

Dr Iftekhar Majeed

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

Requires improvement



Are services safe?

Inadequate



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Requires improvement



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr. Iftekhar Majeed on 21 November 2016. Overall the practice is rated as requires improvement.

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

- There was an open and transparent approach to safety. However, a more effective system for reporting and recording significant events was needed.
- Some risks were identified and assessed, in other cases the absence of, or ineffective systems in place generated risks for patients which had not been mitigated for example those relating to high risk medicines and home visits.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with the GPs and there was continuity of care, with urgent appointments available the same day. There were however concerns expressed by some patients about limited access to a female GP, as appointments with this doctor were limited to two mornings per week.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider must make improvements are:

Summary of findings

- Ensure effective systems are in place to support the safe prescribing of high risk medicines which require additional monitoring.
- Ensure an effective system is in place for the management of patient safety, for example the National Patient Safety Alerts.
- There must be an effective system for identifying vulnerable patients, ensuring there is a system to share information about children who are at risk of harm with health visitors.
- The areas where the provider should make improvement are:
- Consider a structured approach to clinical audits.
- Review the system in place to ensure only current Patient Group Directions are in circulation in the practice.
- Review the approach to the care planning process and review care plans to ensure they are all fully documented.
- Clarify the arrangement in place for checking emergency equipment with the neighbouring practice, as there was no formal arrangement in place to make sure this task was being carried out and by whom.
- Consider how patients can access a female GP when required.
- The practice should continue with efforts to identify carers in order to offer care and support.
- Consider how to further promote health screening in order to improve uptake.
- Review the template for the recording significant events to include actions or learning points.
- Introduce a consistent approach to dealing with home visit requests.

Where a service is rated as inadequate for one of the five key questions or one of the six population groups or overall, it will be re-inspected within six months after the report is published. If, after re-inspection, the service has failed to make sufficient improvement, and is still rated as inadequate for any key question or population group or overall, we will place the service into special measures. Being placed into special measures represents a decision by CQC that a service has to improve within six months to avoid CQC taking steps to cancel the provider's registration.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

- There was a system in place for reporting and recording significant events, however recordings did not include actions taken or learning points.
- The systems for receiving and acting on national patient safety alerts needed strengthening. For example, the practice were unable to demonstrate that patient safety alerts were appropriately managed.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The systems for safeguarding children and vulnerable adults were not effective and the communication with attached professionals needed strengthening to protect patients from the risk of harm.
- There was no system in place to ensure a safe and effective system for the prescribing of high risk medicines which required additional monitoring.
- Patient Group Directions were available and appropriately authorised.

Inadequate



Are services effective?

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were generally at or above average compared to the local and national average for example, 80% of patients diagnosed with dementia had their care reviewed in a face- to- face review in the preceding twelve months. This compared to a CCG and national average of 84%. Also 87% of patients with hypertension had a blood pressure reading measured in the preceding 12 months, compared to a CCG average of 81% and a national average of 83%.
- Clinical audits had been completed. As the audits were single cycle only, the practice was unable to demonstrate improved outcomes as a result.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Requires improvement



Summary of findings

Are services caring?

Good



- Data from the national GP patient survey in July 2016 showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good



- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, the practice had signed up to Sandwell and West Birmingham's Primary Care Commissioning Framework (PCCF) which used a set of clinical standards aiming to improve the overall quality of clinical care and reduce inequality for the whole practice population.
- Patients said they found it easy to make an appointment with the GPs and there was continuity of care, with urgent appointments available the same day. The surgery offered GP appointments between 9.30am and 12.00am and between 4pm and 6pm, every day except Wednesday, when the practice was closed in the afternoon. We were told the practice was carefully considering extending the surgery times to include a Wednesday afternoon, covered by a female GP.
- There was an inconsistent approach to home visits and these were not readily available to patients who may need them, including older patients and those nearing the end of their life. We were told during the visit that whilst carrying out patient reviews, it had not been possible to see two patients who were housebound. A clinician who worked with the practice was concerned about the practice's approach to home visits.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

Are services well-led?

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients but the systems to enable and support this were not always in place and operating effectively. This compromised the practice's ability to ensure the vision was met. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management.
- The practice had a number of policies and procedures to govern activity and held regular governance meetings but the governance meetings had not been effective at enabling the provider to identify risks and take mitigating action to ensure patients were safe, for example in relation to high risk medicines, safeguarding and home visits.
- The provider's systems to enable them to assess and monitor the quality of care being provided needed some strengthening, for example by taking a more systematic approach towards repeating clinical audits to determine whether the actions taken had resulted in improvements in patient care and treatment.
- The provider was aware of and complied with the requirements of the duty of candour. A culture of openness and honesty was encouraged. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.

