly in addition to him being able to access them electronically.

Health, promotion and prevention

The practice described a range of ways in which they identified people needing extra support. These included direct information from patients and/or their carers, hospital letters, information they held about people with long term conditions and opportunistic screening during consultations.

NHS Sandwell and West Birmingham CCG had identified smoking cessation as a health priority for 2013-2014. Staff told us that they would advise patients to go to the local pharmacy where smoking cessation help was available.

The practice provided services to women who are pregnant and had systems in place to inform the community midwife, who is allocated to the practice, about new pregnancies. There were arrangements in place to put parents with young children in touch with a health visitor for support, help and advice regarding children and parenthood. There was a separate child health clinic available for patients in another part of the building. This was operated by a different healthcare provider and was available for new mothers and babies from this and other GP practices in the health centre. Childhood immunisations were provided at the practice and the doctor and nurse provided on-going support.

The practice provided cervical screening in line with the National Programme. The practice nurse was undergoing cervical screening training and was practising under supervision of a mentor until they had successfully completed the required number of tests required. They reported that they actively contacted patients who had not attended for screening.

The practice nurse demonstrated knowledge regarding contraception and sexual health advice which they told us they provided opportunistically during consultations. They had access to methods of contraception and sexual health screening tools and we saw that these were clearly on

Are services effective?

(for example, treatment is effective)

display and available in the nurses consulting room. The nurse explained the signposting process for patients who needed to attend specialised sexual health clinics which could deal with their conditions more appropriately.

There were leaflets in reception for patients about a wide range of subjects including healthy lifestyle and diet, mental health, dementia, cancer, breast screening, diabetes, prescription services and care at home.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Information we gained from our review of information from the National Patient Survey and from Public Health England showed that patients felt treated with care and concern by the GP at the practice.

During our inspection we spoke with six patients and reviewed nine comment cards that patients had completed and left in the practice. All patients we spoke with reported a positive experience regarding the caring nature of the GP and other members of the practice team. Patients commented on the personalised service and that they felt reassured by the staff who knew them and their families well. Some patients reported that their anxieties were reduced by the welcome they received at reception. The patients we spoke with reported that their consultations with the GP and nurse were relaxed and unhurried. They told us that the GP always explained their condition and treatment to them and explained how to take their prescribed medication.

The GP and staff said they worked closely with district nurses when people were being cared for at the end of their life. The GP and staff told us that they knew all their patients well and that people felt comfortable speaking with them at difficult times such as when a family member was at the end of their life. The GP said they were happy for patients to contact them at home.

Patients reported that they were treated with respect and that their dignity was always preserved. During our inspection we observed positive interaction between staff and patients. The staff we spoke with told us that all staff were able to act as chaperones and this was offered to patients when intimate examinations were necessary. Staff explained that some patients wished to have family members with them during examinations and in such cases they respected the patient's wishes.

Our discussions with the nurse showed they were aware of and understood the considerations for some patients when commitments to their faith affected their care and had implications on their health; for example times of fasting for patients with diabetes. The nurse told us they respected the patient's wishes but always ensured that patients were fully informed of potential risks to their health.

Staff explained the system they had in place to protect patients' privacy at the reception desk. This included transferring calls to a secluded part of reception or offering another room to allow a confidential discussion to take place.

Involvement in decisions and consent

Information we gained from our review of information from the National Patient Survey and from Public Health England showed that patients felt involved in decisions about their care and treatment by the GP and by the nurse at the practice.

We spoke with patients who attended the surgery who told us that the GP always involved them in their care and provided choice, as well as ensuring that they understood what their care and treatment involved. Patients told us that the GP and nurse always sought consent before carrying out procedures and explained the procedures to them. The nurse told us that consent for childhood immunisations was always recorded in the Child Health Record before the programme of immunisations started. Staff we spoke with showed that they understood the importance of involving patients in their care and respected their wishes if they wanted their relatives to be involved.

