

Greenfield Medical Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Greenfield Medical Practice on 18 May 2017. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events. There was evidence of learning for incidents to improve the service delivered.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- The practice actively participated in improvement activity to deliver improved outcomes for patients.
- Results from the national GP patient survey were lower than CCG and national averages. This was in contrast to feedback received through CCG comment cards and

patient participation group members who highlighted many positive changes to the service since the provider had taken over and told us that they were treated with compassion, dignity and respect.

- The practice had taken action to improve access which included additional telephone lines and reception staff, the employment of a female doctor and pharmacist independent prescriber. There had also been improvements for supporting patients with long term conditions and refurbishment of the premises had led to improved disabled access. Urgent appointments were available the same day.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- The practice had good facilities and was well equipped to treat patients and meet their needs. There had been recent refurbishment to the premises.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

Summary of findings

- There was a strong focus on continuous learning and improvement. For example, the practice had been involved in a pilot that had improved outcomes for patients with diabetes.

We saw one area of outstanding practice:

- The practice had made significant improvements in clinical performance and to the outcomes of patients with diabetes. The practice had a high prevalence of diabetes at 13% of the practice population (5% higher than the CCG and 6% higher than the national average) and a difficult population in terms of diabetes management. The practice had made significant improvements through the use of clinical audits and had participated in a pilot scheme for the integration of diabetes care across primary and secondary care. As the part of the pilot the HbA1c (a

measure of diabetes control) was collected pre and post intervention and improvements made by the practice resulted in all patients being successfully discharged from secondary care.

The areas where the provider should make improvement are:

- Ensure equipment cleaning schedules are kept up to date to ensure cleaning has been completed.
- Continue to review and take action to improve the uptake of national cancer screening programmes for breast and bowel cancer.
- Consider and implement ways in which carers could be supported.

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?

The practice is rated as good for providing safe services.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients we saw that patient were informed as soon as practicable, received an explanation and apology.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Good



Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- There had been significant improvements in outcomes for patients with diabetes. The practice had high prevalence of diabetes and a population seen as hard to reach in terms of diabetes management. This included close working with secondary care and use of audits to monitor improvements against best practice guidance.

Good



Are services caring?

The practice is rated as good for providing caring services.

- Data from the national GP patient survey and the providers own in-house survey carried out during 2016/17 showed patients rated the practice lower than others for several aspects of care.

Good



Summary of findings

However, in contrast the feedback received from patients from the CQC comment cards and from members of the PPG were positive about the care provided and that they were treated with compassion, dignity and respect.

- Following the inspection the practice commissioned a second patient satisfaction survey in July 2017 this showed significant improvements in patient satisfaction with the service and higher than average results for all questions compared to other participating practices.
- We also saw that the provider had made significant improvements to the practice for example, in improving outcomes for patients with long term conditions. Not all changes made by the provider had been popular such as the challenging of
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice had identified carers but found the population group did not always want support. However the provider recognised this was an area they could improve on.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. The practice actively participated in the Aspiring for Clinical Excellence programme with the CCG and was working to improve the management of long term conditions within the community. In particular diabetes management which was highly prevalent within the practice population.
- Since taking over the practice access to appointments had been addressed for example two additional telephone lines and additional reception staff on duty, appointment of a female GP and more recently a pharmacist independent prescriber. Disabled access and facilities had also been improved as part of the refurbishment of the premises. However, at the time of the inspection these changes had yet to demonstrate impact on patient satisfaction scores in relation to access. National patient survey data and the practices in-house patient survey data showed lower scores for access than other practices nationally and locally.
- Following the inspection the practice commissioned a second patient satisfaction survey in July 2017 this showed significant improvements in patient satisfaction with the service. Questions relating to access had higher than average results compared to other participating practices.

Good



Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from the three examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour and we reviewed we saw evidence the practice complied with these requirements.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels. The practice had participated in a pilot scheme which had successfully led to improved outcomes for patients with diabetes.

Good



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

The practice is rated as good for the care of older people.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and same day appointments for those with enhanced needs. Patients were also available to request longer appointments if needed.
- The practice identified older patients who may need palliative care as they were approaching the end of life. The practice worked with other health professionals to support the needs of this group of patients.
- The practice followed up on older patients discharged from hospital and ensured that their care needs were being met.
- Patients over the age of 75 years were offered a health check. The uptake of the over 75 years health check was 83%.
- Patients over 65 years were offered flu and pneumococcal. The practice uptake was 81% for flu vaccine which was the fourth highest in the CCG and 64% for the pneumococcal Vaccine.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

- Nationally reported patient outcome (QOF) data showed the practice performed well for the management of long term conditions. There was a system to recall patients for a structured annual reviews to check their health and medicines needs were being met. For those patients with the most complex needs, the practice worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care needs were updated.
- The practice was among the lowest in the CCG for emergency admissions for long term conditions.
- The practice had a high prevalence of diabetes (13% of the population, 5% higher than the CCG and 6% higher than the national average. Nationally reported outcome data for

Good



Summary of findings

patients with diabetes was comparable to the CCG and national average overall (88% compared with the CCG average of 91% and national average of 90%). The practice also had lower exception reporting for diabetes indicators at 8% compared to the CCG average of 11% and national average of 12%).

