

Keynell Covert Surgery

Quality Report

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection on 13 February 2015.

We have rated each section of our findings for each key area. We found that the practice provided a safe, effective, caring, responsive and well led service for the population it served. The overall rating was good and this was because on-going improvements had been made that had a positive impact on patient care by staff who were motivated and carried out their roles effectively.

Our key findings were as follows:

- We found evidence that practice staff worked together and were enthusiastic to make on-going improvements for the benefit of patients.
- The practice was visibly clean. The standards of hygiene were regularly monitored to protect patients from unnecessary infections.

- There was a register of all vulnerable patients who were reviewed regularly. Patients we spoke with told us they were satisfied with the care they received and their medicines were regularly reviewed.
- Practice staff had identified carers and entered them on a register. GPs offered them advice and support. There was a dedicated area in the waiting room that offered information about support systems and groups.
- The practice was able to demonstrate a good track record for safety. Effective systems were in place for reporting safety incidents. Untoward incidents were investigated and where possible improvements made to prevent similar occurrences.
- We found that patients were treated with respect and their privacy was maintained. Patients informed us they were very satisfied with the care they received and their ability to book an appointment when they felt they needed to.

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. The practice had a good track record for safety. There was effective recording and analysis of significant events and evidence that lessons learnt were cascaded to all relevant staff for prevention of unnecessary recurrences. There were robust safeguarding measures in place to help protect children and vulnerable adults. GPs held meetings every six weeks with a health visitor to discuss the care needs of those who were identified as being at risk of harm. There were reliable systems in place for safe storage and use of medicines and vaccines within the practice. Staff recruitment systems were robust.

Good



Are services effective?

The practice is rated as good for providing effective services. Care and treatment was delivered in line with both the National Institution for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. Clinical audits were regularly carried out and changes made to ensure patient care was appropriate for their needs. The findings from some audits resulted in changes to patients' prescribed medicines. There was evidence of multi-disciplinary working and the practice had developed a proactive system for ensuring patients received co-ordinated care.

Good



Are services caring?

The practice is rated as good for providing caring services. We found and patients told us that practice staff were caring and helpful. The patients and Patient Participation Group (PPG) members we spoke with were very complimentary about the service they received. The PPG acted as representatives for patients in assisting the practice staff in driving improvements to the services that patients received. Patients we spoke with told us they were satisfied with their care and they had confidence in the decisions made by clinical staff. The comment cards patients had completed prior to our inspection provided positive opinions about staff, their approach and the care provided to them. We observed that staff interacted with patients in a polite and helpful way and they greeted patients in a friendly manner.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. Practice staff demonstrated how they listened to and responded to their patient group. Clinicians demonstrated how they listened to and responded to their patients. Practice staff had reviewed the needs of patients and engaged with the NHS England Area Team

Good



Summary of findings

and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified. We saw that efforts had been made to reach out to each population group to ensure they received appropriate care and treatments. The practice had appropriate facilities and was well equipped to assess and treat patients in meeting their needs. There was an accessible complaints system with evidence demonstrating that the practice responded appropriately and in a timely way.

Are services well-led?

The practice is rated as good for providing well-led services. The systems that were in place confirmed that the service was well led. All staff worked closely together to innovate and promote continuous improvements. There was strong leadership with a clear vision and purpose. We found that all staff were encouraged and involved with suggesting and implementing on-going improvements that benefitted patients. GPs had attended training and were involved with a scheme for improving and ensuring consistent care was provided for patients with long term conditions. Governance structures were robust and there were systems in place to effectively manage risks.

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

Patients aged over the age of 75 years had been informed of their named and accountable GP. All older patients had annual health checks and where necessary, care, treatment and support arrangements were implemented. GPs provided care to patients registered with the practice who resided in a care home. The practice offered proactive, personalised care to meet the needs of older people and had a range of enhanced services. The practice was responsive to the needs of older people, including offering rapid access appointments or home visits for those with enhanced needs.