People may not have the capacity to make some decisions because of illness or disability. In these circumstances health and care providers must work within the Code of Practice for the Mental Capacity Act 2005 (MCA). This helps to protect people and make sure that decisions are made in their best interests. The practice did not have a planned approach to providing care and treatment to people who lacked capacity to provide informed consent. None of the staff at the practice had received training about the MCA. When we discussed this area with the GP we found that they were not familiar with the MCA and the expected processes for assessing people's capacity to make decisions.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We saw that the staff knew the patients well and were welcoming towards them. We learned that over the years the GP had frequently given patients his home telephone details and that patients often contacted him outside surgery hours. On the day of our inspection the GP had already arranged for a person to bring their unwell child to the practice before they arrived to start their surgery. The most recent National Patient Survey information showed that the practice scored among the best for the percentage of patients rating their ability to make an appointment as good or very good.

The GP and staff were familiar with the needs of the local community which was in a socially deprived area and ethnically diverse. The staff at the practice showed respect and consideration for patients' varied cultural needs. Some patients at the practice did not speak English as a first language. Staff told us that they had access to interpreting services and that they used this whenever possible. They said that some people asked for a member of their family to interpret for them. Staff added that in some cases they used their own knowledge of other languages to support people but avoided doing this if possible to avoid misunderstandings.

Staff told us that the GP would always certify deaths at weekends if families needed this to make sure that religious burial requirements could be met.

There was level access for people with mobility difficulties and facilities to help people with sight or hearing problems. The practice was situated on the ground floor of a purpose built health centre. There was level access direct from the car parking spaces for people with disabilities. The reception window was low enough for people in wheelchairs to use. There were Braille signs for people who used this and a hearing loop to assist people who used hearing aids.

Patients we spoke with told us that the GP and nurse cared for them appropriately. Some mentioned their satisfaction at being able to have blood tests at the surgery because it was convenient and reduced their anxiety. One patient told us that the GP had discussed their possible condition and explained the tests requested. They went on to say that the doctor had followed up the results and treated them accordingly. They told us that they were satisfied with how their problem had been investigated and dealt with.

The practice made sure that referrals to specialists were done in a timely way using recognised systems such as 'Choose and Book'. The GP dictated clinical letters which were subsequently added to the Choose and Book system by the reception team.

The practice did not have a structured system for responding to comments, feedback and concerns from patients.

Access to the service

All patients we spoke with reported being able to book appointments when they needed to. They told us that if all appointments had been taken then they would be given a telephone call back that day from the doctor to determine if they needed to be seen. The receptionist, practice manager and GP confirmed that this was the procedure. We observed this happening during the inspection. Reception staff told us that they always gave priority to sick children and vulnerable patients requiring more urgent appointments.

Evening appointment times were available on five days a week for patients to be seen by the practice GP and on two evenings to see the nurse.

The practice did not have a clear and complete practice leaflet available. The opening hours of the practice were printed on small single sheets but these were kept behind the reception desk and contained limited information for patients. There was no written information regarding the out of hours GP service although staff told us that patients phoning out of hours were automatically transferred to the out of hours. Appointments were available to patients by telephone or booking directly at the reception desk.

Concerns & Complaints

The practice had a complaints process but this was not in line with NHS guidelines or the contractual obligations for GPs in England. The process did not set out timelines within which people could expect their concerns to be responded to or dealt with, details of advocacy services or the relevant information about the Ombudsman.

We looked at the complaints folder. The complaints had a single response letter filed against them and most said the

Are services responsive to people's needs?

(for example, to feedback?)

GP was on holiday and that staff would ask them for details when they was back. We asked staff if any further follow up had been made and they said there had not as far as they were aware. The paperwork in the complaints folder was not organised in an efficient way to help the practice use complaints information to monitor investigations and the outcomes of these.

There was no process to use the learning from complaints to help the practice develop and improve. We found a letter from NHS England asking the practice to carry out a root cause analysis in respect of a complaint. We could not find further information to show that the practice had done this. The GP assured us that they had complied with this request. We checked with NHS England who confirmed that although they had needed to remind the practice twice they had then received a satisfactory response.

Are services well-led?

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

Our findings

Leadership & Culture

The practice were not able to provide a statement of purpose and did not have a clear vision, strategy or clear plans for the future of the practice. There [RD1] was an obvious caring ethos within the practice and staff we spoke with confirmed this. Staff told us that general communication took place regularly between all the practice staff, but there were limited meetings where discussions and actions were recorded to implement change and improvements. Staff were able to demonstrate that they were committed to patient care but there was no evidence of leadership or a clear strategy to develop the practice for the future.