- The practice had worked as part of a pilot scheme to manage patients with diabetes working collaboratively with a secondary Care Diabetes Specialist Consultant and Diabetes Specialist Nurse. The practice had successfully improved outcomes for these patients and all were now being managed in the primary care setting.
- The practice ran group education sessions for patients with diabetes.
- Work had been undertaken to improve the accuracy of the diabetes register which had increased from 177 in 2012/13 to 253 in 2016/17.
- Clinical audits demonstrated significant improvement in the use of medicines used in diabetes against national guidance.
- The practice provided in-house spirometry and ambulatory blood pressure monitoring (ABPM) for the convenience of patients.
- Uptake of flu vaccinations for patients at risk was higher than the CCG average.

Families, children and young people

The practice is rated as good for the care of families, children and young people.

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, a weekly ante-natal clinic ran was held at the practice.
- Urgent appointments are available for young children who are seen on the same day and outside of school hours.
- The practice provided baby changing facilities and a private room for breast feeding. A notice was displayed advising patients of a breast feeding friendly service.

Good



Summary of findings

Working age people (including those recently retired and students)

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

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours on two evenings each week (Tuesdays and Thursdays).
- The principal GP would see patients before their first appointment at 8am and carry out home visits at weekends if needed. Members of the patient participation group were aware of this.
- The practice made use of texting to remind patients of their appointments and to get feedback on the service.
- The practice was proactive in offering online services as well as a range of health promotion and screening that reflects the needs for this age group. However, despite efforts there was a low uptake of national cancer screening programme, in particular breast and bowel cancer. These had been identified as one of the priority areas for the practice.
- Data available from the practice showed 92 out of 145 patients invited for a NHS health check in the last 12 months had received one.

Good



People whose circumstances may make them vulnerable

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 such as those with a learning disability.
- Patients with a learning disability were given a learning disability passport which contained important information about them and their likes and dislikes which they took with them as they moved between different services.
- Patients with a learning disability were invited for annual health checks using a nationally recognised tool. Of the 39 patients on the learning disability register 33 patients (87%) have received a health check and had care plans in place.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice worked with the palliative care team to support patients at end of life.
- The practice offered longer appointments for patients who needed them.

Good



Summary of findings

- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice had a significant proportion of patients whose first language was not English. Translation services were available, many of the staff were multilingual and one member of the clinical team could speak Pashto which was spoken by approximately 30-40% of the practice population.

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- Nationally available data for 2016/16 showed 85% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the CCG and national average of 84%. Exception reporting was higher than CCG and national averages at 19% but this related to only three patients.
- National reported data for 2015/16 showed 97% of patients with poor mental health had a comprehensive, agreed care plan documented, in the preceding 12 months which was comparable to the CCG average 88% and national average 89%. There was no exception reporting.
- The practice had highlighted mental health as an area they wished to improve on. Practice staff advised us that they needed to challenge attitudes towards mental health within the community and encourage patients to seek help where needed. They were working with other practices in the local commissioning network to try and bring in support from the Mental Health Trust to improve mental health provision in primary care.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The practice displayed information available for patients experiencing poor mental health about how they could access support.
- Same day and longer appointments were available for patients with poor mental health or dementia as needed.

Good



Summary of findings

- The practice worked in collaboration with the local Mental Health Team/Community Psychiatric Nurse (CPN) to support patients.

Summary of findings

What people who use the service say

The latest national GP patient survey results were published in July 2016. The results showed the practice was performing below local and national averages in terms of patient satisfaction. A total of 355 survey forms were distributed and 52 (15%) were returned. This represented 1.9% of the practice's patient list.

- 59% of patients described the overall experience of this GP practice as good compared with the CCG average of 83% and the national average of 85%.
- 42% of patients described their experience of making an appointment as good compared with the CCG average of 66% and the national average of 73%.
- 50% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 76% and the national average of 80%.

The provider had carried out its own patients survey during 2016/17 using an independent company which compared results against over 4,000 other practices. Results from this survey showed:

- 67% of patients rated overall satisfaction as good or above compared to the national average of 73%.
- 76% of patients said they would recommend the service compared to the national average of 81%.

