Northbrook Group Practice

Quality Report

93 Northbrook Road
Solihull
West Midlands
B90 3LX
Tel: 0121 746 5000
Website: www.northbrook.gpsurgery.net

Date of inspection visit: 28 April 2015
Date of publication: 17/12/2015

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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Good ●

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 Northbrook Group Practice on 28 April 2015. Overall the practice is rated as outstanding.

Specifically, we found the practice to be outstanding for providing effective and responsive services and good for providing safe, caring and well led services. It was also outstanding for providing services for people with long term conditions and those experiencing poor mental health and good for providing services for families, children and young people, working age people, older people and people in vulnerable groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- 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 worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet people's needs.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

- 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 practice had robust systems for the safe management of controlled medicines which included recording of safe receipt and disposal.
- 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 had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice :

- The practice had conducted an education event regarding diabetes for members of the practice population. This included a consultant diabetologist as a guest speaker and representation from other specialists linked to diabetes such as a dietician, ophthalmology, podiatry and representatives from Diabetes UK. Approximately 200 people attended this event and feedback received was positive. Following this event, the practice reviewed and reorganised their diabetic clinics to further improve services provided.
- The practice had a health trainer to support weight management, alcohol reduction and smoking cessation and could demonstrate this had a positive impact for patients using this service.
- Letters were sent in large format to those patients who had recorded sight problems.
- Opportunistic screening was undertaken for dementia during flu clinics and during routine screening of patients assessed with a long term condition.

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 widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There was enough staff to keep patients safe.

Are services effective?

Outstanding 

The practice is rated as outstanding for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the Clinical Commissioning Group. The practice used innovative and proactive methods to improve patient outcomes.

Are services caring?

Good 

The practice is rated as good for providing caring services. Data showed that 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 to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Outstanding 

The practice is rated as outstanding for providing responsive services. Services were planned and delivered to take into account the needs of different patient groups. For example, extended hours services were provided Wednesday and Friday morning and Monday evening and regular cardio vascular disease clinics were held on Saturday mornings to enable the working age population to attend. This enabled the practice to achieve the highest attendance uptake in the clinical commissioning group (CCG) area. Home visits were undertaken to housebound patients including phlebotomy, anti-coagulation and vaccinations. One stop clinics were provided to housebound patients to encourage uptake for health monitoring services.

Summary of findings

In response to the needs of the practice population, the practice referred patients to health trainers who provided diet and lifestyle advice, in-house smoking cessation, anti-coagulation and phlebotomy services were also provided.

The practice engaged with the NHS England Area Team and CCG to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had excellent 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 that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients and it had a very active patient participation group (PPG).

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia care. The practice was responsive to the needs of older people and offered a dedicated telephone line, home visits and rapid access appointments for those with enhanced needs. Home visits were undertaken by GPs, practice nurses and health care assistants. Patients aged over 75 years have a named GP. The named GP was responsible for working with relevant associated health and social care professionals to deliver a multi-disciplinary care package that met the needs of the patient.

Structured annual medicine reviews were conducted for patients in the older age group to ensure that patients are receiving the correct medicine to meet their current needs.

Following any hospital discharge, patients' care plans were updated to reflect any additional needs.

People with long term conditions

Outstanding

The practice is rated as outstanding for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Those patients who were housebound received home visits; anti-coagulation, phlebotomy, vaccination and bespoke one stop clinics were provided to these patients as required.

The practice's care co-ordinator or a GP would provide advice to patients on the unplanned admissions register, signed care plans were in place for these patients. Multi-disciplinary team meetings were held with health visitors, district nurses, Marie Curie nurses and virtual ward matrons, these meetings helped to deliver a multidisciplinary package of care to those patients with the most complex needs. Practice staff reviewed all hospital admissions and accident and emergency department (A&E) attendances and these were discussed in practice meetings with the aim of reducing hospital admissions.

Summary of findings

The practice has set up a dual respiratory clinic to allow patients to have a one stop service including a review of medication, cognitive testing, spirometry and providing patients with a written management plan.

In-house services for patients with diabetes was available, this included a clinic run by the senior nurse covering all aspects of diabetic care including blood monitoring. A diabetes health promotion event took place in a local hotel. Topics covered included evidence based education from experienced clinicians. The practice received excellent feedback following the event and plans to undertake similar events regarding other long term conditions.

The practice was a high achiever regarding the quality and outcomes framework (QOF) and was above the clinical commissioning group (CCG) averages.

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 who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.

Immunisation rates were high for all standard childhood immunisations. Practice nurses also provided school leavers boosters and meningitis C, mumps measles and rubella vaccinations to university students. Appointments were available outside of school hours and the premises were suitable for children and babies. Priority access was given to unwell children with same day appointments being available. We saw good examples of joint working with midwives, health visitors and school nurses.

The practice is a sexual health in practice (SHIP) trained practice. All relevant staff regularly attended training days. Sexual health clinics were provided for contraception and sexual health and a dual coil and implant fitting and removal clinic had been implemented as a response to patient need. Chlamydia and gonorrhoea screening was available for 16-24 year old patients registered at the practice. The practice had a Gillick competence tool kit for teenagers.

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 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

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a full range of health promotion and screening that reflected the needs for this age group. Extended opening hours were provided one evening per week and the practice opened early on two mornings per week. Appointments were available with GPs, nurse practitioners and health care assistants during extended opening.

NHS health checks were offered in early mornings, evenings and on some weekends. The practice had the highest rate of uptake for NHS health checks (40 – 74 year olds) locally.

Students were able to register as temporary patients.

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 asylum seekers and those with a learning disability. The community learning disability coordinator had visited the surgery and validated the practice's list of patients with a learning disability. Annual health checks for people with a learning disability had been completed and 100% of these patients had received a follow-up. These health checks could be undertaken by a GP or nurse during a home visit if required. Longer appointments were offered for people with a learning disability.

The practice were regularly invited to attend learning disability groups to publicise its services to these at risk groups. This helped to ensure that people were not excluded from receiving primary care.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. 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 and out of normal working hours.

Systems were in place for checking and follow up of vulnerable patients to ensure they to attended any agreed referrals

People experiencing poor mental health (including people with dementia)

Outstanding

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). Eighty five percent of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Care plans were in place for those patients with a

Summary of findings

progressive illness such as dementia. Information regarding end of life care including place of death and do not attempt resuscitation was recorded and those patients who were able had signed the care plan.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. Improving access to psychological therapies (IAPT) counsellors worked at the practice each week and patients could be referred to this service. Admiral nurses work with patients with dementia (Admiral Nurses are specialist dementia nurses who give practical and emotional support to family carers, as well as the person with dementia).

Systems were in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Systems were also in place for identifying and following up patients with diagnosed mental health conditions who do not attend appointments. Staff had received training on how to care for people with mental health needs and dementia. Patients with severe and enduring mental illness were offered access to a named GP. Regular review appointments were given and GPs booked any follow up appointments.

The practice was a high achiever regarding the quality and outcomes framework (QOF) and was above the clinical commissioning group (CCG) average.

