The Slieve 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.

Contents

Summary of findings

Overall summary

The Slieve Surgery is located in the Handsworth Wood area of Birmingham and provides primary medical services to patients who live within a one mile radius of the practice.

The practice was safe. There were safeguarding procedures in place and all staff had been trained in safeguarding adults and children. Regular information sharing meetings took place with other teams such as health visitors to work to keep patients safe. There was an open and transparent culture within the practice.

The practice was caring. Patients were treated with dignity, respect and compassion. Patients spoke very positively of their experiences and of the care and compassion that they received from the staff. The GPs were proactive in supporting patients who needed end of life care and there were systems in place to highlight high risk patients who were likely to need support at weekends when the practice was closed.

The practice was effective. There were policies and a procedure in place to make sure that good practice was maintained and that all patients could be assured they received consistent and up to date care and treatment. The practice operated a multidisciplinary approach with effective and timely referral mechanisms in place. Induction programmes were in place and records showed that staff were trained appropriately.

The practice was responsive to patients' needs and met the needs of specific patient groups within its practice population. The practice had an accessible appointments system and premises.

The practice was well led. The practice had a strong and visible leadership which was well supported by the staff team. The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant events meetings.

The practice had systems in place to learn from incidents and near misses. The practice actively sought and acted on feedback about the standard of services they provided. There was an active Patient Participation Group (PPG) in place, which met four times per year. PPGs are a way in which patients and GP practices can work together to improve the quality of the service provided. Systems and procedures were in place to monitor and improve the quality of the service provided. There was a vision and strategic plan in place which laid out future developments for the practice.

We examined patient care across the following population groups: older people; those with long term medical conditions; mothers, babies, children and young people; working age people and those recently retired; people in vulnerable circumstances who may have poor access to primary care; and people experiencing poor mental health. We found that care was tailored appropriately to the individual circumstances and needs of patients in these groups.

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.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

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 worked with other agencies to provide integrated care for older patients who were considered to be high risk. This involved screening patients for signs of loneliness and working together to provide coordinated discharge planning and care for patients.

Patients told us they were always able to get an appointment when they needed one and staff confirmed priority access was given to older patients. Joint working arrangements were in place with the out of hours (OOH) provider to improve outcomes for patients and ensure continuity of care.

People with long-term conditions

There was a system in place to monitor and review patients with long term conditions. The system for issuing repeat prescriptions gave alerts when medicine reviews were due. These reviews enabled both a review of medicines and the patient's condition to be carried out. Patients told us they had regular reviews with their GP. Regular clinics were held at the practice to support patients with their conditions.

The practice checked that carers of patients with long term conditions were supported if needed, particularly where patients had learning disabilities, dementia or mental health problems.

Mothers, babies, children and young people

Systems were in place to make sure that mothers, babies, children and young patients received co-ordinated care. Joint working was provided by the practice, health visitors and the midwifery team to make sure that mothers and young children received the care they needed.

Immunisation clinics for childhood vaccinations and well-baby clinics were provided by the practice and monitored for non-attendance by the GPs.

The working-age population and those recently retired

The practice had an appointments system in place that ensured patients of working age and those recently retired would be able to make an appointment to see a GP at times that were suitable for them.

The practice provided late evening clinics on Thursdays, early morning appointments and telephone consultations were available as preferred.

Summary of findings

People in vulnerable circumstances who may have poor access to primary care

Systems and procedures were in place to share concerns where vulnerable patients were considered to be at risk of harm. The practice engaged in joint working arrangements with other agencies and professionals to monitor and share concerns where they arose.

The practice provided support for patients in this population group, for example patients with learning disabilities and dementia.

People experiencing poor mental health

The practice received support from the local NHS mental health service for patients who experienced poor mental health. Plans were in progress to provide a walk in mental health counselling clinic at the practice.

Regular health checks were offered to patients with mental health concerns. Patients were also offered counselling appointments with the service provided by Birmingham Healthy Minds at the practice.

Patients were given extra time for their appointments as they needed more time with the GP. Patients we spoke with during the inspection told us they had a longer appointment and they felt this was helpful for them to talk about their health with the GP.

Summary of findings

What people who use the service say

During our inspection we reviewed 63 comment cards that patients and members of the public had completed to share their views and experiences of the practice. The feedback from 90% of the comment cards was a positive reflection of the service provided by the practice. The remaining 10% expressed concerns about individual instances where they had been unhappy with the practice. For example, patients expressed difficulty with access to appointments, although they felt they received a reasonable service, and that staff were very caring and gave helpful advice.

We spoke with 13 patients who visited the practice and observed how staff interacted with them. We also spoke with two members of the patient participation group (PPG). PPGs are a way for patients and GP practices to work together to improve services and the quality of care provided. Members of the PPG and patients were very positive about the practice and the staff who worked there. Patients told us that staff were great, that they felt safe and that they had confidence in the staff.

We received positive feedback from the residential care home with residents who were registered patients at the practice. They told us that staff were always very helpful and that GPs treated patients at the home with respect, dignity and compassion. They told us that the GPs always listened to any concerns they had and offered support and advice when needed.

Areas for improvement

Action the service SHOULD take to improve

There should be a system in place to review all clinical audits, to monitor whether the actions identified had been implemented successfully to ensure completed clinical audit cycles.

There should be a system in place that demonstrates actions taken as a result of national patient safety alerts.

All staff employed at the practice should have an awareness of the business continuity plan that is relevant to their role.

The Slieve Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and a GP. The team also included a second CQC inspector, a practice nurse and an expert by experience (a person who has experience of using this particular type of service, or caring for somebody who has).