Following the inspection the practice repeated this survey using the same independent company as before. Results for this survey undertaken in July 2017 showed significant improvement across all 28 questions asked. For example:

- 86% of patients rated overall satisfaction as good or above compared to the national average of 73%.
- 85% of patients said they would recommend the service compared to the national average of 82%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 10 comment cards which were all positive about the standard of care received. Two patients gave specific examples about the compassionate care given to vulnerable relatives. Staff were described as polite, friendly and helpful. The only negative comments were about getting appointments with the female doctor and nurse.

We spoke also spoke with five members of the practice's patient participation group during the inspection. They were very positive about the changes that had been made since the new GP had taken over and how they were challenging cultural barriers in relation to care and treatment. For example, in relation to mental health.

Greenfield Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of CQC Lead Inspector and a GP specialist adviser.

Background to Greenfield Medical Practice

Greenfield Medical Practice is part of the NHS Birmingham Cross City Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

Greenfield Medical Practice is located in a converted house adapted to provide primary health services. Clinical services are provided on the ground floor of the premises which have recently been refurbished. There is no dedicated parking facilities although parking along the street is permitted during surgery opening hours.

The practice registered list size is approximately 2800 patients.

Services to patients are provided under a General Medical Services (GMS) contract with NHS England. A GMS contract ensures practices provide essential services for people who are sick as well as, for example, chronic disease management and end of life care and is a nationally agreed contract. The practice also provides some enhanced services such as childhood vaccinations.

Based on data available from Public Health England, the practice is located within the 10% most deprived areas nationally. The population served is predominantly of Asian origin with Pashto being the main language spoken

among approximately 30% to 40% of the practice population. The practice population is younger than the national average for example, 35% of the practice population is under 18 years compared to the CCG average of 24% and national average of 21%. While 4% of the practice population is over 65 years compared to the CCG average of 15% and national average of 17%.

The principal GP registered with CQC in 2014 as a new provider. Practice staff consist of the principal GP (male) a long term locum GP (female), a practice nurse (female), a pharmacist independent prescriber (female) and a health care assistant. There is a practice and business manager and a team of administrative / reception staff.

The practice is open 8am to 6.30pm daily with the exception of Wednesday afternoon when it closes at 1.30pm. Morning appointments are available between 8.30am to 11.30am Monday to Friday and afternoon appointments between 4.30pm to 6.30pm on a Monday, Thursday and Friday and between 5pm and 6.30pm on a Tuesday. Extended opening is offered on a Tuesday evening until 7pm and Thursday evening until 7.30pm. When the practice is closed patients receive primary medical services from another out-of-hours provider (BADGER) which is contacted via the NHS 111 telephone service.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal

Detailed findings

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations for example, the local clinical commissioning group (CCG) to share what they knew. We carried out an announced visit on 18 May 2017. During our visit we:

- Spoke with a range of clinical and non-clinical staff (including the principal GP, the practice nurse, the health care assistant, the practice manager and administrative/reception staff).
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Observed how people were being cared for.
- Spoke with five members of the practice's Patient Participation Group (PPG).
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

- Reviewed documentation made available to us for the running of the practice.

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

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

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

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

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

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. An incident book was held in reception and staff were encouraged to complete this for incidents and verbal complaints.
- The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). In one documented example we saw a patient had been informed and had received an apology following a referral delay. Checks were put in place in order to minimise the risk of this happening again.
- There were three significant events reported in the last 12 months. We saw from the incident reports that the practice carried out a thorough analysis of the significant events and acted on them.
- We reviewed incident reports, patient safety alerts and minutes of meetings where significant events were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. Staff were spoke with were able to recall incidents that had been discussed in order to share learning at practice meetings.
- Learning from incidents was also shared with other practices through the local commissioning networks.

The practice had effective systems in place for the management of safety alerts received such as those from the Medicines and Healthcare Products Regulatory Agency (MHRA). Comprehensive records were maintained of actions taken in response to the alerts. For example, we saw searches and action taken in response to medicines alerts for sodium valproate, spironolactone and mirabegron.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. Staff had access to contact details for relevant agencies responsible for investigating safeguarding concerns. Information was also available relating to female genital mutilation (FGM). There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. Staff were able to provide examples of safeguarding concerns they which had been referred to relevant agencies. GPs were trained to child protection or child safeguarding level three. The practice nurse and pharmacist independent prescriber were trained to safeguarding level 2. Alerts on the patient record system ensured staff were aware if a patient was vulnerable.
- Notices were displayed throughout the practice advising patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- Since the provider had taken over the practice there had been significant renovation to the clinical areas. This had included new flooring, sinks and furniture such as treatment couches. However we noticed in one consulting room damp showing through the walls. We alerted the principal GP to this who shortly following the inspection sent evidence that the guttering had been repaired.
- We observed the clinical areas to be visibly clean and tidy. There were cleaning schedules in place for the premises. Clinical equipment looked clean and was stored in containers keeping them free from dust. Staff had access to a personal protective equipment and wipes for cleaning equipment. There were cleaning schedules in place for clinical equipment but these did not appear to have been completed regularly.