Summary of findings

What people who use the service say

As part of the inspection we sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received 25 completed comment cards and on the day of our inspection we spoke with four patients. We also spoke with three members of the patient participation group (PPG). All of the comments recorded were positive, we were told that staff were professional, helpful and caring. Patients we spoke with on the day of inspection said that staff were efficient, friendly and the nurse and GP were both excellent. We were told that patients had trust in the GPs and where quickly referred for further investigations or treatments when needed.

We looked at results of the national GP patient survey carried out in 2014. Findings of the survey were based on comparison to the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. In one area the practice performed below the CCG average:

- 63% of respondents who described their experience of making an appointment as good (CCG average 68%, national average73%)

In all other areas the practice performed better than CCG averages. This included:

- 91% of respondents said the last GP they saw or spoke to was good at giving them enough time (CCG average 87%, national average 87%)
- 90% of respondents said that the last GP they saw or spoke to was good at involving them in decisions about their care (CCG average 79%, national average 81%)
- 96% of respondents said the last nurse they saw or spoke to was good at giving them enough time (CCG average 92%, national average 92%)
- 92% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern (CCG average 91%, national average 90%)

These results were based on 120 surveys that were returned from a total of 294 sent out, with a response rate of 41%.

Outstanding practice

- The practice had conducted an education event regarding diabetes for members of the practice population. This included a consultant diabetologist as a guest speaker and representation from other specialists linked to diabetes such as ophthalmology and podiatry. Approximately 200 people attended this event and feedback received was positive. Following this event, the practice reviewed and reorganised their diabetic clinics to further improve services provided.
- The practice had a health trainer to support weight management, alcohol reduction and smoking cessation and could demonstrate this had a positive impact for patients using this service.
- Letters were sent in large format to those patients who had recorded sight problems.
- Opportunistic screening was undertaken for dementia during flu clinics and during routine screening of patients assessed with a long term condition.

Northbrook Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a CQC GP Regional Advisor and a practice nurse specialist advisor.

Background to Northbrook Group Practice

Northbrook Group practice is registered for primary medical services with the Care Quality Commission (CQC). It is a group practice comprising of one male GP partner and one female GP partner, as well as two female and one male salaried GPs. The practice is part of the NHS Solihull Clinical Commissioning Group (CCG) and provides primary medical services to approximately 10,700 patients in the local community under a general medical services contract. The population covered is predominantly white British.

Additional staff include a finance manager, business manager, practice manager, two secretaries, a senior lead nurse, a senior nurse prescriber, two practice nurses and two health care assistants. There are nine reception staff, a prescription clerk, an office manager and a QOF manager who also support the practice.

The practice offers a range of clinics and services including smoking cessation, minor surgery, joint injections, diabetic, sexual health, anticoagulation, respiratory, midwifery, audiology and improving access to psychological therapies (IAPT) clinics and health trainers .

The practice opening times are

Monday 8.30am to 7.10pm (extended opening hours)

Tuesday 8.30am to 6.30pm

Wednesday 7.10am to 6.30pm (extended opening hours)

Thursday 8.30am to 6.30pm

Friday 7.10am to 6.30pm (extended opening hours)

Northbrook Group Practice is a training practice for GP registrars and a teaching practice for medical students from Imperial College London who spend part of their training at the practice. (A GP registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice.)

The practice has opted out of providing out-of-hours services to their own patients. This service is provided by an external out of hours service contracted by the CCG.

Why we carried out this inspection

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

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

Detailed findings

How we carried out this inspection

Before inspecting we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We reviewed 25 comment cards where patients and members of the public shared their views and experiences of the service. We carried out an announced inspection on 28 April 2015. During our inspection we spoke with a range of staff including GPs, nurse, senior nurse prescriber, practice manager and administrative staff and we spoke with patients who used the service. We also spent some time observing how staff interacted with patients. We spoke with three members of the Patient Participation Group (PPG) during the inspection, who told us their experience not only as a member of the PPG but also as a patient of the service. The PPG is a way in which patients and the practice can work together to improve the service.

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 are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- 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 patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Minutes of clinical staff meetings seen demonstrated that significant events were discussed as and when they occurred.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Patients spoken with did not report any safety concerns to us and we were not aware of any major safety incidents that had occurred at the practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We tracked seven incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. Although significant events and complaints were not a standing item on the practice meeting agenda, we saw records to confirm that they were discussed as and when they occurred. We saw that analysis of significant events and complaints took place. There was evidence that the practice had learned from these and shared their findings with relevant staff. Monitoring took place to identify any trends. Staff we spoke with knew how to raise an issue for consideration at meetings. Staff felt that the practice was open and honest and committed to learn from any incidents or complaints so that they could improve outcomes for patients.

Staff used incident forms and sent completed forms to the practice manager who was the lead person for checking safety alerts and for incident reporting. Where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by email to practice staff. These were discussed at clinical staff meetings or full practice meetings dependent upon the subject of the safety alert and the relevance to staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. The practice had a system in place for picking up alerts from the clinical commissioning group (CCG) regarding drug users and missing persons. Alerts were discussed at practice meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. The practice had recently purchased an on-line training package which included training regarding safeguarding vulnerable adults and children. All staff were able to complete refresher training using this system.

The practice had appointed a GP as the safeguarding vulnerable adults and children lead. This GP attended regular safeguarding workshops and meetings. All staff we spoke with were aware who this lead was and who to speak with in the practice if they had a safeguarding concern. All staff we spoke with 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, document safeguarding concerns and how to contact the relevant agencies both in and out of normal working hours. Contact details for the police, social services and the local safeguarding authorities were recorded in the practice's safeguarding policy which was easily accessible to all staff on the computer desktop. We saw that the policy had been regularly reviewed and updated.

GPs attended safeguarding meetings with health visitors and members of the practice team including pharmacy to discuss any vulnerable patients registered at the practice. Meetings were held on a quarterly basis or sooner if required. We saw evidence that a review of systems, policies and procedures had taken place regarding domestic abuse as a result of an incident involving a patient registered at the practice.

There was also 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 with protection plans, children at risk and children, young people and families living in disadvantaged circumstances. Those patients who are deemed vulnerable or at high risk of admission are reviewed by the GP post discharge.

Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. The practice had a 'did not bring' (attend) policy regarding children and young people with a high number of did not attend (DNA) appointments. The practice reviewed DNAs to identify whether patients had poor access to primary care. A DNA audit had been completed for patients aged under 16. All DNAs for patients aged under 16 were brought to the GPs attention, who then worked with other health and social care professionals to ensure care needs were met.

Robust systems were in place for checking to see if vulnerable patients had attended any agreed referrals and for following up those who had not attended.

The GP discussed a recent event which had been reported to the police and safeguarding. We were told that practice staff had been updated with information and an alert sent to neighbouring GP practices.