Good



People with long term conditions

Practice staff recognised the long term condition needs of its practice populations. They held a register of patients who had long term conditions and carried out regular reviews. GP's worked with relevant health and care professionals to deliver a multidisciplinary package of care. Clinical staff had good working relationships with a wide range of community staff and held regular meetings with them to ensure patients received seamless care. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. Practice staff supported patients and carers to receive co-ordinated, multidisciplinary care.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. Appointments were available outside of school hours and the premises were suitable for children and babies. Practice staff liaised with local health visitors to offer a full health surveillance programme for children. Checks were also made to ensure maximum uptake of childhood immunisations. The clinical team offered immunisations to children in line with the national immunisation programme.

Good



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). Community midwives held regular ante natal and post natal clinics at the local health centre situated next door to the practice. The practice offered extended opening hours to assist this patient group in accessing the

Good



Summary of findings

practice. Appointments were available until 6pm on Tuesdays and 7pm Mondays and Fridays. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk of harm.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. Practice staff had identified patients with learning disabilities and treated them appropriately. Practice staff regularly worked with multi-disciplinary teams in the case management of vulnerable people. All patients within this group had received annual health checks. GPs carried out regular home visits to patients who were housebound and to other patients on the day they had been requested.

Good



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). Care was tailored to patients' individual needs and circumstances including their physical health needs. Patients who presented with anxiety and depression were assessed and managed within the National Institute for Clinical Excellence (NICE) guidelines. Annual health checks were offered to patients who had serious mental illnesses. GPs had the necessary skills and information to treat or refer patients with poor mental health. Practice staff worked in conjunction with the local mental health team to ensure patients had the support they needed. Both GPs had attended training in dementia and the Mental Capacity Act to ensure all care provided was in the patient's best interests.

Good



Summary of findings

What people who use the service say

We spoke with seven patients during our inspection who varied in age. Some had been registered with the practice for many years. They informed us that staff were polite, helpful and knowledgeable about their needs. Patients told us they were given enough explanations so they understood about their health status and felt they were encouraged to make decisions about their care and treatment. They all gave us positive feedback about the standards of care they received. Patients told us it was easy to obtain repeat prescriptions and book appointments.

We collected 41 patient comment cards on the day of the inspection. Positive feedback was given by those patients who had made written comments. They included standards of care, ability to book appointments, that staff were caring, friendly, listened, were responsive and the overall patient experience was positive.

It was evident practice staff had listened to opinions made by patients and the Patient Participation Group (PPG) who acted as patient advocates. The PPG worked

with clinical staff in meeting patient's needs and carried out surveys that included suggested actions. For example, patients had reported they waited too long to be seen by the health care assistant. A review was carried out and changes made to the clinic times and length of appointments for patients with complex needs.

The National Patient Survey results from 2013 informed us that the results were average or above average for the practice:

- 80.8% of respondents would recommend the practice, above average.
- 95.11% for the last time patients wanted to speak with or see a GP or nurse and get an appointment, above average.
- 70.1% were satisfied with the opening times, average.
- 82.1% had good or very good experience for making an appointment, above average.
- 91.24% reported their overall experience was good or very good, above average.

Keynell Covert Surgery

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.

Background to Keynell Covert Surgery

Keynell Covert served approximately 1450 patients.

At the time of our inspection there was one female GP and one male GP who provided eight clinical sessions per week. There was a nurse practitioner who was a nurse prescriber and one health care assistant/phlebotomist who worked part time. The practice manager led a team of two receptionists and one administrator who worked varying hours.

The practice offered a range of services including chronic disease management, diabetes, cervical smears, contraception, minor surgery in the format of joint injections, injections and vaccinations.

The practice had opted out of providing out-of-hours services to their own patients. Patients were advised to use the local walk-in centre when the practice was closed or to contact NHS 111 for medical assistance or 999 in an emergency when the practice is closed. This information was available in the waiting area, in the patient leaflet, via the practice telephone and on the website.

CQC has not received any information of concern about this practice.

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.

How we carried out this inspection

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

Detailed findings

- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

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

on 13 February 2015. During our inspection we spoke with a range of staff including two GPs, the nurse prescriber, the health care assistant/phlebotomist, the practice manager and one receptionist. We also spoke with seven patients who used the service and received 41 comment cards from patients. We observed how patients were being cared for and staff interactions with them. We looked at relevant documentation in relation to patient care and treatment.

Are services safe?

Our findings

Safe track record

The practice was able to demonstrate it had a good track record for safety. Practice staff used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents and national patient safety alerts. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. The practice manager showed us that there were effective arrangements in line with national and statutory guidance for reporting safety incidents.