Are services safe?

- There were infection control policies and procedures in place and staff had received training in infection control. Annual infection control audits were undertaken by the CCG. We saw evidence of action taken in response to these audits and the practice had made significant improvements. For example the infection control audit undertaken in September 2015 scored 79% and received a red rating. The audit undertaken in July 16 received a score of 91%.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

We reviewed two personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. The practice had outsourced the human resources function to an independent organisation.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment. We saw fire equipment had been regularly serviced and weekly alarm testing undertaken. There was a fire evacuation plan displayed.

- Electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order. We saw that testing had been completed within the last 12 months.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. During 2016 the practice had looked at demand for appointments and how this had been accommodated. There was a rota system to ensure enough staff were on duty to meet the needs of patients. Staff we spoke with felt there were sufficient staff to deliver the service. They told us that they would support each other during absences and only one member of the administrative team could be on leave at any one time. The practice told us that they tried to use the same locums. The practice was also working with other practices in setting up a federation in which the GPs supported each other when needed.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in the consultation and treatment rooms which alerted staff to any emergency. The exception being the health care assistants room who used the internal telephone.
- All staff received annual basic life support training and there were emergency medicines available.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were also available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- Routine checks were carried out on the emergency medicines and equipment to ensure it was ready for use when needed.

Are services safe?

The practice had a business continuity plan for major incidents such as power failure or building damage. There were reciprocal arrangements with another local practice

should the premises become inaccessible. The plan included emergency contact numbers for services. Staff numbers were not included in the plan but the practice manager told us he held these separately offsite if needed.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. Clinical staff were able to provide examples of NICE guidance they used in the management of patients for example in relation to diabetes and asthma.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.
- The practice made use of templates for the management of long term conditions and worked closely with a diabetic consultant and diabetes nurse specialist in the management of diabetes.
- Guidance from the resuscitation council was displayed in clinical rooms.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were for 2015/16. This showed the practice had achieved 96% of the total number of points available, which was comparable to the CCG and national average of 95%. Overall exception reporting by the practice was 6% compared to the CCG and national average of 6%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Since taking over the practice the provider had significantly improved QOF performance from 59% in 2012/13 to 98% 2016/17.

This practice was not an outlier for any QOF targets. Data from 2015/16 showed:

- Performance for diabetes related indicators was similar to the CCG and national averages. The practice had a high prevalence of diabetes at 13% of the practice population (5% higher than the CCG and 6% higher than the national average). The practice achieved 88% of the total QOF points data for diabetes (compared with the CCG average of 91% and national average of 90%). The practice had lower exception reporting for diabetes indicators at 8% compared to the CCG average of 11% and national average of 12%).
- Performance for mental health related indicators was also similar to CCG and national averages at 89%. The CCG average was 92% and national average 93%. The practice exception reporting for mental health indicators was lower at 4% compared to the CCG average of 10% and national average of 11%.

There was evidence of quality improvement including clinical audit. The practice was proactive in participating in CCG led improvement activity and shared with us clinical audits that had been commenced in the last two years, most of these were completed audits where the improvements made were implemented and monitored. These included:

- A CCG led antibiotic audit 2015/16. This was a full cycle audit that looked at the extent to which antibiotics are prescribed in line with the Pan Birmingham Antimicrobial guidelines. Following the first audit the practice made changes such as reviewing all patients on prophylactic antibiotics and ensuring clinical staff had access to prescribing guidance on their computers. At re-audit the practice demonstrated improved prescribing in line with the antibiotic guidelines from 14% in 2014 to 47% in 2015. There had also been a 36% reduction in antibiotic prescribing.
- Practice staff told us that they had historically been a high prescribing practice for antibiotics and hypnotics. Nationally reported prescribing data for 2015/16 showed antibiotic and hypnotics prescribing was comparable to the CCG and national average and was significantly lower for broad spectrum antibiotics. CCG benchmarking data (March 2016 to February 2017) showed the practice was meeting CCG prescribing targets. Hypnotic prescribing had also gone from being significantly higher to significantly lower than local and national averages.
- Other full cycle medicines audits undertaken that looked at prescribing against NICE guidelines included a

Are services effective?

(for example, treatment is effective)

Clopidogrel (medicine used to minimise the risk for blood clots) and new oral hyperglycaemic drugs (medicines used in diabetes). Both showed improvement on re-audit. All patients prescribed clopidogrel medicine were managed according to NICE guidance. Those on new oral hyperglycaemic showed improvement in all areas reviewed. For example in one indicator the number of clinical reviews of people on new oral hyperglycaemic medicine that had a clinical review in the last 12 months had increased from 40% to 100% on re-audit.