Background to The Slieve Surgery

The Slieve Surgery is located in the Handsworth Wood area of Birmingham and provides primary medical services to patients who live within a mile radius of the practice. The practice covers a culturally diverse population of approximately 5,590 patients. The most common languages spoken in this area of Birmingham apart from English is Urdu, and Punjabi. Many other languages are spoken too. Staff have knowledge of some of the languages spoken by patients, with access to an interpreter service available as required.

The practice has one GP principal partner who is also the registered manager. This GP is supported by two part time salaried GPs, a practice manager, a part time business consultant and an office manager. The practice also employs five full or part time reception and administration staff, and four nurses who work full or part time at the practice.

The Slieve Surgery is an approved GP training practice. This means that fully qualified doctors who want to enter into general practice spend 12 months working at the practice to gain the experience they need to become a GP.

The practice is open Monday to Friday from 8.00am till 6.00pm, with late evening appointment on Thursdays. The practice does not provide an out of hours (OOH) service. When the practice is closed patients can also go to nearby GP 'walk-in' centres, to the Pharmacy First centre or to a specific OOH provider.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we had included them.

How we carried out this inspection

Before our inspection of The Slieve Surgery, we reviewed a range of information we held about this practice and asked other organisations to share what they knew. We contacted Sandwell and West Birmingham Clinical Commissioning Group, the NHS England local area team and the Local Medical Committee (LMC) to consider any information they held about the practice. We attended listening events with local community groups. We spoke with the manager of a residential care home supported by the practice. We also supplied the practice with comment cards for patients to share their views and experiences of the practice.

We carried out an announced inspection on 6 August 2014. During our inspection we spoke with a range of staff that

Detailed findings

included two GPs, the business manager, the business consultant, the nurse practitioner and other clinical and administrative staff. We also looked at procedures and systems used by the practice.

We spoke with 13 patients who visited the practice and observed how staff interacted with them. We reviewed comment cards where patients and members of the public shared their views and experiences of the practice. We also spoke with two members of the Patient Participation Group (PPG). PPGs are a way for patients and GP surgeries to work together to improve services and the quality of care provided.

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Are services safe?

Our findings

Safe track record

The practice had systems in place for reporting and recording incidents or significant events. Significant events (SEs) are prioritised on the basis of their actual or potential consequences for the quality and safety of patient care. We saw records that confirmed this. We spoke with the GPs and staff about these procedures. Staff told us that they were encouraged to record all incidents and events by the GPs and the practice manager. We found there was a clear understanding among staff about safety and learning from these incidents. Records showed that concerns, near misses, SEs and complaints had been appropriately logged and investigated and that changes had been made to clinical practice. For example, we saw recorded in February 2014, where a patient had suffered a bleed due to a side effect of the medicine they had taken. This had resulted in changes in the way that patients on this medicine were to be monitored.

We saw that the practice had regularly undertaken internal clinical audits. These audits had included monitoring the medicine of patients with long term conditions. Findings had been shared with staff and actions and recommendations had been recorded. However, we found there was no documented evidence of reviews of these audits, so the practice was unable to confirm whether the actions identified had been implemented successfully.

Learning from incidents

The practice had a system in place for reporting, recording and monitoring significant events. Staff told us that they received feedback and learning from all incidents and concerns individually, and through staff meetings. We saw that significant events meetings were held three monthly. Incidents, lessons learned and actions taken had been discussed with the team. We found that all learning from incidents and near misses had been managed in an open and transparent way.

Safeguarding

The practice had systems and processes in place to keep patients and staff safe. We looked at a range of policies and procedures relating to safety and spoke with staff about these. Staff told us they had access to policies and procedures either through paper copies which were stored in files or through information available on the practice's intranet.

The senior GP and practice manager told us that a recruitment campaign was taking place for the current staff vacancies caused through recent changes within the staff teams. We saw that the recruitment policy for the practice gave details of the checks that would be carried out routinely on all staff prior to employment at the practice. For example, criminal record checks, references and face to face interviews would be completed with all staff before they started to work at the practice to ensure patient safety.

We spoke with a nurse who had been recruited to the practice within the last 12 months. They confirmed that all recruitment processes had been followed. These included criminal record checks, Nursing and Midwifery Council (NMC) Personal Identification Number (PIN) checks, references and face to face interview. Staff confirmed that an induction programme had been put in place and completed. We saw a completed formal induction for new staff that had included formal review meetings at one and two monthly intervals until the probationary period had been completed

Prior to our inspection we carried out checks that confirmed the GPs working at The Slieve Surgery were registered with the GMC (General Medical Council). All practicing medical doctors in the UK must be registered with the GMC.

The practice had a robust safeguarding policy and procedure in place for the protection of vulnerable adults and children. Staff told us they had completed training in safeguarding vulnerable adults and children and records confirmed this. We saw that the lead GP had completed level three (the highest level for safeguarding children).

Staff confirmed they would take action and share any safeguarding concerns with the lead GP. We were told that information about concerns raised was shared with the local safeguarding authority, whose role it is to investigate and act on any safeguarding concerns. We saw that the practice was also proactive and shared information with health visitors where there were concerns about children under the age of five years, who were considered at risk of abuse or who were looked after by the local authority.

Staff told us that the practice used an alert system on patient records to alert them to those patients who were considered to be at risk.

Are services safe?

There was a chaperone policy in place. Nursing and reception staff confirmed they carried out chaperone duties when requested by patients who were to have intimate examinations. They told us they had received chaperone training and training records confirmed this.

Information about the chaperone facility was made available to patients through information communicated on the screen in the waiting room. Further information was available on the practice website and through the practice leaflet. Staff told us that appointments were not needed for chaperones as they were available to patients on request.