There were clear accountabilities for incident reporting, and staff were able to describe their role in the reporting process and appreciated the importance of reporting incidents. The practice manager recorded incidents and ensured they were investigated. The GPs held regular meetings to review the practice's safety record and to check that the actions taken were effective.

We reviewed safety records and incident reports and saw how the practice manager recorded incidents and ensured they were investigated. These clearly stated the investigations carried out, the resultant actions and which staff the information had been cascaded to. The records we saw told us they had been completed in a comprehensive and timely manner.

Learning and improvement from safety incidents

There was a system for recording, reporting and monitoring significant events which occurred at the practice. There was a process for analysing and learning from near misses. For example; a power failure outside of practice hours that resulted in unsafe refrigerated vaccines. Staff took appropriate advice and actions to protect patients by discarding and re-ordering new stocks of vaccines.

We saw evidence that learning from incidents was shared with staff in a timely and appropriate way in order to reduce the risk of a similar incident occurring again. For example, a newly registered patient displayed concerns about confidentiality when practice staff requested a transfer of the patient records from another practice. The importance of reception staff informing new patients about the process was discussed with staff. We saw evidence of robust communication processes with all relevant staff to

ensure they were fully informed. Significant events concerning safety were reported to the local 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' and buying health and care services.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and vulnerable adults. Practice training records demonstrated that staff had received role specific training on safeguarding children and adults. 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 regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours.

A GP was the designated lead in safeguarding for children and vulnerable adults and had been trained appropriately for this role. They demonstrated they had the necessary skills to identify abuse and take appropriate action. All staff we spoke with demonstrated they would take effective actions if they had a safeguarding concern.

GPs met with a health visitor every six weeks to discuss any patients who were found to be at risk of harm and whether a safeguarding alert should be completed and sent to the local authority who were responsible for carrying out investigations.

A chaperone policy was in place and visible in the waiting area and was included in the practice leaflet. Chaperoning was provided by clinical staff and if they were not available, non-clinical staff carried out this role. Non-clinical staff had received training and appropriate background checks before they were allowed to provide chaperone duties. We spoke with a receptionist who demonstrated how they would carry out the role appropriately.

Medicines management

Vaccines were stored in a lockable medicine fridge. Temperatures had been recorded daily. Staff ensured that vaccines were stored in line with manufacturer's instructions and were safe for administration.

Processes were in place to check medicines were within their expiry date and safe for use. All the medicines we

Are services safe?

checked were within their expiry dates. Emergency equipment was also checked to ensure it was in working order. We were told that GPs did not carry medicines in their visit bags. Practice staff had considered the risk and taken the decision not to carry medicines but to rely on paramedic services.

There was a protocol for repeat prescribing which was in line with national guidance and was followed by practice staff. Patients who had repeat prescriptions received regular reviews to check they were still appropriate and necessary.

Cleanliness and infection control

All areas of the practice were visibly clean and tidy. All patients we spoke with told us they had no concerns about cleanliness or infection control. They also told us that staff always washed their hands prior to carrying out procedures. There was a cleaning schedule in place for cleaning staff to follow.

A GP was the lead for infection control. All staff had received training in infection control.

Practice staff had carried out annual in depth audits. The latest one was dated March 2014; it included actions that needed to be taken such as designated areas for storage of personal protective equipment (PPE) in each clinical room and additional lidded pedal bins were required. We saw that both of these actions had been addressed.

Disposable instruments were used for joint injections and also for parts of medical equipment that came into contact with patient's skin.

An infection control policy and supporting procedures were available for staff to refer to including needle stick injury; which enabled them to plan and implement control of infection measures. For example, PPE including disposable gloves, aprons and coverings for examination couches were available for staff to use. Staff confirmed there were always good stocks of PPE available within the practice.

We found that a Legionella risk assessment had been carried out in December 2014. Legionella is a term for a particular bacteria which can contaminate water systems in buildings.

Each clinical room included a wall chart of daily cleaning instructions for medical equipment for staff to action.

Equipment

Clinical staff we spoke with told us they had sufficient 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. We found recordings confirming that all portable electrical equipment was routinely tested and appropriate recordings maintained.