- The practice had participated in a CCG led audit for the management of atrial fibrillation against NICE guidance. This showed improvement in the management of patients between the first audit in September 2016 and the follow up audit in January 2017 with all standards reviewed being met.
- The practice was also currently participating in CCG led audits for reviewing repeat prescribing and medicines waste and the management of asthma patients against evidence based guidance. These had yet to undergo re-audit but we saw evidence that the practice had identified and discussed the initial findings and where they could improve.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. We spoke with newer members of staff who confirmed they received an induction when they first started and were given a welcome pack and training.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions we saw evidence of training in areas such as diabetes and asthma. Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence.
- The learning needs of staff were identified through a system of appraisals and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. We saw evidence of regular supervision and teaching undertaken by the principal

GP with the pharmacist independent prescriber and practice nurse. We also saw evidence that GPs had undergone revalidation. This is the process by which GPs demonstrate their fitness to practice.

- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- To maintain their skills and update their knowledge, the principal GP worked one session each week at another practice. They were also an active member of Local Commissioning Network (LCN) and participated in CCG led improvement programmes. LCNs provide an opportunity for sharing best practice and peer support.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- We saw the practice was up to date with managing and acting on patient information received by the practice such as hospital letters and test results.
- We found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services. Following a recent incident we saw a systems had been put in place for monitoring referrals sent for the two week wait.
- The principal GP routinely reviewed patients the care and treatment of patients who had unplanned admissions to hospital (including accident and emergency). Those who were frequent attenders were given a mobile phone number to call so that they could speak to a GP and support the patient. The practice told us that this was having a positive effect on accident and emergency attendances. CCG benchmarking data showed that the practice had one of the lowest emergency admissions to hospital for long term conditions within the CCG.
- The practice worked collaboratively with the diabetes specialist nurse and consultant from secondary care to effectively manage patients within the primary care setting.

Consent to care and treatment

Are services effective?

(for example, treatment is effective)

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and guidelines for capacity to consent in children and young people.
- Written consent was obtained for patients attending for joint injections.
- Mental Health Act Guidance was displayed in the clinical rooms.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example: patients receiving end of life care, those at risk of developing a long-term condition and those requiring lifestyle advice such as smoking cessation.

The practice's uptake for the cervical screening programme (2015/16) was 72%, which was lower than the CCG average of 79% and the national average of 81%. The practice explained that there was some cultural reticence to have cervical screening. However, the latest data available from the practice (2016/17) showed a slight increase in the number of patients attending at 78%. We saw that patients eligible for cervical screening were actively contacted on a number of occasions to try and encourage attendance. The practice had recently introduced a system to follow up the receipt of test results following an incident where a patient had called for results but none had been received.

The uptake of national screening programmes for bowel and breast cancer screening was lower than the CCG and national averages. For example,

- 57% of females aged 50-70 years of age had been screened for breast cancer in the last 36 months compared to the CCG average of 69% and the national average of 73%.
- 20% of patients aged 60-69 years, had been screened for bowel cancer in the last 30 months compared to the CCG average of 50% and the national average of 58%.

The principal GP advised us that National cancer screening programmes was an area they wanted to improve on. We saw that the uptake of national screening programmes had been discussed at practice meetings and administrative staff allocated lead roles for targeting eligible patients. The practice had been proactive in working with the local cancer screening service to identify patients who did not attend breast screening and reserve appointments for specific patients at mobile screening units when in the local area. We saw posters displayed in the waiting area promoting breast screening.

Data available for 2015/16 on childhood immunisation rates for vaccinations given to under two year olds were above the national standards of 90%. Childhood immunisation rates for the MMR vaccinations given at 5 years were also above the CCG and national averages. For example: uptake of dose 1 MMR was 100% compared to the CCG average of 95% and national average of 94%. Uptake of dose 2 MMR was 92% compared to the CCG average of 83% and national average of 88%.

The uptake of flu vaccinations (2016/17) in patients over 65 years at the practice was 81%. CCG benchmarking data showed the practice as the fourth highest performing practice in the CCG.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40-74. Data available from the practice showed 92 out of 145 patients invited for a health check in the last 12 months had received one. The practice had also carried out health checks in patients over 75 with 56 out of 67 (83%) of eligible patients taking up the offer and for patients with a learning disability. Of the 47 patients on the practice's learning disability register 46 had received a health check (using a nationally recognised tool). Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard. Consulting room doors were locked by keypad preventing unauthorised access during consultations.
- The reception desk was situated away from the waiting area and glass partition helped minimise the risk of conversations being overheard. A notice was also displayed requesting patients to stand back while other patients were being attended to.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. There was a designated room for this purpose.
- Patients could be treated by a clinician of the same sex.