There was a chaperone policy. Notices advising patients of the availability of chaperones were on display in the waiting room and in consulting rooms. (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). All staff could be called upon to act as a chaperone. However, we were told that nursing staff would be the first point of call. All staff had completed on-line training regarding acting as a chaperone. The senior nurse had developed an interactive training session and had also trained all staff. Administrative staff understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. We were told that where chaperones were used details of who was present during the examination was recorded on patient notes. All staff at the practice (apart from one staff member who worked a few hours per week) had or were in the process of having a check of their criminal record with the disclosure and barring service (DBS). All staff at this practice who acted as a chaperone had a DBS check undertaken.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely in lockable fridges 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. Practice staff followed the policy. We saw that data loggers were used to check the temperature of medicine fridges including at the weekends when the practice was closed. This information could be downloaded onto a computer. We were shown the cool bags and ice packs which were used to store vaccines when the fridge was defrosting or when transferring vaccines to be used off site, for example when completing flu vaccinations in a local care home. This helped to ensure the cold chain was maintained.

Processes were in place to check medicines were within their expiry date and suitable for use including medicines kept in GPs bags for use in an emergency whilst off the premises. The senior practice nurse was responsible for ensuring that medicines were available as required. We saw that spreadsheets were kept which recorded all medicine kept in GPs bags and that to be used in an emergency. The expiry date of these medicines was recorded and the senior nurse told us that it was her responsibility to ensure that all medicine was available as required. We saw evidence that when medicine had reached its expiry date it was replaced. We were shown the protocol for ordering, storing and handling of vaccines. The senior nurse discussed the system for stock rotation and we saw records which included expiry dates for vaccines. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Practice meetings were held on a fortnightly basis to review prescribing data and discuss changes required. The pharmacy support attached to the practice reviewed this information regularly. We were shown clinical audits which demonstrated quality improvements about reducing wasteful repeat prescribing. The practice were under budget on prescribing.

The practice had a system in place for the management of high risk medicines which included regular monitoring in line with national guidance. For example disease modifying anti-rheumatic drugs (DMARDS) are audited on a quarterly

basis and monthly audits of patients prescribed anticoagulation. We saw that appropriate restrictions were in place to ensure that patients received a regular review by their GP before repeat medicine prescriptions were issued.

We discussed systems in place regarding repeat prescribing. The practice's protocol for repeat prescribing followed national guidelines. There was a prescription lead in post who managed the process for authorising and review of repeat prescriptions. Staff who generated prescriptions were trained to do so. GPs reviewed and reauthorised repeat prescriptions as appropriate or undertook a review of the patient to ensure that they were receiving appropriate medicine to meet their needs.

Patients with a long term condition received a review of their medicine at the time of their annual health review. Interim reviews would also be completed by GPs before patients were issued with repeat prescriptions. The practice had undertaken medicine reviews for over 70% of the practice population with a long term condition. Medicine reviews were also undertaken within 72 hours of discharge from hospital. Initial telephone contact was made with patients following discharge from hospital, discussions regarding any changes to medicine would be held. The named doctor would be given the information and follow up would be completed including amending care plans as required. Each patient aged over 75 years of age, if applicable, had a medicine review completed every three to six months and 100% of medicine reviews for this group had been completed.

We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to under a patient group direction PGD. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). This included a PGD regarding human papilloma virus vaccinations. This vaccination was offered to all teenage girls via the school nurse at their place of education, but would be given at the practice if requested.

The practice had identified a need for an expanded pharmacy advisor to work at the practice and had put in a successful bid to the Clinical Commissioning Group (CCG) for funding to fill this post. The pharmacy advisor would oversee the repeat prescribing process. Reviews of prescriptions ensuring patients received the correct prescription at the right dose and also help to ensure patients adhered to their medication requirements. The aim of this was to make prescribing savings at the practice without compromising patient outcomes.

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. Reception staff logged all prescriptions so that they were aware when prescriptions had been sent to the pharmacy. The practice completed a prescription security audit on an annual basis.

We reviewed the systems in place for management of controlled medicine (Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines or controlled drugs. For example morphine). Robust systems were in place including recording details of the medicine, quantity issued, the serial number of any prescription, patient details including information regarding any person who the patient authorised to collect their prescription. Any returned medicines were documented as returned and destroyed and records were signed by two staff members. Controlled medicine information was recorded on the GP admission and data management system on the computer.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy and patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. An external company was contracted to clean the practice. Staff had developed a communication book to pass on information to the cleaning company, for example comments/concerns or additional ad-hoc cleaning tasks to be undertaken. Cleaning schedules were available for all areas of the practice including separate schedules for consultation and treatment rooms. Cleaning records were kept which had been signed by staff to demonstrate tasks undertaken.

The practice's cleaning schedules regarding cleaning of medical equipment identified that a risk assessment should be undertaken to determine the frequency with which equipment should be cleaned. Detailed information was recorded for staff regarding the equipment to be cleaned and the cleaning material be used. In addition to this an infection control policy was available which

recorded up to date evidenced based practice and detailed information for staff regarding staff responsibilities, training and competencies and action to take to maintain infection prevention and control standards. Infection control measures in place included use of personal protective equipment (PPE) such as disposable gloves, aprons and coverings, use of spill kits and clearly labelled sharps bins.

Spill kits were used to treat spills of blood or bodily fluids such as vomit or urine, to reduce the potential for spread of infection. Staff spoken with were aware where spill kits were located within the practice and when they should be used. This would help to ensure that any potentially infectious substances were attended to by staff in a timely and effective manner.

We found that suitable arrangements were in place for the storage and the disposal of clinical waste and sharps. The healthcare waste management policy described the management arrangements for ensuring that all waste was managed in accordance with legal requirements. A contract was in place to ensure the safe disposable of sharps and other clinical waste. Sharps boxes were dated and signed with the date of use to enable staff to monitor how long they had been in place. Diabetic patients were able to bring their full sharps boxes to the practice for disposal by the approved contractor. Clinical waste was securely stored.

The practice had a lead for infection control who had undertaken training to enable them to provide advice on the practice infection control policy. All staff had received infection control training specific to their role and practice nurses and health care assistants had completed an infection control update within the last year. A protected learning time event had taken place where the clinical commissioning group (CCG) infection control lead had provided education on hand hygiene to clinical staff at the practice. 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. Notices advising patients about the availability of hand gel were on display in the waiting room and reception area.

We saw evidence that the lead had carried out infection prevention and control audits and we looked at the audits for 2013 and 2014. We saw that any improvements identified for action were recorded and action taken. The audit for 2014 demonstrated a 100% compliance rate. Minutes of practice meetings showed that the findings of the audits were discussed.

The practice had a policy for the management, testing and investigation of legionella (legionella is a term for particular bacteria which can contaminate water systems in buildings). We saw records which confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

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 and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

The senior nurse told us that they ordered any medical equipment needed by nurses. The practice had recently purchased a spirometer, blood pressure machines, pulse oximeters, a digital camera for use in wound management and monofilament (used for checking lower limb sensation in diabetic patients).

Systems were in place to check firefighting equipment which included a weekly check of the fire alarm and routine checks of fire extinguishers.