There was a lack of managerial direction at the practice to co-ordinate each person's roles and responsibilities. This meant that staff were focused on individual tasks and day to day demands without having an overview of their objectives as a team. The acting practice manager showed a willingness to develop and work hard to make any necessary improvements. They told us that the GP was supportive and was encouraging them to develop in their new role. However, they were new to the responsibilities and challenges of being a practice manager and would need more structured support and training to help them succeed.

Although the GP was approaching retirement age there were no firm plans for the future of the practice. The GP told us that they had been approached by doctors interested in joining the practice with a long term view. However, to date these enquiries had not been taken further.

Governance Arrangements

The practice did not have clearly defined management and governance arrangements. Staff were enthusiastic and committed and we saw that they were diligent in carrying out the tasks they knew they needed to do. The GP was confident that staff would address concerns of any nature to them and staff told us they could raise issues with the GP if needed. However, there was a lack of planning and organisation which meant that some NHS and regulatory expectations were not being addressed.

Systems to monitor and improve quality & improvement

The practice did not have structured arrangements to review or audit the quality of either the underpinning management of the practice or of clinical care and treatment. There had been no completed clinical audit cycles and there was no evidence to show how outcomes for patients, complaints or significant events were used to improve the quality of the service.

The Quality and Outcomes Framework (QOF) is a scheme which rewards practices for providing quality care and helps to fund further improvements. The practice participated in QOF but did not do so proactively and so the information available indicated low achievement levels in respect of the areas measured. We found from our discussions with the GP and staff that low QOF achievement levels were used as periodic triggers to recall patients rather than QOF achievement levels being generated by proactive management of patient care and treatment.

The GP told us they had received an annual appraisal in readiness for their forthcoming revalidation.

Patient Experience & Involvement

The practice did not have a Patient Participation Group (PPG) or any formal mechanisms for gathering and using information about patient experience to help develop and improve the service provided. Many practices now have PPGs to provide a way to work proactively with patients to improve the service. The GP felt that they knew all their patients well and freely communicated with anyone who wanted to discuss anything with them.

Practice seeks and acts on feedback from users, public and staff

The practice did not have a structured process for asking patients for their views. Staff told us they encouraged patients to fill in one of our comment cards but only nine were completed. The practice provided a personalised service to a fewer than 1800 patients and the practice team showed that they knew patients well. The staff told us that because of this they were able to check if people were satisfied with the service when they saw them. Staff assured us that they would act if there was anything that concerned them. The GP was confident they would do this, even if their concerns were about him.

The practice had supplemented their 0845 number with a local Birmingham number because some patients had

Are services well-led?

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

commented that the 0845 number was expensive. The 0845 number was the only one provided on their website although staff said that it was not the best number on which to get through to the practice.

Management lead through learning and improvement

The practice was small and most communication between the staff team was informal. The practice did not have any clear processes for monitoring and improving any aspect of the service it provided. Staff did not have structured opportunities to consider and plan their professional development and objectives. There was no process for setting objectives for the practice as a whole.

Identification & Management of Risk

The practice did not have a risk register or formal risk assessments to help the GP and their team to identify and manage risk. The GP was approaching retirement age and recognised that they would need to plan for the future of the practice but had not yet developed firm plans for this.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

We spoke with the practice nurse (who had been at the practice for three months) and the reception staff regarding services for older people. The receptionist told us that all vulnerable groups, including older people, were given priority appointments. The practice nurse explained that they visited patients at home if they were housebound and unable to come to the practice for their influenza vaccine. They told us about topics they discussed with patients during these visits to educate patients about their health.

Older patients who attended the practice were able to have appointments with the practice nurse for reviews of long term conditions, such as diabetes or asthma. The practice nurse said they had started to contact older patients with long term conditions who they had identified from the practice's clinical system. However, the practice did not have a systematic, robust process for reviewing older patients or giving them health promotion advice.