All of the 10 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients described staff as polite, friendly and helpful and that they were treated with dignity and respect. Two patients gave positive examples of the compassionate care their vulnerable relatives had received from the practice.

We spoke with five members of the patient participation group (PPG). They told us they were happy with the care provided by the practice, that there had been a significant improvement in the practice since the new provider took over. They felt the principal GP was knowledgeable and knew the patients. They said they found the practice appeared cleaner and staff were more friendly. PPG members felt staff treated them with dignity and respect.

Results from the national GP patient survey were lower than CCG and national averages in response to questions about how they were treated. For example:

- 74% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 69% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 80% of patients said they had confidence and trust in the last GP they saw compared to the CCG and the national average of 92%.
- 63% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and the national average of 85%.
- 76% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 91%.
- 64% of patients said the nurse gave them enough time compared with the CCG average of 91% and the national average of 92%.
- 88% of patients said they had confidence and trust in the last nurse they saw compared with the CCG and the national average of 97%.
- 77% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 89% national average of 91%.
- 48% of patients said they found the receptionists at the practice helpful compared with the CCG average of 84% and the national average of 87%.

We discussed the results with the practice. The principal GP and practice manager spoke of their disappointment in these scores despite improvements made to the practice since taking over. This included refurbishment of the premises (including disabled access), improving access to appointments and making substantial improvements to patient outcomes for those with long term conditions. The principal GP felt that some of the scores were probably to do with the close community and that the previous GP had been able to speak directly to patients in Pashto (a language spoken widely in the local community). The principal GP had also not been afraid to challenge attitudes towards antibiotic prescribing and the allocation of sick notes which were not always popular. These were areas in which the practice had made significant improvements and were now one of the best performing in the CCG.

In order to monitor progression against actions taken to improve the practice the practice had also carried out its

Are services caring?

own survey using an independent company which enabled them to be compared against over 4000 other practices. A total of 60 patients responded. The data was starting to show some improvement in patient satisfaction.

- The practices average score for practitioners ability to listen was 75% compared to the national mean score of 82%.
- The practices average score for practitioners concern for the patient was 76% compared to the national mean score of 80%.
- The practices average score for practitioners time for visit was 64% compared to the national mean score of 79%.
- The practices average score for reception staff was 81% compared to the national mean score of 81%.

However, none of the responses received from patients rated the service in the poor category.

Following the inspection the practice repeated this survey in July 2017 using the same independent company as before. A total of 54 patients responded. Results for this survey showed significant improvements in patient satisfaction across all 28 questions asked.

- The practices average score for practitioners ability to listen was 87% compared to the national mean score of 82%.
- The practices average score for practitioners concern for the patient was 86% compared to the national mean score of 80%.
- The practices average score for practitioners time for visit was 89% compared to the national mean score of 80%.
- The practices average score for reception staff was 83% compared to the national mean score of 81%.

Care planning and involvement in decisions about care and treatment

Feedback received from the CQC comment cards and discussions with members of the PPG did not highlight any concerns in relation to patient involvement in decision making about their care and treatment. Care plans were in place for the practices most vulnerable patients who were at risk of hospital admission. These were comprehensively documented and agreed with the patient.

Results from the national GP patient survey showed lower scores than the CCG and national averages for patients who responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 75% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG and the national average of 86%.
- 72% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and the national average of 82%.
- 77% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 89% and the national average of 90%.
- 73% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 85%.

Results from the practice's own survey of 60 patients showed:

- The practices average score for practitioners explanations was 74% compared to the national mean score of 81%.

However, none of the responses did the patients rate the service in the poor category. All were rated fair or above.

A follow up survey undertaken by the practice in July 2017 of 54 patients showed significant improvement in response to this question:

- The practices average score for practitioners explanations was 88% compared to the national mean score of 81%.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. Some of the staff were multi-lingual and were able to provide support. The practice had also recently employed an independent prescriber who spoke Pashto (a language which was widely spoken in the local community).

Are services caring?

- The practice made use of an E-referral system with patients as appropriate. (this is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available within practice which 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. The practice had identified 47 patients as carers (1.7% of the practice list). Although the practice had

a carers register we found little in the way of information to direct carers to the various avenues of support available to them. Reception staff were also unaware of any specific support for this group of patients. The principal GP and practice manager told us there were difficulties in getting patients within the local community to except help. However, during the inspection they realised that they may be able to help in other ways such as greater flexibility around appointments to make access easier for them.

The principal GP gave their mobile number to patients nearing end of life and their families so that they could be contacted if support was needed in the out of hours period including weekends.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population: The practice was participating in the Aspiring to Clinical Excellence (ACE) programme led by the CCG aimed at improving services and patient outcomes as well as delivering consistency in primary care services. We saw that the practice had been reviewing the accuracy of their long term condition registers to ensure patients who needed support were being followed up and we saw evidence of improved patient outcomes.