Monitoring safety and responding to risk

We looked at some of the systems and processes in place at the practice to keep patients safe, such as health and safety monitoring. There was a detailed health and safety policy in place and staff told us they were familiar with the contents and their responsibilities. Risk assessments had been completed and covered risks such as slips, trips, security, electrical, fire and first aid. Existing controls, corrective action and the level of risk had been identified. For example, a health and safety risk assessment had been completed for the front door. This assessment identified that the heavy door made access to the premises for some patients difficult, and the action was needed to address this. The plan gave short term and longer terms actions. For example, a door bell was to be installed to alert staff to assist patients through the door, while a replacement door was sought.

We saw systems were in place that made sure all emergency equipment and medicines were available, in date and in good working order at all times. The practice nurse told us that they were responsible for monitoring emergency equipment and supplies. This included checks of all emergency medicines. We saw that emergency equipment was checked monthly to make sure they were operational. This included both oxygen cylinders and an automated external defibrillator (AED). This is a piece of life saving equipment that can be used in the event of a medical emergency.

Staff told us they were trained in basic life support so that they would know how to respond if an emergency occurred. Training records confirmed that basic life support training (cardio-pulmonary resuscitation) had been completed by all staff. Reception staff knew the protocol in place in the event that a patient had chest pain, or was excessively out of breath and what action they should take. Staff described a situation that had occurred the previous week where they had responded to such an emergency. All staff knew where emergency equipment was stored and how they would access this.

Medicines management

We saw there was a robust system in place for the management of medicines that included handling, administration, storage and disposal of medicines. There was evidence to show that staff fully understood the process for storing vaccines, with records that confirmed checks were carried out on a regular basis. Nursing staff confirmed that arrangements were in place for checking stocks and disposing of unused medicines. We checked emergency medicines, vaccines, joint injections, local anaesthetics, and medicines needed for home visits. We found that all medicines were appropriately stored and in date.

Some medicines and vaccines must be stored within a temperature range specified by the manufacturer. The dispensing log demonstrated the process to be followed if the medicine fridge temperatures fell outside the acceptable range for storage of medicines including vaccines. For example, the medicines may require disposal. We saw that staff had recorded regular checks on the medicine fridge temperatures to ensure this fridge was maintaining the correct temperature.

There was a system in place for issuing repeat prescriptions for those patients who were on long term medicines. Staff told us that repeat prescription reviews were carried out to monitor both the prescribing of medicines and patients' conditions. The computer system flagged an alert when a review of a patient's medicine was needed and the patient was reminded to make an appointment so that a review could be carried out. Some of the patients we spoke with who were on long term medicines told us that they had regular reviews with the GP about their medicines and their conditions.

There was a system in place for the issue and storage of prescription pads, including those used for home visits. The practice nurse showed us the checklist in place to ensure no pads remained in the surgeries at the end of the day. All prescription pads were locked away and monitored by the office manager to prevent misuse or the possibility of theft.

Are services safe?

Cleanliness and infection control

The practice was visibly clean and tidy. We saw cleaning schedules were in place which included risk assessments for cleaning toilets, washrooms, stairways and stairwells, damp mopping and manual handling. These assessments were stored in a folder which cleaning staff accessed easily.

There was an appointed infection control lead and a deputy in their absence. We saw there was a full range of infection control policies and procedures in place which included links with the local infection control team.

Records showed that all staff had received training in infection control and procedures were in place to minimise the risks of cross infection. For example, staff confirmed they had access to personal protective equipment such as gloves and aprons. We saw that wipes were available for cleaning equipment as required. Hand wash was available for all basins, with gel cleanser available in all clinical areas. Staff also had access to spill kits which were in date.

The practice used disposable and single use equipment including for example, tourniquets. We were told however that disposable blood pressure cuffs were not used, and current practice included washing the cuffs when they were visibly dirty. The nurse confirmed however that the cuffs were not routinely wiped after each use and this could increase the risk of cross infection to patients.

Staffing and recruitment

The senior GP and practice manager told us that a recruitment campaign was taking place for the current staff vacancies. The practice had recently experienced a high turnover in clinical and administrative staff through retirement and staff moving on. The GP partner interviewed stated that this had resulted in staffing skill mix and method of working to be reassessed and adjusted to meet patient needs. For example, consultation times for GP clinics had been changed in January 2014 from the mornings to be more evenly spread throughout the day.

A computerised system was used to organise staff levels and skill mix for the practice. This system identified sessions allocated to GPs and nurses at the practice and also the hours required and worked. The practice had not used locum doctors because the GPs at the practice covered their colleagues' annual leave and sickness where possible to ensure patient care was consistent.

Dealing with Emergencies

We saw the current business continuity plan for the practice. This plan included details about roles and responsibilities, burglar or fire alarm problems, evacuation plan, loss of staff, police incident, floods, epidemic or pandemic, and water supply problems. The plan was detailed and also included contact numbers for practice staff who held a key for the premises.

We spoke with staff about the business continuity plan and found that not all staff employed at the practice were aware of the plan and its content. Not all staff had been able to tell us what they would do in the event any of the incidents covered in the plan were to occur. We discussed this with the practice manager at the time of our inspection. They told us they would discuss this with staff in the next staff meeting and also during individual supervision sessions with staff.

Equipment

We found that regular equipment checks had been made. We saw evidence that portable appliance tests of electrical equipment at the practice had been carried out to check the electrical safety of equipment.

We saw that the equipment used to monitor patients with chronic disease at the practice had been annually calibrated in line with the manufacturer's guidelines. Contractual arrangements were in place for annual tests and calibration of equipment used by the practice. This included syringe drivers, defibrillator and blood pressure monitors. Records showed that the most recent tests had been completed on 20 March 2014.

Are services effective?