Staffing and recruitment

We discussed staffing and recruitment with the practice manager and we were told about the systems in place to ensure that appropriate recruitment procedures were followed. An external company provided documentation, advice and guidance about staff recruitment and employment issues. For example the company produced contracts of employment, policies and procedures and gave advice about disciplinary matters. The practice had recently employed an apprentice through Solihull College and were interviewing for another administrative

apprentice within the next week. Funding initiatives are available to support the apprenticeship programme providing a cost effective way of securing the future workforce of the practice.

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.

We saw that relevant checks were completed to ensure clinical staff were up to date with their professional registration, for example nurses were registered with the Nursing and Midwifery Council (NMC). The NMC was set up to protect the public by ensuring that nurses and midwives provide high standards of care to their patients and clients.

The practice occasionally used locum GPs to cover times of annual leave or unexpected sick leave. Sufficient checks had been undertaken to demonstrate that locums used were suitable to work at the practice. This included written references, DBS checks, training information and evidence that the locum was on the performers list with NHS England.

Staff told us about the arrangements for planning and monitoring the number and skill mix of staff needed to meet patients' needs. Systems were in place to ensure that an appropriate number of staff were on duty each day. This included an on-line computer system for staff to request annual leave and the implementation of a system to track and monitor phone calls. Staff logged on to the phone system when they were available to take calls. The number of calls in the queue, the length of time they had been waiting were all logged on the system. This enabled the practice to monitor demand and ensure staffing levels were adequate to meet the demand. The office manager had identified the busiest days at the practice and administrative staff would be required to assist with reception duties at these times. We were told that all administrative staff had been 'upskilled' so that they could undertake any administrative role at the practice and therefore cover annual leave and busy periods. Members of the patient participation group (PPG) had attended the practice to teach patients how to use the self-check in system to try and reduce the pressure on reception staff.

We were also told that appointment systems were flexible, for example if a GP had booked leave, patients would not be able to book in advance to see that GP and the number of 'on the day' appointment slots would be increased with other GPs at the practice.

Arrangements were in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. When staff submitted a request for leave, the practice manager and a senior member of administrative staff would meet to discuss this and annual leave would be planned whilst ensuring that the reception area had sufficient numbers of staff on duty. A diary was used to record reception staff rotas. 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.

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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy and an identified health and safety representative. We saw that all non-clinical staff had undertaken health and safety training.

Workplace risk assessments had been undertaken. This included, for example assessing the risk in clinical and non-clinical areas such as waiting rooms and corridors. A separate risk assessment had been completed for the minor surgery room. Risks were considered such as electric shock, sharps injuries, legionella and control of substances hazardous to health (COSHH). We saw that some risks had been identified and mitigating actions recorded to reduce and manage the risk.

In order to protect staff the practice does not allow lone working of staff. Out of hours access to the practice is via a video intercom and all staff workstations are fitted with panic buttons.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was

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Are services safe?

available including access to oxygen and an automated external defibrillator (AED) (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. 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. Risks were recorded along with mitigating actions to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. A copy of the business continuity plan and GP contact details were also kept off site by the practice manager. The practice manager told us that local emergencies would be discussed immediately with the clinical commissioning group (CCG). The practice had considered practical solutions in regard to an incident which occurred the day before our inspection. This included using a buddy practice to access computerised records.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and had undertaken regular fire drills. We saw that firefighting equipment had been regularly checked and maintained.

We did not identify any issues regarding safety; safe systems were in operation, risk assessments were in place and checks and monitoring undertaken to ensure patient and staff safety was priority.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that the practice had developed evidenced based protocols based on NICE guidelines. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

New guidelines, for example information from NICE, guidance published by professional and expert bodies was brought to clinical staff meetings for discussion. We saw that a medical decision making warning had been discussed at one clinical staff meeting. Staff spoken with had a clear understanding of medical decision making involving the pharmacist as necessary.

The practice held a register of patients with a long term condition which was used to identify those patients and their carers who may need extra support. Vulnerable patients, those with long term conditions and patients over 75 years old were assessed and care plans generated to enable increased monitoring and follow up of these at risk patients. The practice had achieved 100% compliance with health checks for patients with a learning disability (0.2% of the practice population aged 18 plus years of age have a learning disability). Home visits would be undertaken by either a GP or nurse to undertake these health checks. Risk profiling was used to ensure that patients had their needs assessed and care was planned and delivered proactively. Clinical risk tools were used to help doctors detect and prevent unwanted outcomes for patients. The practice used the frailty index to identify those patients who were frail and may need additional support. Multi-disciplinary team working and sharing of information was in place to ensure care needs were reviewed. Systems were in place to ensure timely follow up of patients with long term conditions after hospital discharge.

The practice had a register of patients with complex mental health needs. Records seen demonstrated that:

- 93% of these patients had care plans agreed and in place compared with a CCG average of 79.7% and a national average of 74.5%
- 90% had their alcohol intake recorded compared with a CCG average of 82.1% and a national average of 79%
- 96.9% of patients on the mental health register have a record of a blood pressure check in the preceding 12 months compared with a CCG average of 84.6% and a national average of 82.9%
- 93.8% of patients on the mental health register have a cholesterol check in the preceding 12 months compared with a CCG average of 73.2% and a national average of 68%
- 100% of patients on the mental health register have a blood glucose or HbA1c check in the preceding 12 months compared with a CCG average of 77.9% and a national average of 74.9%.

These figures were above the national averages. New patients who registered at the practice and who had a mental health illness were seen by a GP. Patients with mental health illness who did not attend the practice for an annual health check were followed up. We saw that 85% of these patients had received an annual health check. The practice had systems in place for following up a patient who may have mental health needs, after an accident and emergency (A&E) attendance. We were told that an Improving Access to Psychological Therapies (IAPT) counsellor was based at the practice on a weekly basis.

GPs told us they lead in specialist clinical areas such as palliative care and mental health. GPs visited a local care home and were supported by practice nurses. We were told that practice nurses gave flu vaccines to care home patients at appropriate times of the year. Nurses also gave advice to kitchen staff at the care homes they visited regarding diet for diabetic patients and they completed the annual diabetic checks.

The practice had started a scheme to avoid unplanned hospital admissions by providing an enhanced service. An enhanced service is a service that is provided above the standard general medical service contract (GMS). This focused on coordinated care for the most vulnerable patients and included emergency health care plans. These patient groups included vulnerable, older patients, patients needing end of life care and patients who were at risk of unplanned admission to hospital. The aim was to avoid admission to hospital by managing their health needs at

home. The practice's computerised system highlighted every occasion when a patient on the practice's unplanned admissions list had made contact with services such as hospitals or out of hours providers. This helped to ensure that monitoring took place, patients were regularly reviewed and changes made to care as necessary.

Emergency admissions for the 19 chronic conditions that could be appropriately managed in primary care settings were in line with the national average.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included QOF manager, scheduling clinical reviews, managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out service improvements.