- The practice offered extended hours on a Tuesday evening between 6.30pm and 7.30pm and on a Thursday between 6.30pm and 7pm for working patients who could not attend during normal opening hours.
- The principal GP was also flexible and would see patients before 8.30am when the appointments formally started if it was more convenient for the patient. Reception staff and patient participation group members confirmed they were aware of this arrangement.
- Patients could also obtain telephone consultation where appropriate.
- There were longer appointments available for patients who needed them for example, patients with poor mental health and learning disabilities.
- Home visits were available for patients whose clinical needs resulted in difficulty attending the practice.
- Same day appointments were available for young children, those over 65 years and those with poor mental health who required them.
- The practice made use of text messaging to remind patients of their appointment.
- Patients were able to receive travel vaccines available on the NHS. Information about travel vaccinations was available on the practice website.
- There were accessible facilities, which included a hearing loop, and interpretation services available. Many of the staff spoke second languages which were spoken in the local community enabling them to communicate with patients who did not speak much English.

- The practice had undertaken an Equality Act Access audit of the premises and had made alterations to the premises including ramp access into the premises and a bell to alert staff if assistance was required. Disabled toilet facilities had been installed.
- The practice provided baby changing facilities and a private room for breast feeding. A notice was displayed advising patients of a breast feeding friendly service.
- The practice provided various services in-house for the convenience of patients which included spirometry and ambulatory blood pressure monitoring and phlebotomy.
- A diabetes virtual clinic also operated from the practice with a consultant from secondary care and diabetes nurse specialist. A letter from the consultant seen stated how the knowledge gained by the principal GP at the practice in diabetes had enabled them to discharge more than 30 patients back to primary care for the management of their condition. Diabetes group education sessions had also been run through these clinics.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday with the exception of Wednesday afternoons when it closed at 1.30pm. Morning appointments were available between 8.30am to 11.30am Monday to Friday and afternoon appointments were available between 4.30pm to 6.30pm on Mondays, Thursdays and Fridays and between 5pm and 6.30pm on Tuesdays. Extended hours appointments were also available. In addition to pre-bookable appointments that could be booked approximately two weeks in advance, the practice offered same day and urgent walk-in appointments. When the practice was closed patients received primary medical services from another out-of-hours provider via the NHS 111 telephone service.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was in most areas lower than local and national averages.

- 66% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 74% and the national average of 76%.

Are services responsive to people's needs?

(for example, to feedback?)

- 49% of patients said they could get through easily to the practice by phone compared to the CCG average of 61% and the national average of 73%.
- 41% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 69% and the national average of 76%.
- 89% of patients said their last appointment was convenient compared with the CCG average of 91% and the national average of 92%.
- 42% of patients described their experience of making an appointment as good compared with the CCG average of 66% and the national average of 73%.
- 44% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 53% and the national average of 58%.

We saw that the next available routine appointment with a GP was within two working days of our inspection, with the pharmacist independent prescriber within one working day, with the practice nurse within three working days and for a blood test within one working day.

The practice had also carried out its own survey using an independent company who compare against over 4000 other practices.

- The practice's average score for 'opening hours satisfaction' was 61% compared to the national mean score of 71%.
- The practice's average score for 'telephone access' was 61% compared to the national mean score of 71%.
- The practice's average score for 'appointment satisfaction' was 59% compared to the national mean score of 73%.

However despite these lower than average scores, none of the responses were rated by patients as in the poor category. All were rated fair or above with 90% of patients rating the practice as good, very good or excellent overall. We spoke with staff about the patient survey results, they were baffled as to why access was an issue as since the current provider had taken over there had been increased opening and extended hours. The practice was now open daily 8am to 6.30pm, having previously been closed between 1pm and 4pm. Appointments started at 8.30am but there was flexibility to be seen before then. The provider introduced extended opening on two evening per week and introduced online appointments. The provider had taken on a long term locum and had recently recruited

and trained a pharmacist independent prescriber. The telephone lines had increased from one to three and there were now always two reception staff on duty at any one time. The practice had successfully reduced the number of accident and emergency attendances for those with long term conditions and was now ranked as having one of the lowest number of attendances within the CCG. There had also been improved outcomes for patients with long term conditions as they received regular follow up which had not been in place prior to this provider taking over. The five members of PPG we spoke with also felt that appointments were easier to access since the provider took over the practice.