Requires improvement



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

Requires improvement



- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice did not demonstrate that there was a consistent approach to home visits. This needed to be reviewed by the practice in line with a recent Patient Safety Alert.

People with long term conditions

Requires improvement



- The lead GP took responsibility for chronic disease management and patients at risk of hospital admission were identified as a priority.
- Data showed the practice was performing in line with local and national averages in relation to clinical indicators for patients with long term conditions. For example, 75% of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding twelve months) was 140/80 mmHg or less. This compared to a CCG average of 78% and a national average of 77%. However, the exception reporting for this domain was 19.8%, compared to a CCG average of 8.4% and a national average of 9.2%.
- Longer appointments were available. However, there was an inconsistent approach to home visits which needed to be reviewed by the practice in line with a recent Patient Safety Alert.
- The GPs were unable to check the results of blood monitoring tests for patients receiving high risk medicines. This meant they were unable to determine if it was safe to prescribe those medicines. This was discussed with the GP, who agreed that this should be addressed with the hospital concerned.
- All patients with a long term condition were allocated to a named GP and had a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice nurse was appropriately trained to deliver care to patients with long- term conditions, including diabetes and asthma and undertook reviews as necessary.

Summary of findings

Families, children and young people

- There were systems in place to identify and follow up children living in disadvantaged circumstances and those who were at risk, for example, children and young people who had a high number of A&E attendances.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- There were appointments available outside of school hours. The premises were suitable for children and babies.
- The arrangements in respect of child safeguarding needed strengthening and there was a need for a more effective system for sharing information about children who were at risk of harm with the health visitors to ensure they were protected. Only children on child protection plans had an alert on the system. There were no alerts for lower level concerns or the inclusion of family members. There was evidence to show this information was not always shared with the health visitors.
- Any patient requesting an appointment for a young child would either be offered an appointment, or the GP would call the family to assess the circumstances on the same day.
- The practice offered a confidential service to young people, including full sexual health screening, the provision of condoms upon request and the availability of private services for chlamydia screening.
- All staff had received domestic abuse training.

Requires improvement



Working age people (including those recently retired and students)

- The number of women aged 25-64 who were recorded as having a cervical screening test in the preceding five years was 71%, compared to a CCG average of 79% and a national average of 81%. Exception reporting was 12%, compared to a CCG average of 9% and a national average of 6%.
- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this population group.

Requires improvement



Summary of findings

People whose circumstances may make them vulnerable

- The practice did not routinely offer longer appointments for patients with a learning disability. However, the GP told us they would offer those patients sufficient time to enable them to receive the care and guidance needed. The practice had nine patients on the learning disabilities register. Two of these patients were being reviewed by the hospital with the GP carrying out their medication reviews. Three patients had been reviewed in the last 12 months and one patient had declined a review.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- The practice's computer system alerted staff if a patient was also a carer. The practice had identified 12 patients as carers (0.4% of the practice list) and were taking action to address this, by displaying notices in reception and reminding patients when attending the practice.
- Generally staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. However, a more effective system was required to share information with health visitors about children who were at risk of harm. Only children on child protection plans had an alert on the system.

Requires improvement



People experiencing poor mental health (including people with dementia)

- 80% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which was comparable to both the CCG and national averages.
- 100% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record, in the preceding 12 months, which was higher than both CCG average of 91% and the national average of 89%. However, we noted the exception rate was 21% for this group of patients, compared to a CCG rate of 15% and a national rate of 13%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.

Requires improvement



Summary of findings

- The practice carried out advance care planning for patients with dementia and fridge magnets were offered so that appointment cards could be attached and displayed in a prominent place. This was sponsored by the local NHS estates department.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended A&E where they may have been experiencing poor mental health and a dedicated referral service to the mental health team was in place.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was mostly performing in line with local and national averages. There were 353 survey forms distributed and 88 were returned. This represented a 25% response rate and 3% of the practice's patient list.