(for example, treatment is effective)

Our findings

Promoting best practice

We saw there was a system in place that showed how the practice shared information with the team when they received national patient safety alerts and NICE (National Institute for health and Care Excellence) guidance. Patient safety alerts are issued to healthcare professionals and identify potential risks to patients from medicines or equipment. NICE sets standards for quality healthcare and produces guidance on medicines, treatments and procedures. These alerts advise healthcare professionals on action to be taken to protect patients from harm. We found that there was no system in place that demonstrated the actions taken by the practice as a result of the national patient safety alerts.

Through discussion with staff and the GPs, the practice were able to evidence that care, assessment and treatment of patients was based on recognised national guidance and best practice such as NICE and Gillick competency. Gillick competence is used by clinicians to decide whether a child is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

The practice had a consent policy in place which included guidance for staff on the Gillick competence and the Mental Capacity Act 2005. The Mental Capacity Act provides a legal framework for acting and making best interest decisions on behalf of adults who lack the capacity to make particular decisions for them. We saw that the policy and procedure had been included in the staff induction pack and staff confirmed they had read this as part of their induction into their post.

Staff told us they received in house training about consent and were fully aware of the need to ensure patients were happy about procedures and well informed so they could make decisions about their treatment.

Management, monitoring and improving outcomes for people

The practice had a system in place and was able to show examples of clinical audits they had carried out. Clinical audits enable the practice to monitor and identify areas in which it can improve outcomes for patients. The practice was able to demonstrate the use of clinical audits and peer reviews to measure performance and analyse outcomes. For example, the practice showed us how they held clinical based discussions about a variety of specialities which included the analysis of planned hospital admissions.

Other clinical audits carried out had included monitoring the medicine of patients with rheumatoid arthritis, uncomplicated Urinary Tract Infection (UTI) management; and Ezetimibe prescribing (a medicine which is used alone or with other medicines to treat high cholesterol levels). Findings had been shared with staff and actions and recommendations had been recorded. However, we found there was no documented evidence of reviews of these audits, so the practice was unable to confirm whether the actions taken had been implemented successfully.

Staffing

Staff who worked at the practice were appropriately qualified to carry out their roles. GPs and nursing staff told us they kept their knowledge and skills up to date through annual appraisals and continuous professional development (CPD).

We looked at records which showed staff training records and CPD that staff had undergone. The records were up to date and included evidence of formal induction that had been done. We saw examples where on-going training and learning needs had been identified. This information showed examples where staff had been provided with training they had requested to support their learning and development.

All three GPs had completed training in the past year. This included infection prevention and control training, safeguarding children and adults to the higher level three, basic life support, CPR (cardiopulmonary resuscitation is a first aid technique that can be used if someone is not breathing properly or if their heart has stopped), and DSE (display screen equipment) risk assessment.

We saw evidence that all GPs had current medical indemnity insurance in place. Similarly evidence of checks that had been carried out on PIN numbers for all nurses employed at the practice and evidence of their medical indemnity had been recorded on the spread sheet.

The Slieve Surgery is an approved GP teaching practice. The senior GP told us they supervised and supported the

work of the trainee GPs when working in the practice. They were available for advice if required and held regular supervision meetings to clarify any learning points as needed.

The lead nurse at the practice had responsibility for managing the practice nurses. This nurse took a lead role to update and review any clinical issues related to work carried out by the nursing teams. For example, the minutes of a clinical nurse meeting held on 31 April 2014 provided evidence of discussions about clinical waste. This followed an incident that had occurred at the practice and guidance had been requested from staff. Staff told us they were referred to the relevant policies and procedures and discussions took place around these.

We found that although staff had received annual appraisals, not all staff had received opportunities to discuss their performance and learning needs through regular individual supervision. From the staff records we saw that clinical staff had been regularly supervised. We found however that administrative staff had not received any supervision in which they could discuss any concerns or issues relating to their work on a routine basis. We discussed this with the practice manager. The practice manager acknowledged that regular supervision of administrative staff could have helped them to identify an issue sooner had regular supervision session been carried out. The practice manager told us that supervision of administrative staff would be implemented to ensure on-going monitoring of staff training and support needs.

Working with other services

The practice was able to evidence joint working arrangements with other appropriate agencies and professionals. For example, palliative care was carried out in an integrated way. This was done using a Multi-Disciplinary Team (MDT) approach with district nurses, palliative care nurses and hospitals. We saw that the Gold Standard Framework (GSF) palliative care meetings were held and recorded. The GSF is a practice based system to improve the quality of palliative care in the community so that more patients received supportive and dignified end of life care, where they chose.

Staff told us that meetings were held with health visitors. We saw evidence of this recorded in the staff meeting minutes where the health visitors shared information about their case loads with the practice.

There was also joint working for child health with the health visitor attached to the practice. Access to other services from other providers such as phlebotomy (taking blood samples), chiropody and counselling support via in house clinics were also provided by the practice. Staff told us that a pilot walk in mental health counselling clinic was proposed at the practice.

Joint working arrangements were in place with the out of hours (OOH) provider to improve outcomes for patients and ensure continuity of care. Staff explained that patients could be transferred to, or directly accesses the OOH provider. We saw that OOH information was shown on the screen displayed in the practice waiting room and via the patient information leaflet. We saw that critical patient information such as terminal care, presence of a DNAR (Do Not Attempt Resuscitation) was shared appropriately with the OOH provider by secure fax, and any information to the practice in return was made available to be reviewed by a GP. Where joint assessments and multidisciplinary meetings took place, information from these meetings was shared with the OOH provider.

GPs and the practice manager confirmed that all incoming clinical letters were seen by the GPs each day. These were read and coded before being stored in the patient record. All blood test and other pathology and radiology reports were also seen and actioned each day by the GPs.

