Firstcare Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 23 June 2015 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be good in the safe, effective, caring, responsive and well-led domains. The practice was good at providing services for older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances, and people experiencing poor mental health.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from incidents were maximised.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a result of feedback from patients, staff and from the patient participation group (PPG).
- There were systems in place to keep patients safe from the risk and spread of infection.
- 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.
- The practice held regular multidisciplinary clinical team meetings to discuss the needs of complex patients, for example those with end of life care needs or children who were considered to be at risk of harm.
- The practice had an open culture that was effective and encouraged staff to share their views through regular practice and clinical staff meetings.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated with staff to support improvement. There were robust safeguarding measures in place to help protect children and vulnerable adults. Reliable systems were in place that ensured the safe storage and use of medicines and vaccines within the practice. There was a designated lead to oversee the hygiene standards within the practice to prevent infections. Enough staff were employed by the practice to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

Staff had received training appropriate to their roles. Any further training needs had been identified and appropriate training planned to meet these needs. There was evidence that appraisals and personal development plans were in place for staff. Staff worked with multidisciplinary teams internally and externally to deliver positive health outcomes for patients.

Are services caring?

Good

The practice is rated as good for providing caring services. Feedback we received from patients about their care and treatment was consistently and strongly positive. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We observed a patient-centred culture. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

The practice supported patients to have a forum where they could learn and share ideas that promoted their health. There was an active patient participation group (PPG) at the practice that directed its own agenda and focused on topics that mattered to patients.

Results of the national GP patient survey 2014 showed the practice was generally rated below average for its satisfaction scores than the national average on for appointments and consultations with GPs

Summary of findings

and nurses. The practice had developed an action plan to address the areas which showed below national average scores. The main issue about access had been identified as a fault on the telephone line system that was being addressed by the practice and the telephone provider. The practice had worked with the patient participation group (PPG) to improve survey results to ensure that patients were satisfied with the service they received, that they were given enough time during their appointments and that they were treated with care and concern.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice understood the needs of the population groups registered with them and were proactive in planning services to meet their needs.

The practice had acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG) and patient surveys. The practice reviewed the needs of its local population and engaged with the NHS England area team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Although the national GP patient survey results for 2014 had shown patients had problems with access to appointments, patients we spoke with and comments received had not reflected this. Patients told us that access had improved and they had been able to get an appointment with a named GP or a GP of choice, with continuity of care and urgent appointments available the same day as required.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision for its future development with the provision of high quality medical care as its top priority. Staff told us they were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management.

The practice had a number of policies and procedures in place to govern activity and they held regular governance meetings. There was good and constructive engagement with staff and a high level of

Summary of findings

staff satisfaction. The practice gathered feedback from patients and it had an active patient participation group (PPG). There was evidence of improvements made as a result of feedback from patients.

There were systems in place to monitor and improve quality and identify risk. Staff had received inductions, regular performance reviews and attended staff meetings and events. The practice discussed the learning that had taken place and the changes to practice that had been made to ensure these improvements were maintained.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. Nationally reported data showed that the practice performed well against indicators relating to the care of older people. For example, the practice maintained a register of patients in need of palliative care. The practice held regular multidisciplinary integrated care meetings where all patients on the palliative care register were discussed.

The practice offered home visits and rapid access appointments for those patients with complex healthcare needs. Patients over 75 years of age were offered annual health reviews.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. The GPs and nursing staff worked together in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. Practice staff held a register of patients with long term conditions and carried out regular reviews. For patients with the most complex needs, GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, such as children and young people who had a high number of accident and emergency (A&E) attendances. All consultation rooms were on the ground floor which made the practice accessible for pushchairs and appointments were available outside of school hours. There were policies, procedures and contact numbers to support and guide staff should they have any safeguarding concerns about children. The clinical team offered immunisations to children in line with the national immunisation programme. Immunisation rates were comparable to local and national average.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of the

Summary of findings

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 offered extended opening hours to assist this patient group in accessing the practice. NHS health checks were available for people aged between 40 - 74 years. The practice offered a range of health promotion and screening services which reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including patients with a learning disability. It had carried out annual health checks for patients with a learning disability and all of these patients had received a follow-up where issues were identified. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. GPs carried out home visits on request to patients who were unable to attend the practice.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Care was tailored to patients' individual needs and circumstances including their physical health needs. The practice offered health checks to patients on their mental health register. Practice staff worked in conjunction with the local mental health team to ensure patients had the support they needed. GPs had attended training in the Mental Capacity Act 2005 to ensure all care provided was in patients' best interests.

Summary of findings

What people who use the service say

We reviewed 46 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that generally most of the comments recorded were extremely positive. Patients commented that they would give the practice ten out of ten for the service they provided, that the GPs and all the staff were excellent, staff were very friendly and approachable and that they had received fantastic support from the GPs and receptionists.

We spoke with four patients during the inspection. Patients told us they found the practice communicated well with patients and that they would recommend the practice to everyone. They told us the GPs listened to them and the follow up care was excellent. They also told us they were able to ask questions if they needed to and that they felt very involved in their care and treatment. They were also confident that should they have any complaints they would feel able to make one without any fear of doing so.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey 2014 to 2015 and results of the NHS Friends and Family survey of patients undertaken by the practice during 2015.