Staffing and recruitment

Staffing numbers were based on their experience of how the practice operated. Consideration had been given to the access, care and treatments that patients required. The practice manager told us that non-clinical staff worked part time and were willing to work extra shifts to cover staff holidays and other absences. A receptionist told us there was a bank receptionist who could also be approached to cover shifts. There were occasions when a locum GP had been used to cover GP absences. However, the practice had an arrangement where they and another local practice GP covered for each other to ensure continuity of care for patients.

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 ensure patients were kept safe.

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 via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Monitoring safety and responding to risk

There was a health and safety policy in place and staff knew where to access it.

There were arrangements in place to deal with medical emergencies. We saw that the staff at the practice had received training for dealing with medical emergencies and basic life support. The practice had an automated external defibrillator for emergency treatment of some heart conditions. All of the staff we asked knew the location of the emergency medicines and equipment.

Arrangements to deal with emergencies and major incidents

Are services safe?

The practice had an up to date business continuity plan in place. This covered a range of areas of potential risks relating to foreseeable emergencies that could impact on the delivery of the service. The document covered eventualities such as loss of computer and essential utilities. A copy of the business continuity plan was kept off site by senior staff in their homes to ensure there was access to the document in any eventuality.

A fire risk assessment had been undertaken that included actions required for maintaining fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

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 treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Minutes of practice meetings demonstrated that the practice's performance and patients were discussed and any required actions agreed. Staff we spoke with told us these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. Discussions with the GPs and nurses confirmed that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

We saw no evidence of discrimination when making care and treatment decisions. Our interviews with the GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race were not taken into account in this decision-making.

The clinicians we spoke with confidently described the processes to ensure that informed consent was obtained from patients whenever necessary. They were also aware of the requirements of the Mental Capacity Act 2005 used for adults who lacked ability to make informed decisions.

The practice used computerised tools to identify patients with complex needs and had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital and the actions taken if they required follow-up care.

Management, monitoring and improving outcomes for people

Clinical staff actively participated in recognised clinical quality and effectiveness schemes such as the national Quality Outcomes Framework (QOF) and the local Clinical Commissioning Group (CCG) enhanced service schemes. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' and buying health and care services. QOF is a national performance measurement tool

and the CCG is the NHS body responsible for commissioning local NHS services. We were shown the latest QOF achievements that told us practice staff were either meeting or exceeding all of the national standards.

We saw evidence that a wide range of clinical audits were carried out and where the results affected patient care this was acted upon. They included a review of various medicines including antibiotics and the actions that had been taken to ensure patients received appropriate treatments.

We were shown an audit dated June 2013 that concerned prescribed medicines including controlled drugs, medicine reviews and prescription management. The result indicated that improvements were needed. We looked at a repeat audit dated February 2014 that indicated improvements had been made in all areas of prescribing.

Both GPs held monthly meetings with a pharmacist to discuss patients and where any changes to prescribing were recommended by the pharmacist. Any required changes were discussed with the patient beforehand so that they understood why the change was necessary.

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 the training courses such as annual basic life support. All GPs had completed their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

All staff had annual appraisals which identified any learning needs from which action plans were documented. We saw that the nurse prescriber and health care assistant appraisals were carried out by clinical staff so that their practices could be discussed and appropriately checked. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses.

Working with colleagues and other services

There was evidence of appropriate multidisciplinary team working and it was apparent there were strong

Are services effective?

(for example, treatment is effective)

relationships in place. A multidisciplinary meeting was held every three months to discuss patients receiving end of life care and those considered to be at risk. Community staff attendance included a member of staff from a local hospice, the community matron, community nurses and the case manager. Regular meetings and contact with health visitors enabled children considered to be at risk of harm to be appropriately monitored.

Practice staff worked with other service providers to meet patient's needs and manage complex cases. Test results, Xray results, letters from the local hospital including discharge summaries, out of hour's providers and the emergency service were received at the practice electronically. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for taking any required action.

Patients were invited to contact the practice to receive their test results. However, if a test result was abnormal, patients would be contacted and informed by the GP either face to face or by telephone consultation.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patient care. All staff were fully trained on the system. The system included a facility to flag up patients who required closer monitoring such as children at risk.