Staff explained that discharge letters were read by the GPs each day. A traffic light system of coding was being established to enable planned patient support from the practice. For example, a colour coding system would determine the frequency of contact required for each patient.

Health, promotion and prevention

We saw that a variety of health promotion and disease prevention information was available in the practice waiting room and displayed in the treatment rooms. Information was provided in the waiting room on the display screen and in leaflets that patients could take away with them. This included information about services available to patients such as smoking cessation, weight reduction, dietary advice as well as exercise and counselling services. Patients who were aged 75 or over who do not see the nurse regularly were offered yearly checks. Patients over the age of 16 were offered well man or well woman checks every three years.

Are services effective?

(for example, treatment is effective)

Further information on health promotion and screening was provided in the patient leaflet. For example, patients with long term conditions were advised that they should have regular checks at least twice a year. The practice identified long term conditions such as diabetes, hypertension, heart disease, stroke and asthma. Clinics for these and other conditions were held weekly at the practice.

There was a recall system in place for cytology screening checks which were carried out by the practice. Cytology screening tests look for pre-cancerous, abnormal internal tissue or cell changes in women. Breast screening was offered by the local breast screening unit at the City hospital, for all women aged between 50 and 70 years of age. We saw information was available that encouraged patients to contact their GP should they become concerned or worried about any changes in their breast. Staff confirmed the recall and screening processes.

We saw evidence that the practice identified where patients with long term conditions were supported by a carer. This information was recorded on a template so that checks could be made with carers to identify whether they were getting enough or needed support.

New patients were given a health check on registration at the practice. Nursing staff explained that they carried out checks for existing conditions and to identify any new issues which would be referred to the GP. We spoke with patients who had recently joined the practice and they confirmed they had received a new patient check-up.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients confirmed they were treated with dignity and respect. During our inspection we observed that staff interacted with patients in a polite and respectful way. Staff told us it was important to them that they made sure patients' dignity was maintained at all times.

During our inspection we spoke with 13 patients and reviewed 63 comment cards that patients had completed and left at the practice. Patients we spoke with during the inspection were very positive about the staff who worked at the practice. Staff were described as great, patients told us they felt safe and that they had confidence in the staff. We received positive feedback from the care home with residents registered at the practice. They told us that staff were always very helpful and that GPs treated patients at the home with respect, dignity and compassion. They told us that the GPs always listened to any concerns they may have and offered support and advice when needed.

The waiting room at the practice was comfortable and spacious. Information was made available on the screen display, and leaflets for health promotion were available for patients to take away with them should they wish to do so. Reception staff told us they respected confidentiality and if patients wanted to speak with them in private they would take them into a side room. Patients told us that they had no concerns about their privacy or confidentiality, and that their dignity had always been respected.

The practice provided support for patients, their families and/or carers for those who were receiving end of life care. We spoke to the manager of the residential home whose residents were registered patients with the practice. They told us that the GP was very sensitive to the needs of family and carers, and would take the time to talk with them. The GP advised us that if patients wanted information relating to bereavement counselling services the reception staff would help them. Reception staff told us they would search and obtain information about local services and groups when requested. Staff told us that there was a system in place to alert them when patients had died so they were able to avoid the possibility of making insensitive remarks.

Involvement in decisions and consent

Through discussion with staff and the GPs, the practice were able to evidence that care, assessment and treatment of patients was based on recognised national guidance and best practice such as NICE and Gillick competency. Gillick competence is used by clinicians to decide whether a child is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

The practice had a consent policy in place which included guidance for staff on the Gillick competence and the Mental Capacity Act 2005. The Mental Capacity Act provides a legal framework for acting and making best interest decisions on behalf of adults who lack the capacity to make particular decisions for them.

The consent policy provided guidance to staff when they gave care and treatment to patients. This policy made reference to the Gillick competency for assessing whether children under 16 were mature enough to make decisions without parental consent. This allowed professionals to demonstrate that they had checked a person's understanding of proposed treatment, and used a recognised tool to record the decision making process. The GP told us that they had no current examples where they had needed to apply the Gillick competency.

We saw that the policy and procedure had been included in the staff induction pack and staff confirmed they had read this as part of their induction into their post. Staff showed that they understood the importance of involving patients in their care and respected their wishes if they wanted their relatives to be involved. For example, the practice nurse confirmed that benefits and risks for immunisation were explained to parents and parental consent was obtained before immunisation was given.

Staff told us they received in house training about consent and were fully aware of the need to ensure patients were happy about procedures. Clinical staff told us they made sure patients were given information to help them make informed decisions about their treatment. Some of the staff at the practice were multi- lingual and were able to communicate with patients in their own preferred language.

We spoke with the manager of the local residential care home where some of the residents who were registered with the practice had dementia. The manager told us they

Are services caring?

had no concerns about the way in which the practice managed patients with dementia. They told us that the practice were very supportive, respectful and gave patients time when they visited them at the home.

Patients told us that they were always involved in discussions about their healthcare and that referrals had been made to other services as necessary. Patients told us that treatment options had also been discussed with them in a way they understood and felt they were always listened to by the GPs and the practice staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice understood the needs of the population registered with them and responded to patients' needs accordingly. The practice population was also ethnically and culturally diverse and the practice looked to manage their services to reflect the diversity of patients. For example, staff told us they had supported patients with their diabetes management through Ramadan. Ramadan is the month of the Muslim year, during which strict fasting is observed from dawn to sunset.

Where patients did not speak English as a first language interpreter services were available to support patients to access health care. Some of the staff (clinical and administrative) were able to speak more than one language and would translate with the patient's consent.