Results of the national survey showed the practice was generally rated below average for its satisfaction scores for appointments and slightly lower than the national average on consultations with GPs and nurses. GP Survey data showed that:

- 73% of patients were satisfied with appointment times, which was comparable with the national average of 76%.
- 30% described their experience of making an appointment as good compared with the national average of 74%.
- 37% would recommend this practice to someone new to the area which compared with national average of 78%.
- 81% of patients said the last GP they saw or spoke with was good at listening to them compared with the national average of 87%.
- 71% of patients said the last GP they saw or spoke with was good at involving them in decisions about their care compared with the national average of 81%.

The results of the NHS Friends and Family Test carried out in April 2015 showed that 73% of respondents were either 'extremely likely' or 'likely' to recommend the practice to a friend or a member of their family. This showed an increase of 36% had been achieved by the practice on the results of the GP patient survey.

The practice had produced an action plan to address the areas which showed below national average scores. The main issue about access had been identified as a fault on the telephone line system that is being addressed by the practice and the telephone provider. The practice had worked with the patient participation group (PPG) to improve survey results to ensure that patients were satisfied with the service they received.

Firstcare Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team included a GP and Practice Nurse specialist advisors, and a second CQC inspector.

Background to Firstcare Practice

Firstcare Practice is centrally located, less than two miles from the centre of Birmingham. They provide primary medical services to patients registered with the practice, covering an area within three miles of the practice location. The practice has four GPs including two female GPs, nursing staff including a practice nurse, a health care assistant (HCA), a phlebotomist (a person who takes blood), administrative and reception staff. The practice is an accredited training practice although as yet does not have any trainee GPs. There were 5,758 patients registered with the practice at the time of the inspection.

The practice is open from 8am to 6.30pm Mondays to Thursdays, from 8am to 8pm on Fridays and from 8am to 1pm on Saturdays. Home visits are available for patients who are too ill to attend the practice for appointments. There is also an online service which allows patients to order repeat prescriptions, book and cancel appointments and view parts of their medical record.

The practice does not provide an out-of-hours service but has alternative arrangements in place for patients to be seen when the practice is closed. For example, arrangements are in place to ensure patients receive urgent medical assistance when the practice is closed. If patients call the practice when it is closed, an answerphone message gives the telephone number they should ring depending on the circumstances. Information on the out-of-hours service is provided to patients and is available on the practice's website.

The practice treats patients of all ages and provides a range of medical services. The practice provides a number of clinics such as disease management clinics which includes asthma, diabetes and heart disease. Other clinics include minor surgery, maternity care and family planning clinics.

Firstcare Practice has an Alternative Provider Medical Services (GMS) contract. The APMS contract is the contract between general practices and NHS England for delivering primary care services to local communities. This contract allowed Firstcare Practice to take over a previously failing practice and make improvements to provide a service to meet patients' needs.

Why we carried out this inspection

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

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

Detailed findings

How we carried out this inspection

Before our inspection of Firstcare Practice we reviewed a range of information we held about this practice and asked other organisations to share what they knew. We contacted Birmingham South and Central Clinical Commissioning Group (CCG) and NHS England area team to consider any information they held about the practice. We also supplied the practice with comment cards for patients to share their views and experiences of the practice.

We carried out an announced inspection on 23 June 2015. During our inspection we spoke with a range of staff that included two GPs, one of whom was also the practice manager, a practice nurse, administration and reception staff. We also looked at procedures and systems used by the practice.

We observed how staff interacted with patients who visited the practice. We spoke with four patients who visited the practice during the inspection. We reviewed 46 comment cards where patients and members of the public shared 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?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People whose circumstances may make them vulnerable
- People experiencing poor mental health

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. We reviewed safety records, incident reports and minutes of meetings where these were discussed. These records showed the practice had managed these consistently over time and could show evidence of a safe track record over the year.

Staff told us they were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. For example, we saw that an event had been recorded which had involved an abusive patient. The analysis of the incident and details of action taken had been recorded. We saw that significant events had been discussed at practice meetings which demonstrated the willingness by staff to report and record incidents. Staff told us that a folder was kept in reception area with blank forms for them to record any incidents or events accordingly, which were then forwarded to the lead GP for action.

Learning and improvement from safety incidents

The practice had system in place for recording, responding to, monitoring and reviewing significant events. There were records available to show significant events that had occurred over several years. We reviewed those that had occurred during the last 12 months. We tracked four such incidents and saw records had been completed in a comprehensive and timely manner. For example, we saw where a patient had been discharged from hospital and the full details of prescribed medicines had not been recorded. We saw from minutes of meetings that learning had been established from this event and adjustments had been made to procedures that staff followed when patients were discharged from hospital.

We saw another example where, as a result of a referral delay for a patient the practice had analysed the event and implemented changes to ensure that similar delays were not repeated. A spread sheet had been introduced to monitor referral and follow up of all two week referrals to ensure none were missed. The lead GP told us this had seen improvements for patients and ensured that early referral responses were achieved.

Staff, including receptionists and nursing staff knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. Staff told us they could also access the forms for recording events from any computer within the practice. The reporting gave detailed guidance for staff to follow for each incident reported and included guidance on what action they should take. We saw evidence that showed patients were told about significant events on an individual basis.