Both GP's we spoke with told us they had good working relationships with community services, such as community nurses. There was evidence of robust joint working relationships and their ability to make contact with each other at short notice when a patient's condition changed to enable provision of appropriate care.

Consent to care and treatment

The patients we spoke with told us they had been involved with decisions about their care and treatments. They told us they had been provided with sufficient information to make choices and were able to ask questions when they were unsure.

Patients who had minor surgery had the procedure explained to them and the potential complications before they signed the consent form.

GPs knew how to assess the competency of children and young people about their capability to make decisions about their own treatments. They understood the key parts of legislation of the Children's and Families Act 2014 and were able to describe how they implemented it in their practice. GP's demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 years of age who have the legal capacity to consent to medical examination and treatment).

Health promotion and prevention

The practice manager told us all new patients were offered a health check by a practice nurse or health care assistant. New patients who were receiving medicines were given an appointment with a GP to review the medicine dosage and if it was still appropriate. We spoke with a patient who had recently registered with the practice who confirmed these arrangements.

Patients who were due for health reviews were sent a reminder and if necessary contacted and asked to make an appointment. Patients were asked about their social factors, such as occupation and lifestyles. These ensured doctors were aware of the wider context of their health needs.

We were told that if patients failed to arrive for their childhood vaccinations reminders were sent out to parents. The most recent data available to us showed immunisation rates were either in line or above the average for the Clinical Commissioning Group (CCG).

One of the GPs told us they had achieved a high uptake of flu vaccinations. The year end figures were 80% for all patients who were at risk and 87% for those aged over 65 years.

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. We saw a variety of health and welfare information displayed in the waiting area. Many were in leaflet format for patients to take away with them. Posters provided the contact details of various organisations that patients could contact for advice, support and weight loss.

Are services effective?

(for example, treatment is effective)

Patients were also informed about chlamydia (bacterial infection) screening that was offered to female and male patients under 25 years of age. The practice also screened patients of any age who were at risk of sexually transmitted infection.

The practice website provided patients with a wealth of information for a wide range of circumstances or conditions. For example; healthy living, sexual health and contraception, common health conditions, long term conditions and the latest health reports.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. Reception staff told us that a consultation room was always available if a patient requested a private discussion. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room and that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultations took place behind closed doors so they could not be overheard.

Feedback provided by patients we spoke with or via the comment cards we received gave us positive feedback about the relationships they had with various grades of staff. No-one we spoke with or any of the written comments were negative about the way that staff approached them.

Patients confirmed they knew their rights about requesting a chaperone but they commented this service was offered to them by clinical staff. Some patients had used the chaperone service and reported to us they felt quite comfortable during the procedure.

There was a privacy and dignity policy in place and all staff had access to this. We saw that all clinical rooms had window blinds and privacy screening. Clinical staff told us the consulting room door was kept closed when patients were being seen. We observed staff knocking on doors and waiting to be called into the room before entering.

Care planning and involvement in decisions about care and treatment

We found that patient care was an absolute priority and was embraced by the whole practice team. The seven patients we spoke with told us that staff gave them time by explaining their health matters until they felt fully informed and understood about the need for care or treatments.

The practice's patient survey report dated March 2014 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice well in these areas. For example, respondents said the GP involved them in care decisions and they felt the GP was good at explaining treatment and results.

The Mental Capacity Act 2005 governs decision making on behalf of adults and applies when patients do not have mental capacity to make informed decisions. Where necessary patients had been assessed to determine their ability prior to best interest decisions being made. Staff we spoke with and both GPs had attended training in the Mental Capacity Act.

Patient/carer support to cope emotionally with care and treatment

Following bereavement the respective GP contacted the family by phone to offer them information about the various bereavement counselling services available to them. Counselling services were arranged if family members felt it would be beneficial for them. One of the patients we spoke with commented about the good support they had received after their relative had died.

The practice held a register of those patients who cared for other persons. The practice website and a notice board in the waiting area provided information for carers. It included details of services that could be requested. For example, chiropody, eye sight checks and carers support and respite services.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice delivered core services to meet the needs of the various patient population groups they treated. Registers were held for patients who had long term conditions, those who received palliative care and patients who were identified as being at risk. Patients were offered screening services for effective monitoring of patients who had long term conditions. For example, asthma, hypertension and diabetes. Staff had identified those patients who had a learning disability and all clinical staff had received training from a learning disability specialist nurse. We saw that all patients who were in this group had received annual health checks. The practice had a mental health register and those patients had had a health check.