The practice had a system in place for completing clinical audit cycles. We saw that six clinical audits had been undertaken in the last two years. All audits had completed at least two cycles. One audit seen focussed on processes and prescribing. Comprehensive sustained improvements were noted. An audit regarding asthma had taken place. A clinical management plan had been issued to 344 patients since 1 April 2014, this audit was ongoing. The actions taken to improve outcomes were recorded as well as the annual cost savings to the practice. The actions taken had contributed to high quality care offered to asthma patients. Other examples included audits to confirm that GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The practice had considered ways of reducing demand in accident and emergency (A&E). Reviews were undertaken and where patients were attending A&E frequently or inappropriately, they were sent a letter. This gave the patient information about the surgery such as opening times, types of appointments and details of the out of hours services. The letter also signposted the patient to the practice website. A copy of the NHS Choose Well leaflet was attached with the letter. This leaflet gave examples of the services available and advice regarding the service that was appropriate to certain symptoms.

Performance was being monitored and required changes to practice acted upon in a timely manner. The practice had extremely high QOF results. A QOF manager was employed who arranged appointments and followed up patients who did not attend (DNA). The practice had introduced a text reminder service. Patients were sent a text reminder 48 hours before their appointment. This had decreased the DNA rate from 320 to 237. 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 voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results were published annually. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 99.5% of the total QOF target in 2014, which was above the national average of 94.2%. Specific examples to demonstrate this included:

- 96.4% of patients on the diabetes register, had a record of a foot examination and risk classification within the preceding 12 months compared to a national average of 88.3%
- 98% of patients with physical and/or mental health conditions whose notes recorded their smoking status in the preceding 12 months compared with a national average of 95%
- 94% of women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding 5 years compared with a national average of 81%
- 93.7% of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months compared with a national average of 86%

The practice were looking beyond QOF targets and looking at specific areas of need within the CCG. The practice showed us strong evidence of ongoing quality improvement work for example dermatology and respiratory medicine.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

There was a focus on improving outcomes for patients and developing the roles of the practice nurses and healthcare assistants to support patients with long term conditions. The practice had redesigned diabetic clinics to include home visits and visits to nursing home patients. This had resulted in better QOF scores. The practice was using QOF results to plan for the following year's improvements in care. Call and recall processes were in place covering all QOF areas. Information from the CCG, QOF and medicine audits were used to improve the quality of services.

The practice sent a letter to patients who had been given a rapid access appointment. (Rapid Access provides a quick and early assessment for patients that may have suspected cancer). Patients were told to contact the surgery if they had not received an appointment within a week so that the practice could follow this up on the patient's behalf. A spreadsheet recorded the name of the patient, date of referral, speciality and the date they should have received a response. We saw that 76.9% of patients who had been given a rapid access appointment were seen within two weeks.

The practice had implemented the gold standards framework for end of life care. It had a palliative care register and had monthly meetings with link nurse representatives from Marie Curie, virtual ward and district nursing staff. District nursing staff visited the practice on a daily basis. These staff could communicate with the practice via a message book and electronic messaging. This helped to ensure that the care and support needs of patients and their families were met by a multi-disciplinary team of staff.

The practice had participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area but we were told that the practice was working on improvement plans where they were identified as an outlier. We were told that the practice met with Solihull clinical commissioning group (CCG) on a quarterly basis with 14 other practice located in Solihull. Issues discussed included prescribing trends with a view to becoming more cost effective, enhanced services and financial deficits.

The practice nurse delivered the childhood vaccination programmes. The most recent data available to us showed that the practice was mostly above the local CCG rate for childhood vaccinations. The practice was slightly above the uptake rates for cervical cytology compared with national averages. The practice nurse had systems in place to follow up patients who did not attend screening or immunisations. We saw that patients were sent letters and received telephone contact to remind them of the need to visit the practice.

The practice was regularly invited to attend learning disability groups to publicise its services to these at risk groups. This helped to ensure that people were not excluded from receiving primary care and had a greater understanding of the services available to them.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending training courses such as annual basic life support. The practice had purchased a training package which was introduced in November 2014. Records seen showed that staff had undertaken a variety of training including manual handling, infection control, safeguarding, data protection and health and safety awareness. Educational meetings were held once per month for clinical staff and local consultants were invited to these meetings to discuss relevant topics or changes in NICE guidelines. The practice was pro-active and provided training to ensure staff were able to meet the needs of the practice population. We were told that continuous professional development took place for all clinicians involved in chronic disease management. Nursing staff had also been trained to undertake some minor surgical procedures. This nurse led clinic provides an alternative choice to patients and reduces the pressure on GPs time to undertake this task.

Staff told us that they all had annual appraisals. We saw the appraisal documentation for three members of staff. Systems were in place to ensure that staff were able to discuss their jobs, performance and learning and development needs. Learning and development plans were in place for all staff and action plans documented. Staff spoken with told us that they were able to raise any issues or concerns regarding working practices during their performance appraisal.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

We were told and saw documentation to demonstrate that the senior nurse had updated nursing staff appraisal documentation to include the 6Cs (care, compassion, competence, communication, courage and commitment) used for the revalidation of nurses.

Practice nurses had job descriptions outlining their roles and responsibilities. Records seen provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of childhood immunisations and cervical cytology. All four practice nurses were trained and regularly updated in immunisation for the whole practice population and in cervical cytology. The nurse was also trained to deliver smoking cessation.

We were told that the locum GPs were used at the practice to cover any of the GPs leave. The practice had developed a locum pack which gave information to locum GPs about the systems and processes in place at the practice. This was emailed to any locum GP who was due to work at the practice in advance of their start date. This enabled the locum member of staff to have information required before attending the practice. We saw that a locum agency was used to recruit locums and the relevant pre-employment checks had been undertaken.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service 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 these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received.

There were clear lines of communication with midwives, health visitors and school nurses, including electronic messaging and attendance at multi-disciplinary meetings. We were told that district nurses had access to appropriate parts of the practice's computer system and were therefore able to follow up patients who had recently seen the GP. The practice had a good working relationship with district nurses who visited the practice daily and fed back any issues to practice staff.

The practice held multidisciplinary team meetings every eight weeks. Minutes of meetings demonstrated that discussions were held regarding life limiting conditions and those with end of life care needs. These meetings were attended by virtual ward nurses, palliative care nurses, community nurses and health visitors and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

The practice had a clear protocol for sharing relevant information with antenatal services during pregnancy.

The practice manager told us that patients were signposted to various local services as required. The practice signposted patients to voluntary groups such as" and the "breast feeding club". .

Information sharing

The practice used several electronic systems to communicate with other providers. For example,

systems were in place to ensure that summary care records and special patient notes were shared with local care providers. End of life care information was also shared with local care services. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance service. The practice attended a quarterly meeting with the clinical commissioning group (CCG). There were robust processes in place to share information. We were told about a system wide issue that had been identified about sharing information with the out of hours service. The CCG was addressing this.

Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice had signed up to the electronic Summary Care Record and this was now fully operational. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems in place to provide staff with the information they needed. The system in use enabled staff to look at information regarding hospital admission,

clinical correspondence and test results. An electronic patient record was also used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

We were told that health visitors attended the practice on a regular basis to collect information regarding newly pregnant mothers, newly registered children, details of children who do not attend (DNA) childhood immunisations or any DNA appointments regarding children. This helped to ensure that relevant information was forwarded to the appropriate people such as health visitors for follow up.