The practice had a safety alert protocol and procedure in place which we saw had been reviewed in March 2015. National patient safety alerts were disseminated by email to practice staff. Staff we spoke with gave us examples of recent alerts that were relevant to the care they were responsible for, such as a recent alert which concerned the use of a prescription medicine. They also told us that alerts were discussed at the practice meetings to make sure all staff were aware of any that were relevant to the practice and any action that was needed.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. There were safeguarding policies in place for both adults and children. We saw that both these policies had been reviewed during 2015. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible for staff, available both on practice computers and on notices displayed throughout the practice.

The practice had a GP identified as the safeguarding lead for vulnerable adults and children. They had been trained and could demonstrate they had the knowledge and understanding to enable them to fulfil this role. Staff we spoke with told us they were aware who the lead was and who to speak within the practice if they had a safeguarding concern. Staff gave us an example of an incident that had occurred at the practice that they had escalated to the GP lead as a child protection concern. All procedures had been

Good

Are services safe?

followed and staff confirmed that they would continue to report concerns should they have any. We saw details of referrals made for both an adult and a child and saw that all procedures had been followed accordingly.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example children who were considered to be at risk of harm or who was in the care of the local authority. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as health visitors and social services.

There was a chaperone policy available to all staff on any of the practice computers. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. Information about a chaperone service was provided for patients on the practice's website, in reception and in the waiting room. GPs told us they offered the chaperone service to patients and where chaperones were used had recorded this on patient records. GPs also recorded when a chaperone service had been offered but declined.

Staff we spoke with told us they acted as chaperones when needed, they confirmed they had received chaperone training and they were clear about their responsibilities. This included, for example knowing where to stand when intimate examinations took place. The lead GP told us that reception staff that were willing to act as chaperones had been given training to do this. The training included the type of examination and what was required of a chaperone. We saw training records that confirmed all staff had completed chaperone training.

Medicines management

The practice had a medicines management policy in place dated January 2015. We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The fridge temperatures were monitored daily and recorded on a spread sheet which we were shown. The cold chain policy was reviewed annually, with the last review carried out June 2015. A cold chain is a system of transporting and storing vaccines within the safe temperature ranges as specified by the manufacturers. Staff were seen to follow the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. We saw that logs were kept of checks carried out that included the quantity of the medicines held and their expiry dates. We saw that stock levels of medicines were kept to a minimum and rotated to ensure they were used in date order. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Nursing staff administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw that copies of all directives were available in the nurse's room. These were up-to-date. We also saw evidence that nurse had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Prescriptions were computer generated with a log kept of the prescription numbers. Staff told us that prescriptions were removed from the computer each evening and locked in a secure cupboard. We saw that regular audits of the prescription pads were carried out to ensure that all prescriptions could be accounted for.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. The practice employed a company to carry out the cleaning of the premises and cleaning schedules were in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Patients told us through the comment cards that they always found the practice to be clean and hygienic and that they had no concerns about a risk of infection.

The main GP partner had been the lead for infection control but this was now to be managed by the recently appointed practice nurse. Staff confirmed they had received infection control training and annual updates and records showed this training was provided by the Clinical Commissioning Group (CCG) lead. An infection control

policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. This policy was available to staff on any of the practices computers and had been reviewed in January 2015. For example, personal protective equipment including disposable gloves, aprons and coverings for examination couches were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy. We saw that curtains were cleaned every six months and a curtain cleaning schedule was in place to ensure this was done.

There was also a policy and guidance in place for needle stick injury and staff knew the procedure to follow in the event of an injury. The policy was available for staff online and guidance for staff was also clearly displayed in treatment rooms. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Single use disposable equipment was used by the practice to ensure hygiene was maintained.

We saw evidence that regular infection control audits were carried out with the latest audit completed 22 April 2015. From this audit we saw that action was required for one area. For example, the audit showed that up to date contact telephone numbers for local infection control contacts had not been available to staff for occasions when advice may have been needed. We saw that action had been taken to address this followed by discussion at team meetings. The minutes of meetings confirmed this.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). This policy was available for staff to access on the computer system. We saw records that confirmed that regular checks to reduce the risk of infection to staff and patients had been carried out.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested by a company that was employed by the practice. They carried out testing on equipment and we saw labels indicating the latest testing date of February 2015 displayed on equipment.

The practice kept a full inventory on all the equipment held and where it was located at the practice. Records confirmed that measuring equipment used throughout the practice was checked and calibrated each year to ensure they were in good working order. For example, we saw that annual calibration (testing for accuracy) of relevant equipment such as weighing scales, ear syringes, nebulisers and blood pressure monitoring machines had been carried out during January 2015.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. This included the completion of DBS checks for clinical and non-clinical staff. We spoke with staff who confirmed that all the checks had been carried out prior to their employment. The practice policy was that all staff completed a DBS check every three years. The DBS status of all staff on the register showed that all staff had up to date DBS checks in place.

The lead GP told us about the new induction programme through the Care Certificate they were to implement for new starters. The Care Certificate was officially launched in March 2015 and aimed to equip health and social care staff with the knowledge and skills to provide safe and compassionate care.

We spoke with staff about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. They told us they were flexible and covered for each other and would work additional hours if required. Staff told us that there was back up for each person's role too as staff were trained on how to carry out another persons' role in the event they were on leave or off sick.

Good

Are services safe?