- 79% of patients found it easy to get through to this practice by phone compared to the CCG average of 60% and a national average of 73%.
- 61% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 61% and a national average of 76%.
- 84% of patients described the overall experience of this GP practice as good compared to the CCG average of 75% and a national average of 85%.
- 77% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 66% and a national average of 79%.
- 79% of patients said the GP was good at listening to them compared to a CCG average of 83% and a national average of 89%.
- 75% of patients said the GP gave them enough time compared to a CCG average of 81% and a national average of 87%.
- 79% of patients usually waited 15 minutes or less after their appointment time to be seen compared to the CCG average of 54% and the national average of 65%.

- 81% of patients said the last nurse they saw or spoke to was good at listening to them compared to the CCG average of 87% and the national average of 91%.
- 82% of patients said the last nurse they saw or spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 91%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 14 comment cards which were mostly positive about the standard of care received. Patients felt that the practice provided a good service; they were happy with the availability of appointments and found staff helpful and friendly. One comment suggested the opening hours were not the most convenient for those working 9am to 5pm. A few patients commented they would welcome the additional availability of a female GP.

We spoke with four patients during the inspection. All patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. The practice had invited patients to complete the NHS Friends and Family test (FFT). The FFT gives each patient the opportunity to provide feedback on the quality of care they received. We looked at the results for 2015 which indicated that 70% of patients would recommend this practice to someone who had just moved to the local area.

Areas for improvement

Action the service MUST take to improve

- Ensure effective systems are in place to support the safe prescribing of high risk medicines which require additional monitoring.
- Ensure an effective system is in place for the management of patient safety, for example the National Patient Safety Alerts.
- There must be an effective system for identifying vulnerable patients, ensuring there is a system to share information about children who are at risk of harm with health visitors.

Summary of findings

Action the service **SHOULD** take to improve

- Consider a structured approach to clinical audits.
- Review the system in place to ensure only current Patient Group Directions are in circulation in the practice.
- Review the approach to the care planning process and review care plans to ensure they are all fully documented.
- Clarify the arrangement in place for checking emergency equipment with the neighbouring practice, as there was no formal arrangement in place to make sure this task was being carried out and by whom.
- Consider how patients can access a female GP when required.
- The practice should continue with efforts to identify carers in order to offer care and support.
- Consider how to further promote health screening in order to improve uptake.
- Review the template for the recording significant events to include actions or learning points.
- Introduce a consistent approach to dealing with home visit requests.

Dr Iftekhar Majeed

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team also included a GP specialist adviser.

Background to Dr Iftekhar Majeed

The surgery is situated in Nechells, central Birmingham. The surgery operates out of modern, purpose-built premises. Ample on-site parking is available and the facilities are accessible for patients with a disability. The staffing team consists of one male GP and a part-time female GP locum. There is also a part-time practice nurse, a part-time practice manager who is supported by four part-time receptionists and a medical secretary.

The practice is open between 8am and 6.30pm Mondays to Fridays. Appointments with the male GP are from 9.30am to 12pm and 4pm to 6pm on Mondays, Tuesdays, Thursdays and Fridays and from 9.30am to 12pm on Wednesdays. The female GP is available on Monday and Friday mornings, between 9.20am and 12.20pm. We noticed that these appointment times were not reflected in the current practice leaflet.

When the practice is closed, patients are redirected to 'Badger', an out of hours provider in the Birmingham area.

There are 2,929 patients on the practice list and the practice population experience lower than average levels of deprivation. The practice is in the first decile for deprivation. In addition, 58% of the practice population are either of African or Bangladeshi origin and 34% are aged between 0-19 years old.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 21 November 2016.

During our visit we:

- Spoke with a range of staff including the GP, the practice manager, the practice nurse, a receptionist and a medical secretary. We also spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Detailed findings

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

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

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

- Older people

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

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

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out an analysis of the significant events. We noted that the template for the recording of these lacked detail with no actions or learning points recorded.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw regular team meetings had taken place during 2016 at which significant events had been discussed. MHRA alerts and safety alerts were managed by the practice manager, who took responsibility for ensuring these were dealt with appropriately and discussed at the relevant staff meeting.
- A notice in the waiting room advised patients that chaperones were available if required. The staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy, with a comprehensive cleaning schedule and monitoring process in place. The GP was the infection control lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. An external infection control audit had been completed in November 2016 and had rated the practice as compliant. In addition, the practice was undertaking self-audits every six months.
- However, there was no system in place to ensure GPs had sufficient information to continue the prescribing of certain high risk medicines safely.
- The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- Patient Group Directions were available and appropriately authorised. However, out-of-date directions were also available and had not been removed from circulation, in order to prevent staff referring to them inappropriately.
- We reviewed two personnel files and found undertaken prior to employment. For example, proof of

necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. The GP was trained to adult or child safeguarding level 3 and the nurse trained to level 3 for adults and level 2 for children.