Consent to care and treatment

Clinical staff we spoke with were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. A copy of the mental capacity act was available in all clinical rooms. Policy guidelines and a guidance leaflet had been produced for all staff to read regarding the Mental Capacity Act. Training for staff was underway. Mental health awareness training was covered during protected learning time for all staff.

Staff understood the key parts of the legislation and were able to describe how they implemented it in their practice for adults who lacked capacity to make decisions. We saw evidence that an independent advocate had been arranged for a patient via social services. A notice in the waiting area advised patients about advocacy services. We were told that where capacity issues were identified appropriate codes would be placed on the patient's computer record to alert staff that capacity may be an issue.

Care plans were in place for patients with learning disabilities and those with dementia. Patients were involved in agreeing these care plans and a section was available stating the patient's preferences for treatment and decisions. These care plans were reviewed annually or when there was an event such as the death of a carer, admission to hospital or a change in health. Advanced care planning had been completed for people with dementia on an individual basis in line with the person's wishes.

Staff spoken with were aware of the relevant consent and decision making requirements of legislation and guidance including the mental capacity act and children's acts. There was a lead GP regarding mental capacity. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). We saw evidence that this was used routinely and information was documented using a computer based algorithm (An algorithm is a list of steps to follow in order to solve a problem).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent. An audit had been undertaken to demonstrate that the consent process for minor surgery was being followed.

We were told that a practice nurse had been trained to complete minor surgery. We saw that a risk assessment regarding the minor surgery room had been completed.

Health promotion and prevention

The practice provided information to patients regarding various support groups to enable the patient to maintain a good quality of life, manage existing conditions and prevent future ill health.

Health promotion information was played on the TV screen in the reception area and advice leaflets and various pieces of useful information about local health promotion services were available in the waiting rooms. The practice offered smoking cessation clinics and had recorded the smoking status of 97.5% of patients within the last 12 months compared with a CCG average of 95.7% and a national average of 94.6%. A record had also been made of smoking cessation support and treatment offered to 98.5% of patients compared with a CCG average of 94% and a national average of 93.1%. The practice had a health trainer to support weight management, alcohol reduction and the practice could demonstrate that this had a positive impact for patients using this service. The practice offered referral to exercise on prescription at a local leisure centre via the DocSpot exercise referral scheme or Living Well which provided a healthy lifestyle programme for children aged six to 15 who meet specific requirements.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The practice actively encouraged health promotion appointments, back to work via the fit note scheme and the drug and alcohol liaison services.

All nurses at the practice were sexual health trained. Sexual health clinics were provided for contraception and sexual health and a dual coil and implant fitting and removal clinic had been implemented as a response to patient need. Information on display in the waiting area signposted patients to the availability of chlamydia screening. The practice provided both chlamydia and gonorrhoea screening to 16-24 year olds.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years and had the highest attendance rate for these checks locally. These 'one stop shop' health checks were offered early mornings, evenings and on a Saturday morning. This helped to ensure that patients who were unable to attend during the week due to work commitments had the opportunity to have this health check. This screening identified patient's risk of developing cardiovascular conditions. The practice undertook other tests and screening and had checked the blood pressure of 91% of working age patients registered at the practice within the last five years.

The practice's performance for the cervical screening programme was 94.2%, which was above the national average of 81.89%. The practice had uptake rates for mammography (60.2%), abdominal aortic aneurysm (78%) and bowel cancer (47.1%) and the practice had systems in place to follow up patients who did not attend screening appointments. Practice nurses had responsibility for following up patients who did not attend. We saw evidence that patients were contacted by telephone and sent letters and alternative appointments made.

The practice offered whooping cough vaccination to pregnant females. Systems were in place to record the number of patients who had received the vaccination and for ensuring those who required this vaccination were offered it. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was in line with or above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 42.79%, and at risk groups 77.5%. These were similar to national averages.
- Childhood immunisation rates for the vaccinations given to under two's ranged from 86.1% to 99.1% and five year olds from 93.9% to 100%. These were slightly above CCG averages.

We were told that new patient consultations for children newly registered with the practice were completed by the health visitors. Health visitors notified the practice of milestone checks, for example a child's 36 week check. Practice nurses completed all childhood vaccinations which were pre-booked in advance. The advanced nurse practitioner spoken with said that the main 'did not attend' (DNA) related to childhood vaccinations. Systems were in place to contact the parents of children who DNA for these vaccinations which included phone calls and letters. The practice performs regular audits on immunisation uptake and the parents of children who are not up to date with immunisations are contacted by the practice's senior nurse. Parents are asked to sign a disclaimer if they do not wish to have their children immunised, however they are told that they are able to change their mind at any time.

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 16 to 24 years and offering smoking cessation advice to smokers. Chlamydia screening posters were on display in patient toilets. Information regarding smoking cessation and health trainer information regarding healthy lifestyle and weight management was also available.

We were told that patients with a learning disability were offered a physical health check with the nurse practitioner. We saw that blood tests and an annual health check had been completed as required.

The practice had a register of carers and had developed a carer's pack to give to these patients. The carers pack gave useful information and contact details to enable carers to receive appropriate support.

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Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey for 2014 and a survey undertaken by the practice's patient participation group (PPG). The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors. For example:

- 92% said the GP was good at listening to them compared to the CCG average of 88% and national average of 89%.
- 91% said the GP gave them enough time compared to the CCG average of 87% and national average of 87%.
- 97% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%
- 92% said the nurse was good at listening to them compared to the CCG average of 91% and national average of 91%.
- 96% said the nurse gave them enough time compared to the CCG average of 92% and national average of 92%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 25 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service, that staff were helpful, kind and caring and that the GPs always gave good advice. We also spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. Changes were planned to the partition on the reception desk in response to patient and PPG suggestions. Reception staff told us that patients could speak with practice staff in private if they wished. We observed reception staff dealing with patients in a polite, efficient and friendly manner.

We were told that all patients receive a hand written birthday card on their 100th birthday.

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 89% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 86%.
- 90% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and national average of 81%.

Both these results were above average compared to CCG results. The results from the patient participation group satisfaction survey showed that 83% of patients said that the quality of care by the GP was excellent/very good and 85% said the quality of care by the nursing team was excellent/very good.

Patients we spoke with on the day of our inspection told us that they felt involved in decision making about the care and treatment they received. They also told us they felt

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listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We were told that the staff spoke multiple languages and had knowledge of locally spoken ethnic languages.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 86% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 85%.
- 92% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff were professional, helpful and caring.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer and a carers register was in place. We were shown the written information available for carers (the carers pack) to ensure they understood the various avenues of support available to them. We were told that the practice set up a carer's station during the routine flu clinics held in 'flu season' and all carers registered at the practice were contacted and offered flu vaccinations. This helped the practice identify carers and ensured that they were offered extra support, flexibility with appointments or to ensure vaccinations were offered to carers to try to keep them healthy.

Staff told us that if families had suffered a bereavement they were would be offered an appointment with the GP and would be given advice on how to find a support service such as CRUSE or Solihull Bereavement Counselling Service. CRUSE is a bereavement charity that provides support following the death of someone close.