The practice communicated with the district nursing service to discuss and plan the care for older patients with chronic conditions who needed additional support from other services.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The Quality and Outcomes Framework (QOF) is a scheme which rewards practices for providing quality care and helps to fund further improvements. The General Practice Outcome Standards provide a way to measure the performance of GP practices in comparison with other practices. The GPOS information we looked at before the inspection and the QOF information we reviewed during the inspection highlighted that the practice was not actively managing the care of patients with long term conditions.

The practice had not been routinely recalling patients with long term conditions such as chronic obstructive pulmonary disease, diabetes and asthma to be reviewed. Staff told us that set clinic times had not been successful in the past. They explained that generally patients were followed up when they contacted the practice for other reasons such as making a repeat prescription request. One of the staff told us that they often contacted people to prompt them to come for checks if they saw that the QOF results looked low.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice provided services to women who are pregnant and had systems in place to inform the community midwifery team about new pregnancies. We spoke with the receptionist who showed us the process for referrals to the midwife. Appointments were readily available for women who experience any problems during pregnancy which require medical attention.

The practice had arrangements to put parents of young children in touch with a health visitor for support, help and advice regarding children and parenthood. There was a separate child health clinic available for patients in another part of the building. This was operated by a different healthcare provider.

Childhood immunisations were provided at the practice and the doctor and nurse provided on-going support. One patient we spoke with said that they had received good support with an on-going problem with their child's development. The receptionist told us that any parent who calls with a sick child is seen that day as a priority. During our inspection we observed one patient who had been given an emergency appointment for their sick child.

The practice nurse demonstrated knowledge regarding contraception and sexual health advice which they told us they provided opportunistically during consultations. They had access to methods of contraception and sexual health screening tools and we saw that these were clearly on display and available in the nurses consulting room. The nurse explained the signposting process for patients who needed to attend specialised sexual health clinics which could deal with their conditions more appropriately.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice held afternoon and evening surgeries until 8pm one evening a week and until 6:30pm on the other four evenings. Evening appointments for the nurse were available two days each week. Staff said that these hours appeared to meet people's needs locally.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

Staff at the practice told us that they had very few patients with learning disabilities but did support a small care home for people with those needs. We spoke with the owner of the care home who confirmed that the practice provided a caring and personalised service to the four people at the home. The people from the home went to the practice for appointments and were always seen on the day they rang. The person gave us an example of action the GP had taken that resulted in an improvement in the health of one of the people living at the care home.

The GP and staff had not received training in the Mental Capacity Act 2005 and were unfamiliar with the expectations of care professionals regarding mental capacity and consent. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability.

Staff did not know how many patients they might have from the travelling community. One of them told us they did not have any travellers registered whilst another told us that a family of travellers was registered.

All the staff we spoke with were aware of the need to report safeguarding concerns but they had not received specific safeguarding vulnerable adults training. Information about adult safeguarding contact details was pinned on a noticeboard for staff. The document was dated 2009 and was overdue for review to make sure the details were still correct.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

A counsellor from a local mental health organisation called Birmingham Healthy Minds came to the practice two days a week to provide support to patients experiencing poor mental health. This was a contracted service available to all GP practices in Birmingham. We saw leaflets in reception about mental health services.

The practice did not have an organised way to monitor the numbers of patients with poor mental health or to proactively review their physical as well as their mental health.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **Patients were not protected against the risk of inappropriate or unsafe care because:** **The provider did not have suitable systems for identifying, assessing and managing risks. Regulation 10 (1) (b)** **The provider did not have systems to assess and monitor the quality of the service or to ensure that any incidents, significant events or accidents were used to identify any learning and improvement that may be necessary. Regulation 10 (1) (a) and 10 (2) (c) (i)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **Patients were not safeguarded against the risk of abuse because the provider did not have suitable arrangements in place in respect of adult safeguarding. Regulation 11 (1)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The provider did not have effective recruitment procedures to reduce the potential for unsuitable people gaining employment. Regulation 21 and Schedule 3**

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The provider did not have suitable arrangements in place to ensure that staff received appropriate training, professional development, supervision and appraisal. Regulation 23 (1) (a)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The provider did not protect patients against the risks associated with the unsafe use and management of medicines. Regulation 13**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints **The provider did not have an effective complaints policy which met NHS guidelines and provided patients and others with clear and accurate information about how to complain, who to complain to and what to expect regarding timescales and information. Regulation 19 (1) (2)**