The percentage of patients aged 65 and over registered with The Slieve Surgery was higher than the England average according to information from NHS Sandwell and West Birmingham Clinical Commissioning Group (CCG). Staff told us that home visits for older patients who were unable to get to the surgery were available and housebound patients were able to order repeat prescriptions over the telephone. Home visits were also arranged for various conditions such as flu vaccinations, chronic disease management checks, hypertension management, asthma, and blood tests. This included weekly visits to the local residential care home. Patients who were aged 75 or over who did not see the nurse regularly were offered annual health checks.

The practice offered a range of clinics and services that included travel advice and immunisations, cervical smears, asthma, diabetes, smoking cessation, child health and child immunisations to its patients.

There was also joint working for child health with the health visitor attached to the practice. Easy access to other services from other providers such as phlebotomy (taking blood samples), chiropody and counselling support via in-house clinics were also provided by the practice. Staff told us that a pilot walk in mental health counselling clinic was to be trialled at the practice.

Access to the service

The Slieve Surgery was accessible to patients, situated on the ground floor of the premises. The waiting room at the practice was comfortable and spacious. Information was made available on the screen display, and leaflets for health promotion were available for patients to take away with them should they wish to do so. We saw that a hearing loop induction system was available for patients with hearing difficulties. Staff told us they regularly supported some of the patients to use this when they attended for appointments at the practice.

The waiting room and corridors provided space for patients who used a wheelchair or walking aid to access the practice easily. One of the counters in the reception area had been lowered so that patients who used wheelchairs had access to speak with the receptionist directly. There were disabled toilet facilities with emergency alarms fitted, and disabled parking spaces were available.

The practice opened from Monday to Friday from 8am – 6pm and Wednesdays 8am – 5pm each week. The practice provided extended hours from 6.30pm – 8pm on Thursdays. All clinics were available by appointment and patients could book these on the telephone or at the reception desk at the practice. Telephone consultations were also provided at agreed times with the patient.

Staff told us that patients who required urgent appointments could access services the same day. Reception staff completed an 'I want' appointment form and the operational manager would telephone the patient to obtain further information from them. These appointment requests were then brought to the GPs attention who responded to the request accordingly.

The practice offered a Choose and Book option for patient referrals to specialists. The Choose and Book appointments service aims to offer patients a choice of appointment at a time and place to suit them. Patients could choose where they attended for specialist appointments.

The practice provided co-ordinated and integrated care for the patients registered with them. They held a range of clinics to provide help and support for patients with long-term conditions such as diabetes, hypertension and asthma. Other clinics offered include patients smoking cessation, weight reduction, dietary advice, minor surgery, child health care and immunisation. The practice also hosted clinics run by health visitors and Birmingham Healthy Minds.

Are services responsive to people's needs?

(for example, to feedback?)

We saw evidence that the practice identified where a patient with long term conditions were supported by a carer. This information was recorded on a template so that checks could be made with carers to identify whether they were getting enough or needed support. These forms were completed by people who had caring responsibilities or by patients who had appointed carers. Examples were given by staff of carers for patients with Learning Disabilities, patients with dementia and mental health problems.

Concerns and complaints

We saw that 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. The practice manager was the designated person responsible for responding to all complaints for the practice.

We saw that all complaints received had been managed according to the complaints procedure for the practice. An annual overview of complaints had been completed for complaints received throughout 2013. This overview gave a summary of the nature of the complaint and the action taken to resolve the complaint. The nature of these complaints was analysed so that any themes, trends and training needs could be identified and appropriate action could be taken.

Staff confirmed they understood the complaints procedure and what action they would take should a patient wish to make a complaint. Staff told us that if a patient wanted to make a complaint they would discuss this verbally with them and give them a complaint form to complete. Staff told us that the practice would get back to the complainant within two days to acknowledge the complaint.

Staff told us they were made aware of all complaints received. These were discussed in significant events meetings, where any learning was identified and action taken to make the changes required as a result of the complaints.

We found that information about the complaints procedure was available to patients in the practice leaflet.

Staff confirmed that it was usual practice for patients to talk to receptionists about complaints and for the receptionist to provide patients with a copy of the complaints form. However, complaints leaflets were not freely available for patients to complete should they wish to remain anonymous, which may discourage patients from sharing concerns or providing feedback.

Are services well-led?

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

Our findings

Leadership and culture

Staff told us that there was a positive culture and focus on quality at the practice. There was a clear and visible leadership and management structure in place, and staff said that they felt supported in their roles. We saw examples where staff had been supported and encouraged to develop their skills. Their efforts had been rewarded and they had been promoted within the practice. We spoke with a GP who confirmed that there was an open and transparent culture of leadership, encouragement of team working and concern for staff well-being. They told us they felt well supported and motivated as a result.

The practice had a clear vision and strategy, which it had developed together with other practices in the area, called 'Active Care'. Active Care worked to the principle of proactive integrated care for patients at high risk especially in two areas. These areas were the over 65's patient group (screening for loneliness), and integrated discharge planning with acute hospitals and co-ordinated post discharge care.

Governance arrangements

All staff had access to policies, procedures and clinical guidelines either through paper copies which were stored in files or through information available on the practice's intranet. All documentation on the intranet and the paper copy files were kept up to date with dates for reviews recorded. Staff told us they were able to access either when they needed information or were guided to read the latest information. We saw from staff meeting minutes that changes and updates were discussed and staff confirmed these discussions took place.

Staff told us they were clear about their roles and responsibilities and knew who they should refer to on occasions where their responsibilities were exceeded. We saw from policies and procedures that clear processes were in place with lead staff identified. For example, lead infection control and lead safeguarding personnel were identified utilising staff skills and expertise.