Overview of safety systems and processes

The practice had some systems, processes and practices in place to keep patients safe which included:

- Some arrangements were in place to safeguard children and vulnerable adults from abuse. However, only those children with care plans were set up with an alert. The practice were unable to demonstrate how they ensured all vulnerable patients were easily identifiable. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The GP was the lead for safeguarding. The GP attended safeguarding meetings when possible and always provided reports where

Are services safe?

identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in reception. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had other risk assessments in place to monitor safety of the premises such as fire, the control of substances hazardous to health, infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for the reception staff to ensure that sufficient staff were available during busy periods.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. These were shared with the neighbouring practice and were accessible in the main reception area. We discussed the arrangement in place for checking emergency equipment with the neighbouring practice and it was agreed that both parties would clarify their respective responsibilities for the maintenance of this equipment.
- A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.
- The practice had signed up to the clinical commissioning group's (CCG) Primary Care Commissioning Framework (PCCF), which was a set of clinical standards aiming to improve overall quality of clinical care and reduce inequality for the whole practice population. This included falls prevention which was a common and serious problem for older people. The practice had implemented a system to identify, manage and record patients who were at risk of falling or who had experienced a fall within the last 12 months. Any of those identified patients were considered for discussion at a multi-disciplinary meeting for appropriate action to be taken.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed the practice had achieved 95% of the total number of points available, with an exception reporting rate of 16%. This compared to a CCG average of 9.5% and a national average of 9.8%. We looked at the exception rates in general and discussed these with the GP. We saw that work had been undertaken to address this, particularly for patients with asthma and diabetes through increased intervention by the GP as well as nurse

clinics. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

We discussed four areas of significant variation compared to local and national averages. These were:

- The ratio of reported versus expected prevalence for Coronary Heart Disease (CHD) was 0.47 compared to the national rate of 0.71. This was however comparable with the CCG figure of 0.61.
- The percentage of women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding 5 years was 71%, compared to a CCG average of 79% and a national average of 81%.

The main explanation we were given for high exception rates was the low prevalence, which was borne out by the CCG comparisons in CHD and diabetes. Cervical screening uptake had become an historical challenge, with the high numbers of ethnic group women showing reluctance to engage in the process, again borne out by the more comparable CCG average.

Data from 2015/2016 showed:

- Performance for diabetes related indicators was comparable with the CCG and national averages. For example, 75% of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding twelve months was 140/80 mmHg or less, compared to a CCG average of 78% and a national average of 77%.
- Performance for mental health related indicators was above the CCG and national averages. For example, 100% of patients with schizophrenia, bipolar affective disorder and other psychoses had had a comprehensive, agreed care plan documented in the record, in the preceding 12 months. This compared to a CCG average of 91% and a national average of 89%, although the exception rate was 21%.
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less was 67%, compared to a CCG average of 77% and a national average of 80%.

Are services effective?

(for example, treatment is effective)

There was evidence of quality improvement including clinical audit.

- There had been two clinical audits completed in the last two years. The practice did not demonstrate these audits had been fully developed and had contributed to improvement in patient care.

The practice participated in local schemes for avoiding or reducing unplanned hospital admissions. This was carried out using risk stratification tools and data analysis along with an in-depth clinical knowledge of each patient. This allowed those patients that were at most risk of an unplanned hospital admission to be identified.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The learning needs of staff were identified through a system of appraisals. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- All Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. Role specific training had been provided, including immunisations and cervical screening.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. We did however notice that some care plans we looked at were not completed fully.

- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

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

The practice team were part of local pilot schemes to improve outcomes for patients in the area. For example, the practice had implemented a new service called 'Care Connected' which had been rolled out across Birmingham, Sandwell and Solihull. This allowed doctors, nurses and other registered healthcare professionals working in secondary care to view information from a patient's GP record, with the patient's permission, to provide them with better, safer care.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support, including patients receiving end of life care, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. For example, a postural stability service for those patients susceptible to falls and a chlamydia screening service for young people.

Are services effective?