The practice told us they used a small group of locum GPs and although they had no specific Service Level Agreement (SLA) in place for these locums they had carried out employment checks according to their policy and procedures. We saw that the practice had complete records in place that included details of qualifications and checks that ensured they were able to work at the practice in the same way as other staff employed by the practice.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the environment, medicines management and dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and the practice employed a company to oversee the management of health and safety at the practice.

The GPs told us there were sufficient appointments available for high risk patients, such as patients with long term conditions, older patients and babies and young children. Patients were offered appointments that suited them, for example the same day, next day or pre-bookable appointments with their choice of GP.

Staff told us they were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, staff explained how they had responded to a patient who had experienced a mental health crisis. They told us they had supported them in a calm way recognising their anxious state while they called for GP support. Staff also confirmed they were aware of the panic alarm system available in the practice and how they should respond if this was used. There was a policy in place with guidance for staff to follow in the event the panic alarm was used.

There was a system in place that ensured patients with long term conditions were invited for regular health and medicine reviews and contact was made to follow up on patients where they failed to attend. The practice told us that patients were offered extended appointments with an appropriate clinician. The practice nurse was trained and experienced in providing health care for patients with diabetes. They told us about the plans for the future of the practice to set up diabetes clinics which would run in conjunction with the diabetic lead GP.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw evidence that basic life support training had been completed by all staff including reception staff. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff we spoke with all knew the location of this equipment and records confirmed that it was checked regularly so that it was suitable for use.

Emergency medicines were available in a secure area of the practice and staff spoken with knew of their location. These included those for the treatment of cardiac arrest (where the heart stops beating), a severe allergic reaction and low blood sugar. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Copies of the plan were kept in the reception area, on the practice's computer system and the lead GP confirmed they kept a copy at home. Risks identified included power failure, loss of telephone system, loss of computer system, GP sickness and annual leave, and loss of clinical supplies. The document also contained relevant contact details for staff to refer to which ensured the service would be maintained during any emergency or major incident. For example, contact details of local suppliers to contact in the event of failure, such as heating and water suppliers. We saw there was a procedure in place to protect computerised information and records should there be a computer systems failure.

The lead GP told us that a disaster pack was kept in reception for staff to respond to unexpected events. This pack included for example, spillage kits for use in the event of spillage of bodily fluids. Staff told us they were aware of this and its purpose.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We found from our discussions with the GPs that they completed assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate. We saw hard copies in the GPs room and evidence of clinical discussions that had taken place following guidance issued. For example, there had been guidance issued on warfarin (blood thinning) medicines prescribing policy and a protocol issued for the foot care of diabetic patients.

Nurses told us they accessed NICE guidance and actioned recommendations where these were applicable. Shared records were in place to enable best practice guidance to be stored and shared by all staff. We saw minutes of practice meetings where new guidelines had been discussed and shared.

GPs at the practice each led in specialist clinical areas such as sexual health, safeguarding adults and children, diabetes, palliative care, women's health and minor surgery. The nurses supported this work, which allowed the practice to focus on the specific conditions. The GPs attended educational meetings facilitated by the Clinical Commissioning Group (CCG) and engaged in annual appraisal and other educational support. The annual appraisal process required GPs to demonstrate that they had kept up to date with current practice, evaluated the quality of their work and gained feedback from their peers. Clinical staff told us they ensured best practice was implemented through regular training, networking with other clinical staff and regular discussions with the clinical staff team at the practice. We were told that GPs were very approachable and that clinical staff felt able to ask for support or advice if they felt they needed it.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that they encouraged a culture in the practice of patients cared for and treated based on need. The practice took account of patients' age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audits. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through systematic review of care and the implementation of change. It includes an assessment of clinical practice against best practice such as clinical guidance to measure whether agreed standards were being achieved. The process requires that recommendations and actions are taken where it is found that standards are not being met.

The practice showed us four clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed to ensure outcomes for patients had improved. For example, one of the audits we looked at dated April 2015 reviewed the number of patients who were prescribed two types of medicines that may not be effective when taken together. Three patients were found to be prescribed these medicines. The practice invited them for a review of their medicines to ensure they were prescribed the most effective for them. A re-audit was carried out in May 2015 and this found that no patients were prescribed these medicines and a date for a further audit was set out for December 2015.

We looked at another audit that had been carried out in April 2015 to review the use of equipment (injectors) used to administer medicines for an allergic reaction. This audit had been carried out in response to a Medicines and Healthcare products Regulatory Agency (MRHA) alert sharing information about additional guidance that was now included in the product information. The advice included that patients should be prescribed two injectors in the event that a second dose was required if patient had not recovered within the timescale specified. The audit identified six patients who had been prescribed one injector. Action had been taken as a response to the findings of the audit and guidelines and a second prescription was provided. A re-audit was carried out in May 2015 and found no further patients affected and a date for a further audit was set for November 2015. We saw that discussions about the audits had taken place at clinical meetings.

The Quality and Outcomes Framework (QOF) is a voluntary incentive scheme for GP practices in the UK. The practice also used the information collected for QOF and

Good

Are services effective?