Systems to monitor and improve quality and improvement

We saw evidence of Quality and Outcomes Framework (QOF) targets and action taken in relation to the consistent performance of the practice over the past 12 months. QOF is the annual reward and incentive programme which awards practices achievement points including the management of chronic disease, such as asthma and diabetes.

The practice was able to evidence through discussion with the GPs and via documentation that there was a clear understanding among staff of safety and of learning from incidents. Concerns, near misses, Significant Events (SEs) and complaints were appropriately logged, investigated and actioned. For example, an incident where a patient had suffered a bleed due to a side effect of medicine they were taking. This led to a change in policy in February 2014 for monitoring patients on this medicine. GPs from the practice attended local clinical groups which met regularly and reviewed clinical issues. This ensured the practice clinical staff stayed up-to-date with local health economy clinical issues.

The practice also regularly carried out clinical audits internally, such as medicine monitoring of patients with rheumatoid arthritis, uncomplicated Urinary Tract Infection management, and Ezetimibe prescribing (medicines that are used alone or with other medicine to treat high cholesterol). We saw these audits for 2014. Findings were shared with staff and actions and recommendations were recorded. However, there was no documented evidence of reviews for these audits, so the practice was unable to confirm whether the actions they had taken had been implemented successfully.

Patient experience and involvement

The practice operated a patient participation group (PPG) which met four times per year. PPGs are a way in which patients and GP practices can work together to improve the quality of the service. We spoke with two members of the PPG during our inspection. They told us that they held monthly meetings and discussions about any issues arising from complaints received were discussed during these meetings. The results of the annual patient questionnaire were also shared by the practice with the PPG to inform their discussions.

During the inspection we spoke with 13 patients who told us they were happy with the service they received. We also received positive comments from 90% of the comments cards that patients or their relatives had completed. The negative comments mainly reflected individual difficulties with access to appointment times. Comments included that on occasions they had had to wait for their

Are services well-led?

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

appointment with the GP, in excess of half an hour in one instance. This was discussed with the practice manager who advised that staff were encouraged to explain to waiting patients when a delay had occurred and offer to rearrange appointments. Staff told us that they followed this procedure but generally patients had chosen to wait rather than rearrange their appointment.

Practice seeks and acts on feedback from users, public and staff

The practice responded to information from the patient participation group (PPG) and demonstrated to us that action had been taken. For example, we saw from the PPG report of January 2014 how responses to the survey questionnaires had been collated, analysed and an action plan had been produced. We saw that one of the actions identified the need for improved access to appointments at the practice. This had been given priority and changes had been made to the range and number of appointment times for patients as a result of this.

We saw from minutes that staff meetings took place every two weeks. Practice discussions and information sharing took place during these meetings. Staff told us that they felt able to make contributions and suggestions at all times, and their views were actively sought and acted upon.

Management lead through learning and improvement

Regular staff and team meetings took place to provide for continued learning and improvements. For example, nursing staff management meetings took place three monthly and meetings for all staff were held fortnightly.

We saw how the practice responded to areas that needed to be improved. For example, a management meeting took place on 7 April 2014 in which the Quality and Outcomes Framework (QOF) was discussed. The QOF rewards GPs for implementing 'good practice' in their surgeries. The QOF showed a poor rating for The Slieve Surgery in relation to the identification of diabetes. From this meeting action was taken to train a member of the nursing staff to carry out diabetic checks. A specialist nurse and a GP now regularly attend the practice to review patients with poorly controlled diabetes. One of the GPs at the practice had completed a diabetes course at Warwick University, and another GP planned to commence training this year.

Identification and management of risk

We found the practice to be open and transparent, and prepared to learn from incidents and near misses. Three monthly significant events meetings were held where these were discussed. Lessons learned from these discussions were shared with the team. We saw the system in place for the dissemination of safety alerts and National Institute for Health and Care Excellence (NICE) guidance. Although the system in place for safety alerts was organised there was no action log in place to demonstrate what actions had been taken as a response to these.

The management of the practice were clear about the future of the practice and the changes that were necessary. It was clear that they had introduced a skill mix and additional nursing services in response to recent staff shortages. They told us that staffing arrangements had been included in their succession plans to meet the future demands of the practice population.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

Staff told us that patients in this population group were given priority access to appointments on the same day. There were aids and adaptations in place to support patients with their needs. For example, there was an induction loop in reception for patients with hearing difficulties. Further facilities included disabled toilets, wheelchair access and disabled parking spaces. There was also a chair reserved in reception for elderly and disabled patients. We spoke with some patients in this population group during the inspection. They confirmed they were always able to get an appointment when they needed one and that the surgery was accessible to them.

Staff told us that home visits for older patients who were unable to get to the surgery were available and housebound patients were able to order repeat prescriptions over the telephone. Home visits were also arranged for various conditions such as flu vaccinations, chronic disease management checks, hypertension management, asthma, and blood tests. Patients who were aged 75 or over who did not see the nurse regularly were offered annual health checks.

The practice sought to arrange better support services to help prevent emergency admissions of patients into hospital. Multi-disciplinary team meetings (MDT) meetings were held regularly to share information about patients at risk. This also involved screening patients for signs of loneliness and working together with other services to provide coordinated discharge planning and care for patients. The practice was able to evidence joint working arrangements with other appropriate agencies and professionals. The practice worked with district nurses, palliative care nurses and hospitals to improve the quality of palliative care in the community so that more patients were able to receive supportive and dignified end of life care.

There was also a system in place where referrals were made by the practice to the community matron or non clinical case manager to arrange better support services for patients where this was needed. For example, housing support carer workers going in to see patients, to help for example with food shopping, and arranging access to other voluntary or social services.

The practice looked after patients that lived in a residential home for older people. The main GP undertook visits each week at the home. We spoke with the home manager who told us they were satisfied with the level of support they received from the practice. They described the GP as caring and kind and that they listened to what they had to say and dealt with any concerns promptly.