Outstanding ☆

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 needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example letters were sent in large font to those patients who had recorded sight problems. In response to patient feedback the patient calling system was adapted to include both audio and large print visual prompts.

Longer appointments were available for people who needed them. For example, the practice's computer system alerted staff of patients with learning disabilities or complex mental health needs so that double appointments could be offered. Blood tests were undertaken at the practice. This helped patients with mental health problems who may not wish to travel or wait in hospital to have a blood test. In response to the increasing number of over 65 year old patients registered, the practice had developed an in-house and domiciliary phlebotomy service. The practice also provided domiciliary vaccination and anti-coagulation checks. Housebound patients received their annual long term disease review at home and the practice had implemented a robust call, re-call system to ensure no patient was missed.

We were told that practice nurse appointments had changed from 10 to 15 minutes. A review had been undertaken and telephone triage had been stopped. This had saved 70 hours of nursing time which could be focussed on patient care to help ensure that patients received appointments when needed. Triage is the process of determining the priority of patients' treatments based on the severity of their condition when there are insufficient resources to treat everyone immediately. Home visits were also undertaken by the GP or practice nurse and patients were able to make appointments with a named GP or nurse.

Antenatal care was provided at the practice each week by midwives. Patients booked appointments direct with the midwife. Information was recorded on the practice computer system and patients had a named midwife. Post natal checks were co-ordinated with immunisation appointments which benefited new mothers. There were also patients registered at the practice with palliative care needs.

The practice held a palliative care register and alerts on the computer system identified that these patients may require additional support. The practice manager reported a good relationship with health visitors and district nurses and multidisciplinary meetings were held every eight weeks to discuss patient and their families care and support needs. The practice had an alert system to highlight patients on their palliative care register so as to ensure they were offered same day access to the GP and / or nurse when they rang for an appointment. The practice staff told us improving patient access and communication with other agencies ensured continuity of care for patients and reduced hospital admissions.

Systems were in place to assess and manage the care of patients with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD). A new dual respiratory clinic had been set up to allow patients to have a one stop service encompassing spirometry, Medical Research Council (MRC) scale for breathlessness, cognitive ability tests (CAT), review of medication and providing patients with a written management plan to facilitate improved outcomes for patients. In-house smoking cessation and diabetic services were also provided. The practice nurse attended meetings of the clinical commissioning group (CCG) steering group to agree priorities regarding diabetes. The practice nurse had undertaken additional training regarding GLP-1 (a therapy for diabetes which increases insulin production and reduces production of the hormone with elevates blood glucose). Senior GP partners at the practice had undertaken additional training in diabetes.

The practice had organised a diabetes event on a Saturday morning at a local hotel. The event was attended by approximately 200 members of the public. A presentation was given by a consultant diabetologist and a podiatrist. A dietician and an ophthalmologist were available to answer questions and give information. Various gifts were given to attendees. Forty seven percent of people who completed an evaluation of the event reported that it exceeded their expectations and 42.8% said that it met their expectations. Comments were made that people had a better understanding of their condition and how it affected their

body. Due to the positive feedback received the practice were considering providing similar events regarding dementia and chronic obstructive pulmonary disease (COPD).

Following the diabetes event, the practice reorganised their diabetic clinics which were changed to incorporate all vascular long term conditions including Chronic heart disease (CHD), stroke, hypertension, chronic kidney disease (CKD), peripheral vascular disease, atrial fibrillation (AF) as well as diabetes in a one stop holistic service. All patients attending the clinic are screened using the 6 cognitive impairment test (6-CIT) dementia toolkit. This one stop approach, allows 30 minute appointments for all patients. Those with health issues that could not be addressed by the practice nurse were referred to the GP.

We were told that opportunistic screening was undertaken for dementia during flu clinics and during routine screening of those patients assessed with a long-term condition. Patients could also book an appointment with a GP for dementia screening. We saw that the percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was slightly higher than national averages. Admiral nurses work with patients with dementia (Admiral Nurses are specialist dementia nurses who give practical and emotional support to family carers, as well as the person with dementia).

Multi-disciplinary home visits were undertaken to patients who were unable to attend the practice. The practice was in the process of organising a social group to enable patients without families suffering from social isolation to meet with like-minded patients on a regular basis.

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). For example 52% of patients rated the practice as excellent/very good for the ability to get through to the practice on the telephone. To increase satisfaction levels the practice have introduced new telephone activity monitoring software which gave information regarding how many phone lines were in use, how many people were on hold and for how long. The practice were also promoting on-line access to services.

The practice was regularly invited to attend learning disability groups to publicise its services to these at risk groups. This helped to ensure that people were not excluded from receiving primary care.

Tackling inequity and promoting equality

The practice had a clear understanding of their practice population and had tailored resources and planned services accordingly. For example, longer appointment times were available for patients with learning disabilities or other patients as required. Home visits were conducted to patients who were unable to attend the practice and extended morning and evening opening hours were provided.

Staff told us that they did not have any patients who were of "no fixed abode". We were told that that if necessary the practice would register them as a temporary patient so they could access services and ensure that any urgent needs would be met. The practice had a population of 96.7% English speaking patients though it could cater for other different languages through translation services and staff who were multilingual with knowledge or locally spoken ethnic languages.

The practice nurse had conducted a disability discrimination act assessment of the premises and no issues for action were identified. Northbrook Group Practice was a single storey building with ramped access to enable those with mobility difficulties easy access to the practice. Non-slip flooring was provided throughout the building and accessible toilet facilities were available for all patients attending the practice. An audio and visual call system was in place to alert those with either hearing or sight difficulties of their appointment. 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.

We were told that the practice provided the free message in a bottle service. This service enabled important information including emergency contacts, the doctor's surgery details, allergy information, medicine details and pet information to be available in the event of an accident or emergency.

Access to the service

The practice opening times were 8am to 6.30pm on Tuesday and Thursday, 7am to 6.30pm on Wednesday and

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Friday and 8am to 7.30pm on Monday. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were able to book appointments in person at the practice, over the telephone or on-line. Approximately one quarter of patients had registered to receive on-line services.

One third of available appointments were able to be booked on the day with the remaining appointments available to be booked in advance or for urgent or on-line appointments. We were told that the availability of urgent and on the day appointments was reviewed regularly and was subject to change dependent upon the number of clinicians available. Staff we spoke with felt that this system worked well. There had been a change from using a system of triage to enable patients to get an appointment to open access. The practice had monitored this change to ensure it benefited staff and patients. The practice were flexible with their appointments to meet demand and had ensured that sufficient resources were available where they had identified increased usage of the service. A hearing loop and microphone were in place at the reception desk which helped patients with a hearing impairment communicate with reception staff.

We were told about the systems in place to assist those patients who worked during normal office hours to access the service. This included extended opening hours on a Monday evening and two mornings per week, use of on-line booking and text message reminder for appointments and test results.