There were immunisation clinics for babies and children and women were offered cervical screening. All patients who were eligible were offered and encouraged to attend the practice for cervical screening. There was an uptake of 89% of cervical screening over the last five years. Patients over the age of 75 years had an accountable GP to ensure their care was co-ordinated. All older patients were offered annual health checks. A phlebotomy (taking blood sample) service was provided during two mornings each week for ease of access for patients.

Quarterly multidisciplinary meetings were held to discuss patients and their family's care and support needs. We saw that all patients who were receiving palliative care were discussed to ensure they received co-ordinated care. The case manager also met separately with the GPs to review patient's needs. Care plans were in place for patients who were at high risk of admission to hospital. Meetings were held every six weeks with a health visitor to review the needs of those patients who were at risk of harm.

One of the GP's carried out a weekly round for patients registered with the practice who resided in a nearby care home. GPs also responded to requests from the home staff for them to visit patients at short notice. We spoke with a senior member of staff for the home who gave us positive feedback about the service they received.

There was a male and female GP available at the practice which gave patients the option of receiving gender specific care and treatment.

The practice had a Patient Participation Group (PPG). PPGs are a way in which patients and practice staff can work together to improve the quality of the service. We spoke with the chairperson of the PPG who told us the PPG made positive contributions to the service patients received. They told us they had reported the unsafe pot holes leading to the practice entrance. They said that staff had taken action and the pot holes were repaired promptly.

The latest patient survey report dated March 2014 was available from the practice website so that patients could readily access it. The results in the report were positive regarding the service provided to patients. The report included action plans. For example a campaign had been commenced to encourage patients to use the on line facilities for booking appointments and requesting repeat prescriptions. Progress against actions were discussed during each PPG meeting.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where these had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. A GP attended the monthly CCG meetings and cascaded information from them to all relevant staff.

The practice had a website and patients were able to order repeat prescriptions and book appointments around their working day by telephone or on line.

Patients we spoke with told us they were given choices about which hospital they wished to be referred to. They said that the GP would go through the system with them to assist them in making an informed decision.

Tackling inequity and promoting equality

The premises were fit for purpose and accessible to patients who had difficulties with their mobility. The patient toilet included grab bars for those who had problems with their stability. Staff had assessed that the doorway and room size was unable to accommodate wheelchair access.

Are services responsive to people's needs?

(for example, to feedback?)

Staff told us that translation services were available for patients who did not have English as a first language. This service could be arranged to take place either by telephone or in person. Both GPs were able to speak with patients in Hindi and Urdu.

The practice had equality and diversity policy and staff were aware of it. Patients we spoke with did not express any concerns about their rights about how they were treated by staff.

Access to the service

Appointments were available from 9am until 11:30 am each day, 4pm until 6pm each Tuesday and 4pm until 7pm Mondays and Fridays. Both GPs offered telephone consultations for patients who were unsure if they needed an appointment and for the convenience of those who had difficulties in accessing the practice. The seven patients we spoke with told us they could make appointments for when they needed them. The comment cards we received informed us that those patients were satisfied with the appointments system.

Patients were advised to use the local walk-in centre when the practice was closed or to contact NHS 111 for medical help or 999 if it was an emergency. This information was available in the waiting area, in the patient leaflet, via the practice telephone and on the website.

Patients could make appointments by telephone, on line or in person. The practice manager told us they regularly checked the appointments system to ensure they were able to meet patient demands.

Reception staff told us that patients who requested to be seen urgently were offered a same day appointment.

Requests for appointments for children were treated as urgent so that they were seen the same day. We were given examples where GPs had worked prior to and beyond their clinical session times to accommodate urgent appointments.

We asked some patients how long they usually waited when they arrived for their appointments. All responses told us patients were seen on time or shortly afterwards.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

The practice website and patient leaflet informed patients of how to make a complaint. Patients could request a separate leaflet that gave in depth guidance for making complaints. It included the contact details of NHS England and the local ombudsman if the complainant was not satisfied with the outcome of the investigation. On receipt of a complaint an acknowledgement letter would be sent to the complainant. An investigation would be carried out and a response sent to the complainant including any resultant actions that staff had taken to prevent similar recurrences. Practice staff we spoke with told us the outcome and any lessons learnt were discussed during practice meetings.