(for example, treatment is effective)

performance against national screening programmes to monitor outcomes for patients. The practice had reached performance levels that were mixed when compared with the national average. For example, the number of patients diagnosed with dementia whose care had been reviewed in the preceding 12 months was 100% which was higher than the national average of 83%. However, the practice had achieved 90.6% for their total QOF points, which was slightly lower than the national average of 94%.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of patients in vulnerable population groups such as patients with a learning disability. The practice carried out structured annual reviews for patients with long term conditions.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for patients with long-term conditions, such as diabetes and that the latest prescribing guidance was being used. The computer system used at the practice flagged up relevant medicine alerts when the GP prescribed medicines. We saw evidence to confirm that, after receiving an alert the GPs had reviewed the use of the medicine in question and, where they continued to prescribe these outlined the reason why they had decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The lead GP maintained a register for all staff who worked at the practice. We saw from the register that details about registrations with professional bodies, latest training courses completed and appraisal status for all clinical staff were up to date.

We reviewed staff training records and saw that staff were up to date with training such as annual basic life support and safeguarding of vulnerable adults and children. We noted a good skill mix among the GPs who collectively had additional diplomas as medical education trainer, in learning disabilities, minor surgery, diabetes and family planning. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Staff told us that the practice provided training and funding opportunities for relevant courses. Firstcare Practice was a training practice although educational support was not provided to any trainee GPs at the time of the inspection.

Practice nurses and health care assistants (HCAs) had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, ear syringing, quit smoking programme and lifestyle advice. Those with extended roles as in monitoring patients with long-term conditions such as asthma, diabetes and heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, x-ray results and letters from the local hospital including discharge summaries and the out-of-hours GP services both electronically and by post.

The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The lead GP took responsibility to check these documents, the results and was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings every three weeks with the Macmillan nursing team and the district nurses. They reviewed patient care, patients who had died and discussed the overall care and wishes of complex patients. For example, those with end of life care needs or children who were considered to be at risk of harm. Decisions about care planning were documented in the patient's record. Staff told us this system worked well. GPs told us that they worked closely with the team to make sure patients' needs were met and that important information was shared.

Good

Are services effective?

(for example, treatment is effective)

In addition the practice had regular quarterly meetings with the patient participation group (PPG) and quality premium care meetings to discuss issues and concerns around safeguarding adults and children. We saw that minutes were available for all staff at the practice for all meetings that took place.

The practice also worked with an urgent care service provided for patients in Birmingham. Information leaflets were available for patients. The leaflets advised that should an urgent referral be needed the GP could call Birmingham Community Healthcare's Single Point of Access Urgent Care service. This responsive and flexible service worked with practices throughout Birmingham and enabled patients to receive responsive care and support in their own homes instead of automatic admission to hospital. This service also included ongoing liaison with the patient's GP to manage their clinical care.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP extended hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and told us that the system was safe and easy to use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We saw that the practice had a policy for documenting consent. Clinical staff we spoke with were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. GPs told us they recorded decisions about consent and capacity in patient records. The GPs we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance. They confirmed they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures a patient's written consent was documented and then scanned into the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure where applicable. Staff told us that consent was also obtained where possible, from patients before any information was shared with carers.

The clinical staff we spoke with understood the key parts of the legislation and they were able to describe to us how they implemented it in their practice. For example, staff told us consent was sought prior to the administering of immunisations and was documented in the patient's record. Staff told us they had completed training about consent and training records we looked at confirmed this.

Patients with a learning disability were supported to make decisions through the use of care plans, which they were involved in agreeing. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. The GPs also demonstrated a clear understanding of Gillick competence. The 'Gillick Test' helps clinicians to identify children under 16 years of age who have the legal capacity to consent to medical examination and treatment.

The practice had not needed to use restraint but staff told us they were aware of the distinction between lawful and unlawful restraint. The practice had a zero tolerance policy and told us they had needed to refer to this on occasions. Staff were able to give us two examples where incidents had occurred and the police had been involved on both occasions.

Health promotion and prevention

The practice provided a range of services for their patients. Their comprehensive website gave detailed information about all the services they provided. This also included links to additional information about health conditions and other services that patients could access outside the practice. The website also had a translation section where information could be translated into any of 90 languages for patients. Further information leaflets about health, care and community services were available for patients in the practice reception and waiting areas.

It was practice policy to offer a health check with a nurse to all new patients registering with the practice. The practice told us that the health care assistant (HCA) was trained to

Good

Are services effective?

(for example, treatment is effective)

carry out the health checks on patients and this included new patients, patients who were 40-70 years of age and also some patients with long term conditions. The NHS health check programme was designed to identify patients at risk of developing diseases including heart and kidney disease, stroke and diabetes over the next 10 years. GPs and clinical staff showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and described how they scheduled further investigations. GPs told us they would also use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by promoting the benefits of childhood immunisations with parents or by carrying out opportunistic medicine reviews.

Staff told us they aimed to provide good chronic disease management, with patient education as the key to improvements in patient health. They told us that giving patients adequate guidance and education helped them to manage their own health. For example, the lead GP told us the practice was in touch with the national bowel cancer screening programme team to educate patients on the new bowel scope service being offered as screening to their patients.

The practice had numerous ways of identifying patients who needed additional support and it was pro-active in offering help. For example, the practice kept a register of all patients with a learning disability and ensured that longer appointments were available for them when required. Annual health reviews were also carried out and these had been completed for all 59 patients with a learning disability registered with the practice.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. Clinical staff described the policy and procedure in place for following up patients who failed to attend by either the named practice nurse or the GP. The practice offered flu vaccinations to patients over the age of 65 and to patients with chronic diseases such as asthma, diabetes, heart disease, and kidney disease. For example, last year's performance for patients over 65 who had received the flu vaccine at 75% was higher than the national average of 73%.