Home visits were made to patients who required this service each day when the practice was open. GPs and practice nurses also visited a local care home on a specific day each week.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 75% were satisfied with the practice's opening hours compared to the CCG average of 71% and national average of 75%.
- 60% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 61% and national average of 65%.
- 83% said they were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 83% and national average of 85%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. There was a designated responsible person who handled all complaints in the practice. Reception staff spoken with were aware who was responsible for handling complaints and were aware where complaint leaflets were located.

We saw a poster on display in the waiting area telling patients to speak with the practice manager if they had any concerns or complaints. The practice website and leaflet guided patients to contact the practice manager to discuss complaints. Patients were informed that the practice had a complaints policy which was in line with NHS requirements. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

Complaints were discussed at practice meetings as and when they were received, they were not a standard agenda item. The practice had received 11 complaints within the last 12 months. The practice reviewed complaints annually to detect themes or trends.

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 a clear vision to deliver high quality care and promote good outcomes for patients. Staff spoken with felt that the health and wellbeing of patients was at the heart of everything that they did. Staff were involved in activities to monitor and improve patient outcomes and were very focussed on improving quality of life for patients. GPs told us that the practice had an ethos of teamwork with the aim of offering the highest standards of care for patients. We were told that ensuring staff morale was high, investment in staff training, listening to any concerns and involving staff all helped to ensure that high quality services were provided. The practice had an open culture and promoted patient and staff involvement. There was a strong focus on quality moving beyond Quality and Outcomes Framework (QOF) requirements. (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). Patients we spoke with and nationally reported data on patient satisfaction confirmed that patients were satisfied with the quality of the service provided.

GPs discussed the future changes planned for the practice and all staff and PPG members were aware of these planned changes. The practice had considered future workforce needs and had recently employed an apprentice through Solihull College and were interviewing for another administrative apprentice.

We saw that a copy of the practice charter was on display in the waiting room. This document recorded the responsibilities of the GP such as to treat patients with respect and courtesy and the responsibilities of the patient, for example to attend appointments. Patient's rights and responsibilities were also recorded on the practice website.

We spoke with seven members of staff who demonstrated an understanding of their areas of responsibility and took an active role in ensuring that a high level of service was provided. Staff we spoke with gave examples of how they promoted person centred care and a good quality service that was accessible to all patients. Staff said that they were proud to work for the practice and confirmed that they were kept up to date with all changes that took place. GPs told us that they were not afraid to change and felt that they were experts in change management.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We were shown a spreadsheet which contained links to policies and procedures. This enabled staff to easily access this information. All of the policies and procedures we looked at had been reviewed annually and were up to date. The practice manager was responsible for human resource policies and procedures. We reviewed a number of these policies, for example staff recruitment and whistleblowing which were in place to support staff. Staff spoken with were aware of the location of policies and confirmed that they were easily accessible. We saw that staff had undertaken training regarding bullying and harassment in line with policy requirements.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and named GPs were the lead for safeguarding, mental capacity and palliative care. Staff we spoke with were clear about their roles and responsibilities and said that they would speak to staff with the lead roles if they needed any help or advice.

The practice used the QOF to measure its performance. The practice had achieved 99.5% of QOF targets and exception reporting was low at 3.5% overall. We saw that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and any action plans had been produced and implemented regarding areas that needed addressing. For example risk assessments were in place for newly expectant mothers. Infection control audits demonstrated 100% compliance with standards; systems in place helped to ensure that staff maintained high standards of infection prevention and control.

The practice had completed the information governance toolkit and obtained a satisfactory rating which was the

Are services well-led?

Good

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

highest rating achievable. (The IG Toolkit is an online system which would enable the GP practice to assess themselves against Department of Health Information Governance policies and standards).

Leadership, openness and transparency

GPs were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The practice had a culture of striving for continuous improvement and staff said that this was embedded in all systems and processes. All staff were involved in discussions about how to run and develop the practice. Staff were encouraged to identify opportunities to improve the service delivered. Appraisal records seen record that staff were encouraged to 'bring their ideas to the table' in order to produce best outcomes for patients.

We saw from minutes that full practice team meetings were held quarterly. Management and clinical staff meetings were also held every two weeks separate to the practice meetings. Minutes of all meetings were available on the computer desktop so that they were easily accessible to all staff.

We found there was a low staff turnover. Staff spoken with said that they enjoyed their work and felt proud of their achievements. Staff confirmed that there was a strong teamwork ethos and a supportive culture within the practice. They said they felt respected, valued and supported. We were told about the events that took place provided by the GP partners as a thank you to staff. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. The practice had an active PPG which met every three months. We were told that a GP attended meetings and practice staff provided support to the group, writing minutes and agendas. PPG members we spoke with told us that the practice were open and honest during meetings and listened and acted upon suggestions made. The PPG had completed satisfaction surveys and the results of these surveys were available on the practice website. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The PPG members mainly comprised of patients aged 65 and above; and the group was aware that some population groups were underrepresented. The practice had a PPG recruitment drive which was led by the PPG chair. We were told that patients where advised of the PPG and slips were handed out to patients inviting them to join. The TV screen within the reception area was used to promote the PPG and encourage new members. The practice website was used to inform patients about the PPG. We were told that the PPG chair had spent some time trying to recruit from a cross section of society, but found that younger males and females had work commitments and childcare commitments and were therefore unable to dedicate their time to the group.

Members of the patient participation group (PPG) had attended the practice to teach patients how to use the self-check in system to try and reduce the pressure on reception staff.

We saw evidence that the practice had reviewed its results from the friends and family test (FFT) and the national GP patient survey undertaken in 2014 to see if there were any areas that needed addressing. We saw that action had been taken to address issues raised. For example the practice had identified the need to improve communication between the practice team and between patients and the practice. Actions taken to address these issues included using the clinical system to send electronic messages to staff. This helped to ensure part time staff were aware of changes and developments. A new staff structure was introduced which included team members being made responsible for cascading information. Two newsletters had been developed which contained up to date information and highlighted seasonal and topical campaigns. Evidence seen demonstrated that the practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. We were told that the practice manager and GP had an 'open door' policy meaning that staff could speak with them at any time. Staff told us they would not hesitate to give feedback and

Are services well-led?

Good

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

discuss any concerns or issues with colleagues and management. Staff said that they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff on the computer desktop. Staff said that they had not had cause to use this policy but would do if necessary. Whistleblowing is when staff report suspected wrong doing at work referred to as 'making a disclosure in the public interest'.

Management lead through learning and improvement

We spoke with the practice facilitator for Solihull CCG during our inspection. We were told that the practice had a good level of interaction with the CCG and attended protected learning time events regularly. The practice was thought to be very innovative, thorough and passionate about care. We were told that GPs were passionate, driven, shared information and provided training to ensure that the practice was able to meet the changing demands of general practice.

Northbrook Group Practice is a teaching and training practice and GP registrars and medical students spend part of their training at the practice. (A GP registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice. They will usually have spent at least two years working in a hospital).

The practice had completed reviews of significant events and other incidents and shared these with staff via meetings to ensure the practice improved outcomes for patients. We saw evidence to show learning from significant events, alerts and complaints received. There was an annual review of significant events or complaints to identify any themes or trends.