We saw the practice's log of complaints it had received. The review recorded the investigation details and outcome of each complaint and identified where learning from the event had been shared with staff.

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

One of the GPs explained they had a clear vision for the future of the practice. The aim was to improve access and the services offered to patients in a sensitive way and a concentration on developing happy motivated staff who would deliver services in a friendly manner.

We spoke with six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. They told us they felt an integral part of the team and were actively encouraged to make suggestions for making further improvements. The practice manager told us they would continue striving to improve the service.

Governance arrangements

One of the GPs had taken on responsibility for liaising with four other practices who were used as pilot sites for making and identifying where improvements could be made. Meetings were held every two months and the results sent to the local CCG and provided further updates during their monthly attendance at the meetings.

The practice had a clear governance structure designed to provide assurance to patients and the local CCG that the service was operating safely and effectively. There were specific identified lead roles for areas such as safeguarding, cervical screening and checking vaccinations and emergency medicines and equipment. Responsibilities were shared among GPs, the nurse prescriber, the health care assistant and the practice manager.

Monthly meetings were held with all practice staff invited to attend. A receptionist told us they were encouraged to participate and to make suggestions for possible areas of improvement. The nurse prescriber told us that because of the hours they worked they did not attend the meetings but did read the minutes when they were made available. We saw a sheet that contained signatures staff had made when they were unable to attend meetings.

Leadership, openness and transparency

We saw evidence of staff appraisals that were regularly undertaken. Staff members we spoke with told us that they aimed to provide a caring service for patients.

Staff members we spoke with felt supported in their roles and were able to speak with the practice manager if they had any concerns. They told us that opportunities for progression were discussed and actioned where appropriate.

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

We found there were strong, positive relationships between practice staff and the Patient Participation Group (PPG). We looked at the minutes from the PPG meetings; these were held regularly and the practice manager attended. The minutes informed us there was a good informing process between both parties to keep everyone updated. They also included progress against any areas where improvements had been made.

The chairperson of the PPG told us about an initiative they had suggested. When patients collected their prescriptions they were given written information about common illnesses and information about the local walk-in centre. The purpose was to reduce the number of patients who visited the accident and emergency department of the local hospital.

Staff we spoke with told us they felt well supported and were able to express their views about the practice. They said they were encouraged to make suggestions for improvements and these were taken seriously by senior staff.

Management lead through learning and improvement

Aspiring to Clinical Excellence (ACE) is a programme offered to all Birmingham Cross City Clinical Commissioning Group (CCG) practices. The ACE programme is based on the strategic objectives of the CCG and the NHS Outcomes Framework indicators. ACE is a programme of improvement aimed at reducing the level of variation in general practice by bringing all practices up to the same standards and delivering improved health outcomes for patients. There are two levels, ACE Foundation and ACE Excellence. The two components of the ACE Excellence Pilot were holistic care and diagnosis of patients with long term conditions and integration of community teams into general practice. Achievement of ACE is verified by a practice appraisal process.

A GP told us they had completed the ACE Foundation programme last year and were concentrating all of

Are services well-led?

Good 

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

the areas from ACE Excellence. The practice was the lead for this programme and was working with four other practices in taking this forward. Learning from this was fed back to the CCG to facilitate evaluation of the project. Practice staff had improved the standard of care for patients who had learning disabilities. They had also identified carers and provided a dedicated notice board in the waiting area that provided details of where to find advice and support. This meant that efforts were being made to provide high standards and consistent care and treatment to these patients.

We saw evidence that learning from significant events took place and changes implemented to reduce similar occurrences. We saw there were processes in place for

practice staff to audit and review significant events and appropriate action plans had been implemented. For example, a patient attended the practice and informed practice staff that they were unable to get through on the phone. The phone line was found to be out of order due to a power cut and the event was raised as an issue within the business continuity plan. The phone provider was contacted and the phone line restored without loss of data. Staff discussed the event and decided the situation was unavoidable as the whole area was without power. The learning from this was that the vaccine fridge should be checked immediately. Staff had replaced all vaccines to ensure patient safety.