Up to date care plans were in place that were shared with other providers such as the out-of-hours and multi-disciplinary case management teams. Patients aged 75 years or over and patients with long term conditions were provided with a named GP.

Last year's performance for cervical smear uptake was 80%, which was slightly lower than the national average of 82%. The practice had a policy to contact patients who had not attended for cervical smears and the practice carried out annual audits for patients who failed to attend.

We saw that a range of health promotion leaflets were available in the reception area, waiting room, treatment rooms and on the practice's website. Clinical staff we spoke with confirmed that health promotion information was available for all patients. They told us that they discussed health issues such as weight loss and lifestyle with patients when they carried out routine checks with patients. Staff told us that patients could also take part in the local health programme Lifestyle services. This was a service developed through Birmingham City Council to support vulnerable or disadvantaged people who wanted to improve their lifestyles by for example, by losing weight or to stop smoking. An easy read booklet was available in the practice waiting area that gave patients information about who was eligible and how they could apply for access to this service.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We gathered patients' views by looking at 46 Care Quality Commission (CQC) comment cards patients had filled in. On the day of the inspection we spoke with four patients, three of whom were members of the Firstcare Practice patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

We looked at data available from the NHS England GP patient survey results for 2014 to 2015. This data showed that the practice scored below the national average for most areas of caring for patients. For example, data showed that 87% of patients had confidence and trust in the last GP they saw or spoke to, which was lower than the national average of 91%; 81% reported that the last GP they saw or spoke with was good at listening to them, which was below the national average of 87%; and 72% of patients said the last GP they saw or spoke to was good at giving them enough time which was lower than the national average of 85%.

We found however, that information written by patients in the comment cards gave a positive picture of patients' experiences. Patients used phrases such as the GPs had been really supportive and compassionate about their care; staff had always been very helpful, caring and considerate; and reception staff were extremely caring and treated patients with utmost respect.

Patients we spoke with explained staff were helpful, caring and that there were always staff who listened to them at the practice. One patient told us that their partner did not speak English as their first language and was delighted an interpreter was always present to ensure clear communication for them.

A patient whose children had physical disabilities explained how the practice had not kept them waiting and they were seen straight away which was helpful to them. Another patient described an acute problem one of their children had experienced and how efficiently the child was dealt with. The practice was described as culturally sensitive. Staff spoken with explained the GPs were supportive, approachable and caring.

We spoke with the practice manager about the survey results and they told us they had been actively looking at ways to make improvements to the practice in order to improve patients' experiences. The practice had analysed the data and put an action plan in place to address areas for improvement. For example, we were shown information that confirmed additional appointments had been made available for patients. The lead GP told us this had meant that GPs were able to give more time for patients. The practice had worked with the patient participation group (PPG) to improve survey results to ensure that patients were satisfied with the service they received, that they were given enough time during their appointments and that they were treated with care and concern.

Chaperone posters were seen in the consultation rooms and waiting areas naming the chaperones in order to ensure dignity and respect for patients.

Care planning and involvement in decisions about care and treatment

We looked at the NHS England GP patient survey results for 2014 to 2015. This showed that most patients surveyed had not responded positively to questions about their involvement in planning and making decisions about their care and treatment; 78% said the last GP they saw or spoke to was good at explaining tests and treatments which was lower than the national average of 86%; and 71% said the last GP they saw or spoke to was good at involving them in decisions about their care compared with the national average of 81%.

Patients we spoke with however told us that they were involved in decisions about their care and treatment. They explained the doctors were very informative and explained things to them. Patients who were diagnosed with diabetes were referred to a structured education programme to discuss their worries and provide them with information and help about their condition. Patient feedback on comment cards we received was also positive. Some patients specifically commented that GPs explained things to them and kept them informed.

The lead GP told us the practice had worked with the patient participation group (PPG) in order to make changes and improve on the survey results. The lead GP also told us that while they recognised the survey results had reflected the views of 13% of the total number of patients registered with the practice, they had taken the results seriously and had made arrangements with the PPG to carry out a patient survey at the practice to continually review their improvement progress.

Good

Are services caring?

Staff and patients told us that interpreting services were available for patients who did not speak English as their first language. The administration team also helped to translate when required. British Sign Language interpreters were also available via an agency. There was a hearing loop in reception for patients with hearing impairments. The practice information leaflets were also available in different languages. We saw for example, that the influenza vaccination leaflets were available in Urdu.

Patient/carer support to cope emotionally with care and treatment

Patients who completed comment cards told us that health issues were discussed with them and 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. Patients commented that all clinical staff at the practice were particularly good when treating them and took the time to make sure they fully understood their treatment options.

We saw evidence of care plans and patient involvement in agreeing these. For example, each patient with a learning disability was given a longer appointment so that they could be given time to discuss their individual care plans. Other patients who were diagnosed with asthma also had individual care plans. Staff demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Staff told us that patients were always encouraged to be involved in the decision making process. They told us that they always spoke with the patient and obtained their agreement for any treatment or intervention even if a patient had attended with a carer or relative.