Following the inspection the practice repeated this survey in July 2017 using the same independent company as before. A total of 54 patients responded. Results for this survey showed significant improvements in patient satisfaction across all 28 questions asked. For example, questions relating to access showed:

- The practice's average score for 'opening hours satisfaction' was 83% compared to the national mean score of 71%.
- The practice's average score for 'telephone access' was 85% compared to the national mean score of 71%.
- The practice's average score for 'appointment satisfaction' was 85% compared to the national mean score of 73%.
- The practice's average score for 'waiting time' was 85% compared to the national mean score of 61%.

The practice had a system to assess:

- Whether a home visit was clinically necessary - reception staff collected relevant information from the patient and passed this onto the GP.
- The urgency of the need for medical attention. Patients were advised to call 999 in the event of a medical emergency such as chest pain.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.

Are services responsive to people's needs? (for example, to feedback?)

- We saw that information was available to help patients understand the complaints system. There was a complaints leaflet for patients to take away and a poster which advised patients what to do if they wished to make a complaint. Patients could also complete and submit a complaints and comments form on-line from the practice website.

The practice had received three complaints within last 12 months. We found that these had been dealt with in a timely way. Complaints were discussed at staff meetings to share any learning. The practice also collected verbal as well as formal complaints which were documented by staff in the practice's incident book.

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.

- Practice staff advised us that they saw the vision of the practice as being one of a friendly family practice.
- The principal GP had faced many challenges since taking over the practice and had made considerable progress in addressing those challenges. For example, when they took over the practice all patient records were hand written notes, patients had not received medication reviews and there was a low prevalence on disease registers. The practice was low performing in terms of the QOF, was an outlier for patients attending accident and emergency and walk in centres, was a high prescriber of antibiotics, had no female GP and no patient participation group. Patient notes have now been summarised and held on electronic patient records, disease registers have been improved and patients are receiving regular follow up and medication reviews with the practice.
- The practice was aware of where it needed to focus such as national cancer screening uptake and mental health. We saw that this had been discussed at practice meetings.
- The practice was working with four other practices with plans to merge to form a federation allowing the sharing of resources and extension of services.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff from their computers. Those seen were updated regularly.
- A comprehensive understanding of the performance of the practice was maintained. QOF performance had improved significantly over the last few years. For example, in 2012/13 the practice achieved 59% of the total QOF points, in 2013/14 this had increased to 93% and in 2016/17 to 98%.

- There had been improvements to the disease registers. For example, the diabetes register had increased from 177 patients in 2012/13 to 253 in 2016/17, the chronic obstructive pulmonary disease register (COPD) had increased from 7 in 2012/13 to 23 in 2016/17 and dementia register from 2 in 2012/13 to 9 in 2016/17. The practice actively used available information such as local pharmacy reports, Aristotle and primary care web (provides statistics on individual practices), CQC intelligent monitoring to identify areas for improvement.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions, such as those relating to the safety of the premises and management of emergencies.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

On the day of inspection the principal GP demonstrated that they had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. Staff told us the GPs and managers were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour and encouraged a culture of openness and honesty. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). From the sample of documented complaints and incidents we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

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

- The practice held and recorded meetings with health and social care professionals to monitor vulnerable patients.

Are services well-led?

Good 

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

- Staff told us the practice held regular team meetings. These included whole staff team meetings and meetings between the GPs and practice manager.
- Minutes from the meetings were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the principal GPs and felt able to contribute in discussions about the practice.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- The patient participation group (PPG) and through surveys and complaints received. The PPG met regularly and had approximately 10 active members. The principal GP also attended the PPG meetings. We spoke with five members of the PPG who told us about some of the changes and discussions that had taken place with them to improve the service. For example, refurbishment of the premises including improving wheelchair access and fire doors and earlier starting time for appointments (from 8.30am). They also told us they had discussed mental health as a priority area to develop and to challenge local attitudes towards this. Members of the PPG we spoke with told us that they felt their input was valued and that they were listened to.
- Staff were able to provide feedback through staff meetings, appraisals and general discussions. Staff told us they the GP and practice manager engaged with them and that they felt confident in raising any concerns they might have.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.

The practice was one of four GP practices that participated in a pilot scheme for the integration of diabetes care across primary and secondary care. The pilot focused in an areas with a population that was considered difficult to engage with in relation to diabetes management. These areas had a predominantly Asian population with a high prevalence of diabetes that were also socially deprived. The practice was allocated a consultant and diabetes specialist nurse for one session per month to discuss and manage patients with poorly controlled diabetes and to organise patient teaching. Education sessions were also given to practice staff. As the part of the pilot the HbA1c (a measure of diabetes control) was collected pre and post intervention. Of 154 patients across the four practices, improvements were seen in diabetic control and 70 patients were successfully discharged from secondary care. For Greenfield Medical Practice all patients were successfully discharged from secondary care. The principal GP told us that they felt more confident in managing diabetes in primary care and due to the success of the scheme the focus of the monthly sessions had changed to group patient education sessions.