(for example, treatment is effective)

Immunisation rates were relatively high for all standard childhood immunisations. For example, immunisation rates for the vaccinations given to under two year olds ranged from 0% to 95%, compared to CCG averages of 39% to 94% and national averages of 73% to 95% and for five year olds from 0% to 89%, compared to CCG averages of 55% to 95% and national averages of 81% to 95%. The practice was looking at ways of improving these rates, by contacting parents and taking the opportunity to remind them when they attended the surgery for other reasons.

Patients had access to some appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

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

Most of the 14 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with one member of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was similar to or above average for some of its satisfaction scores on consultations with the GP. For example:

- 79% of patients said the GP was good at listening to them compared to the (CCG) average of 83% and the national average of 89%.
- 75% of patients said the GP gave them enough time compared to the CCG average of 81% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and the national average of 95%.

- 78% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 79% and the national average of 85%.
- 91% of patients said they found the receptionists at the practice helpful compared to the CCG average of 81% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

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

- 80% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and the national average of 86%.
- 82% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 76% and the national average of 82%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted staff if a patient was also a carer. The practice had identified 12 patients as

Are services caring?

carers (0.4% of the practice list) and were taking action to address this, by displaying notices in reception and reminding patients when attending the practice. Written information was available to direct carers to the various avenues of support available to them. A dedicated noticeboard had been provided in the reception area offering advice and contact details of support groups.

We were told that if families had suffered bereavement, they were sent a sympathy card.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice did not routinely offer longer appointments for patients with a learning disability. However, the GP told us they would be offered sufficient time to enable them to receive the care and guidance needed.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. There was an inconsistent approach to home visits and these were not readily available to patients who may need this.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- A travel vaccination service was available on the NHS and those only available privately were referred to other clinics.
- There were accessible facilities for patients with a disability, a hearing loop and translation services were available.
- Those patients with dementia and those experiencing poor mental health, including those with a learning disability, were offered same day appointments.

Access to the service

The practice was opened between 8am and 6.30pm Monday to Friday.

Appointments with the male GP were from 9.30am to 12pm and 4pm to 6pm on Mondays, Tuesdays, Thursdays and Fridays and from 9.30am to 12pm on Wednesdays. The female GP was available on Monday and Friday mornings, between 9.20am and 12.20pm. We noticed that these appointment times were not reflected in the current practice leaflet.

When the practice was closed, patients were redirected to Badger, an out of hours provider in the Birmingham area.

In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent appointments were also available for people that needed them.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was higher than local and national averages. For example:

- 82% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and the national average of 78%.
- 79% of patients said they could get through easily to the practice by phone compared to the CCG average of 60% and the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

We were told the receptionist passed all requests for home visits to the GP, who would decide whether to carry out telephone triage to determine the exact nature of their request, before deciding whether a home visit was appropriate. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system through information displayed in reception and in the practice leaflet.

The practice had received eight written complaints in the last 12 months and we were able to look at three from the records. These had been dealt with in accordance with the practice's policy and to the complainant's satisfaction.

Are services well-led?

Requires improvement 

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

Our findings

Vision and strategy

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

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions but not all of these were effective and the systems needed reviewing and strengthening to ensure patients were safe.
- The practice's programme of continuous clinical and internal audit, used to monitor quality and comprehensive. The practice were unable to demonstrate completed cycles of audit, or that improvements were being made to patient care as a result.

Leadership and culture

The GP told us they prioritised safe, high quality and compassionate care. Staff told us the GP was approachable and always took the time to listen to them.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The GP encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings and we saw evidence of this.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported. Staff were involved in discussions about how to run and develop the practice, and the GP encouraged staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly and submitted proposals for improvements to the practice management team. For example, we were told of a patient with mental health issues, who, due to their medicines, had a problem with their sleeping patterns, which often meant they were not able to call the practice early in the morning for an appointment. The practice manager changed the arrangements for this group of patients, enabling them to call later in the day and still be offered an appointment. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management and that they felt involved and engaged to improve how the practice was run.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. Systems were not in place for the monitoring and review of high risk medicines.</p> <p>Processes were not in place to ensure an effective system for the management of patient safety alerts, for example general practice home visits.</p> <p>This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment</p> <p>How the regulation was not being met:</p> <p>The registered person did not operate or establish an effective system for identifying vulnerable patients, processes did not ensure effective sharing of information about children who are at risk of harm with health visitors.</p>

This section is primarily information for the provider

Requirement notices

This was in breach of regulations 13(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.