Notices in the patient waiting room also directed people to a number of local and national carers' organisations. The practice had leaflets regarding bereavement services in the waiting areas. Staff we spoke with in the practice recognised the importance of being sensitive to patient's wishes.

The practice had devised a condolence letter which was very sensitive, detailed and comprehensive. The practice also followed up on this with a phone call to the families. All the carers were recorded on a register and were coded on the practice's computer system so that this was kept under consideration during consultations.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients that this service was available. Some staff who worked at the practice were multi-lingual and were often able to help patients with understanding and translation.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The practice understood their population and showed us the systems in place to deliver the service that patients required. Staff told us the practice population consisted of a higher number of younger patients. For example, national patient data showed that the number of patients in the over 65 years of age population group registered with the practice was 6% compared with the national average of 17%. The population group of patients over 75 years of age registered with the practice was 3.3% compared with the national average of 8%. Patients under the age of 18 however were 23% compared with 15% national average.

The practice provided a range of services for families, children and young people population. This included a weekly health visiting service which coincided with the immunisations clinics held at the practice. Family planning services were also available so that patients could access these close to where they lived. Confidential services including contraception were advertised for young people to encourage them discuss concerns or requirements in confidence.

The NHS area team and Clinical Commissioning Group (CCG) told us that the practice regularly engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised. GPs told us they attended these quarterly meetings and shared information with practice staff where actions had been agreed to implement service improvements and manage delivery challenges to its population.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The purpose of the PPG is to discuss the services offered and discuss how improvements could be made to benefit the practice and its patients. For example, the PPG report for 2014 and 2015 identified that improvements were needed in accessing appointments for patients. As a result of this feedback, investigations had been carried out and determined that there was a fault in the telephone system at the practice. This was being addressed in conjunction with the telephone line provider and we saw evidence that confirmed this.

Tackling inequity and promoting equality

The practice was proactive in removing any barriers that some patients may face in accessing or using the service. For example, the practice had one female GP who was able to support patients who preferred to see a female GP. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

There were arrangements in place to ensure that care and treatment was provided to patients with regard to their disability. The practice building was purpose built and had easy access for wheelchair users. There was provision for patients with a hearing impairment at the practice. We saw signs within the waiting area to indicate a hearing loop was available; there was a screen which provided visual prompts for patients to be aware that they were being called for their appointment and staff told us that longer appointments would be made for patients with a hearing impairment.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. Parking bays were available for patients with limited mobility to be able to park close to the entrance of the practice.

The practice had recognised the needs of different groups in the planning of its services such as carers and vulnerable patients who were at risk of harm. The computer system used by the practice alerted GPs if patients had a learning disability, or if a patient was also a carer so that additional appointment time could be made available. Where patients were also identified as carers we saw that information was provided to ensure they understood the support that was available when needed. Staff told us that translation services were available for patients who did not have English as a first language. This service could be arranged to take place either by telephone or in person. There was a translation service also available on the practice website and many staff at the practice spoke a variety of languages and could translate for patients if they preferred this.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice was signed up to the learning disability direct enhanced service (DES) to provide annual health checks for their patients with a learning disability. The service is intended to reduce the incidence of the presence of one or more additional disorders and premature deaths for people with learning disabilities. The DES is designed to encourage practices to identify patients aged 14 and over with the most complex needs and offer them an annual health check as well as a health action plan. As part of this service, the practice maintained a register of patients with learning disabilities. For the 2014 and 2015 year there were 59 patients on the register and an annual health check had been completed with all of them.

The practice had an equality and diversity policy in place and records showed that training had been completed by all staff through an e-learning programme. Clinical staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included details on how to arrange urgent appointments and home visits. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. There was an answerphone message which gave the telephone number patients should ring depending on their circumstances. Information about the out-of-hours service was provided to patients in leaflets, through information displayed in the waiting room and on the practice website.

The practice was open from 8am to 6.30pm Mondays to Thursdays, from 8am to 8pm on Fridays and from 8am to 1pm on Saturdays. Home visits were available for patients who were too ill to attend the practice for appointments. There was also an online service which allowed patients to order repeat prescriptions, book and cancel appointments and view parts of their medical record.

Patients confirmed on the comment cards that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Patients commented that they had always usually been able to make appointments when they were in urgent need of treatment on the same day of contacting the practice, although there had been comments made about the difficulty getting through to the practice on the telephone.

This feedback differed with the results from the national GP patient survey for 2014 and 2015, which showed the practice was generally rated below average for its satisfaction scores for appointments. For example, 73% of patients were satisfied with appointment times, which was slightly lower than the national average of 76%; 30% of patients described their experience of making an appointment as good compared with the national average of 74%; and only 37% of patients would recommend this practice to someone new to the area which compared with national average of 78%.

The survey results had reflected the views of 13% of the total number of patients registered with the practice, however we saw that the practice had taken action in response to these results. An action plan was in place which recorded action taken to address the areas identified for improvement. The main issue about access had been identified as a faulty telephone system. The provider told us that the improvements needed could involve major work to the telephone connection at the practice such as the installation of a new cable. We saw documentation that showed the ongoing investigations between the practice and the telephone line provider to address the problems experienced with telephone access. The practice had taken action to improve access as much as possible while the telephone line problems were being addressed. For example, they promoted the on-line booking of appointments facility with the support of their PPG to improve patient access to services.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their 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 found that there was an open and transparent approach towards complaints. Accessible information was provided to help patients understand the complaints system on the practice's website and in a complaints leaflet made available at the practice. We saw a copy of the complaints form available for patients to use should they wish to make a formal complaint. The form also included a copy of the procedure and explained to the patient what

Good

Are services responsive to people's needs?

(for example, to feedback?)

they could expect once their complaint was submitted to the practice. There was also a third party consent form for completion in the event a person made a complaint on a patient's behalf.

Patients recorded on comment cards that they were aware of the process to follow should they wish to make a complaint. From the comment cards and the patients we spoke with none of the patients had ever needed to make a complaint about the practice. Staff told us that they were aware of what action they would take if a patient complained. Staff confirmed that complaints were discussed at monthly clinical meetings and they were made aware of any outcomes and action plans were put in place to address any changes needed. We saw minutes that confirmed these discussions had taken place.

We saw that the practice had recorded all complaints, including verbal and written complaints. Annual reviews of complaints had been carried out to identify themes or trends. We looked at the review for the period April 2014 to end of March 2015. This showed the practice had received 12 complaints during this period with responses to and outcomes of complaints clearly recorded.

We saw evidence that showed lessons learned from individual complaints had been acted on and included for example, further training needs where they had been identified. Overall learning from the annual review of complaints was shared with all staff to ensure that learning continued to be shared and reviewed in an open and responsive way.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had undergone significant changes in the past three years when the two main partners took over the practice. In the time since the takeover they had worked to establish systems and procedures to move the practice forward and make improvements to the services provided for patients.

The practice sent us a copy of their statement of purpose prior to the inspection of the service. This told us that the aims of the practice was to provide high quality services available to all irrespective of gender, race, disability, sexual orientation, religion or belief.

The vision of the practice was aligned to the clinical commissioning group (CCG) strategy. The practice had a clear vision to deliver high quality care in a safe environment. It was evident in discussions with staff during the day that this vision was shared throughout the practice.

Governance arrangements

We saw evidence of clinical audits carried out by the practice for example, prescribing audits and consent audits. The practice had a number of policies and procedures to govern activity including confidentiality and chaperone policies, all of which were available to all staff electronically. We looked at a sample of the policies and procedures and found they were up to date.

The practice had meetings to share information, to look at what was working well and where improvements needed to be made. We saw minutes of these meetings and noted that complaints, significant events and Medicines and Healthcare products Regulatory Agency (MHRA) alerts were discussed. Staff we spoke with confirmed that complaints and significant events were discussed with them.

The practice had systems in place for identifying, recording and managing risks. We looked at examples of significant events and actions taken as a consequence. Staff were able to describe how changes had been made to the practice as a result of significant events. There were designated GP lead roles although the lead GP also managed the practice which gave them an overview of the practice as a whole.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is a national performance measurement tool. The QOF data for this practice showed that in all relevant services it was performing above or in line with national standards. We saw that QOF data was regularly discussed at weekly meetings and action taken to maintain or improve outcomes.

Leadership, openness and transparency

Although the lead GP managed the practice, including all policies, procedures, referrals, audits, strategy and training, staff told us they were still open to ideas from the team. All staff were clear about their own roles and responsibilities. They told us they felt valued and well supported and by the practice and the lead GP.

There was a very caring approach towards all staff working at the practice. Staff told us they spent time together outside practice hours to help them build their relationships as a team. Staff gave examples of when they had been in difficult situations in their personal lives and the lead GP had been very understanding. We talked with the lead GP who agreed with us that they could delegate more and that they would benefit from a manager and another GP partner on site to help protect their future health and promote safer business contingency planning. All staff we spoke with told us that the practice was a friendly and supportive workplace and there was an open door policy. Staff were enthusiastic and told us they enjoyed working at the practice. We saw examples of staff working together as a team throughout the inspection. The lead GP was open and approachable.

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

The practice had a well-established patient participation group (PPG) which met quarterly. PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. During the inspection we met with three members of the PPG. They gave a positive picture of the practice and gave us plenty of examples from their own experiences of ways the practice had worked to provide patients with good quality care.

The PPG had made a recommendation to the practice to put up noticeboards with more information for patients. This had been implemented by the practice. The PPG had made another recommendation about the phone lines and the length of time taken to get through to the practice. They established that there had been a problem with the telephone system and the cables. There were plans in

Are services well-led?

Good

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

place to change the telephone system within the next quarter. The PPG members stated that the lead GP always attended the meetings and was very helpful and listened to them. They all felt well supported and part of the team.

Staff and patients we spoke with on the day told us they felt supported and that the team were approachable. Staff said they felt they could raise any concerns they had and felt valued. Staff we spoke with told us that they regularly attended staff meetings.

Management lead through learning and improvement

Firstcare Medical Practice had been approved as a training practice for GP trainees but was not yet active. A GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice. Only approved training practices can employ GP trainees and the practice must have at least one approved GP trainer. The lead GP told us that they would be in a position to offer GP training once they had more staff employed at the practice.

We saw that staff appraisals took place annually and staff confirmed the practice was very supportive of training and development opportunities. Procedures were in place to record incidents, accidents and significant events and to identify risks to patient and staff safety. The results were discussed at clinical and practice meetings and if necessary changes were made.