Patients were also offered health checks when attending the practice. The practice actively targeted older patients to attend the practice for flu vaccinations. We spoke to the practice nurse who told us that health promotion information would be given when patients attended for flu vaccinations.

Patients told us they were always able to get an appointment when they needed one and staff confirmed priority access was given to older patients. Joint working arrangements were in place with the out of hours (OOH) provider to improve outcomes for patients and ensure continuity of care.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

There was a system in place for monitoring and reviewing patients with long term health conditions. Regular clinics were held by the practice. These included chronic disease management clinics, B12 clinics (Vitamin B12 or foliate deficiency anaemia can cause a wide range of symptoms), minor surgery clinics, a recall system for Zoladex patients (Zoladex is a hormonal therapy used to treat prostate cancer, breast cancer and some other conditions). There were also routine health checks, long term conditions management, and influenza and immunisation clinics. An asthma trained nurse was available at the practice to support and advise patients on their conditions.

The recall of patients was achieved through a systematic and opportunistic approach to consultations. We found that appointment days and times for patients with long term conditions were flexible to accommodate patients' preferences. Staff told us they achieved a higher compliance rate by providing appointments at times that suited the patient.

The practice was running a pilot scheme for patients with diabetes; a diabetes specialist nurse and a GP held clinics every two to three months for patients with poor diabetes management. This service was provided at the practice and had improved accessibility and greater attendance for patients.

There was a system in place for issuing repeat prescriptions for those patients who were on long term medicine. Staff told us that repeat prescription reviews were carried out to monitor both the prescribing of medicines and patients' conditions. The computer system flagged an alert when a review of a patient's medicine was due and the patient was reminded to make an appointment so that a review could be carried out. Some of the patients we spoke with who were on long term medicines told us that they had regular reviews with the GP about their medicines and their conditions.

We saw evidence that the practice identified where patients with a long term condition were supported by a carer. This information was recorded on a template so that checks could be made with carers to identify whether they were getting enough or needed more support.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice had systems in place to offer co-ordinated care for this population group. There was joint working for child health with the health visitors and the midwifery team in the provision of care to mothers and young children. The health visitors told us the practice staff supported them with their well-baby clinic and they could always speak to the GPs if they needed to. Staff demonstrated knowledge of the need to respond quickly and prioritise sick children who required more urgent appointments.

Staff at the practice told us that two well-baby clinics were held each month, and where a child failed to attend a clinic or a hospital appointment the GP would follow this up. Children were automatically sent appointments to attend immunisation clinics by the local Health Authority. Information about the immunisation schedule for babies was available on the website, on the screen displayed in the waiting room and through practice leaflets available for patients to take with them if they preferred.

There was a recall system in place for cytology screening checks which were carried out by the practice. Cytology screening tests look for pre-cancerous, abnormal internal tissue or cell changes in women. We saw information was available that encouraged patients to contact their GP should they become concerned or worried about any changes in their breast. Staff confirmed the recall system in place for screening of patients.

We found that children were protected from the risk of abuse because the practice had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. We saw certificates that showed staff had received training in safeguarding children at a level appropriate to their role. Staff told us they knew what they would do if they suspected a child was at risk of abuse. There was an up to date policy in place for safeguarding children which clearly identified a children's safeguarding lead within the practice.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice had an appointment system in place that ensured patients of working age and those recently retired would be able to make an appointment to see a GP at times more suitable for them. We spoke with patients of this population group during our inspection. We were told that they had been able to get appointments as they needed them. The PPG report for 2014 showed that feedback from annual surveys had indicated that there were not sufficient appointment times available for this population group. Changes were made in response to this feedback.

The practice now provided a late evening clinic every Thursday, early morning clinics and telephone consultations if needed. Patients within this population group were now able to fax requests for repeat prescriptions, and there was a cancellation line to text and cancel an appointment if the patient was at work and unable to call the practice direct. The practice manager told us that a leaflet had been created to provide details of nearby walk in phlebotomy (taking blood samples) clinics, which would be available for patients to attend should that be more convenient.

There was a proactive cervical screening programme in place for women aged 25 years and above and a robust system in place for following up the results and outcomes of cervical screening tests. Breast screening was offered by the local breast screening unit at the City hospital, for all women aged between 50 and 70 years of age.

Staff told us they followed the procedure and informed patients of potential delays but generally patients had chosen to wait rather than rearrange their appointment. Staff told us there was an understanding of patients' work commitments and they tried to accommodate out of work hours appointments for patients. Staff told us they were trained to make patients aware at time of their arrival if the clinician was running late. On these occasions patients were given the choice to wait or re-book their appointment in case they needed to go back to work.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

We found the practice had systems in place to support patients who were vulnerable. We saw that the practice was proactive and shared information with health visitors where there were concerns about children considered at risk of abuse.

Staff told us they had completed training in safeguarding vulnerable adults and children. We saw certificates that showed that staff had received training in safeguarding children and vulnerable adults. We saw that the senior or lead GP had completed level three (the highest level for safeguarding children). Staff confirmed they would take action and share their concerns with the lead GP. We were told that concerns were shared with the local safeguarding authority, whose role is to investigate and act on any safeguarding concerns.

Staff told us that the practice used an alert system on patient records to alert them to those patients who were considered to be at risk. We saw evidence of the alert system used on the computer at the practice that showed where a patient was at risk or identified as a safeguarding concern.

We saw evidence that the practice identified where a patient with a long term condition was supported by a carer. Staff told us that carers' contact details were recorded in patient notes where there were concerns about a patient's mental capacity. This enabled the practice to involve carers in best interest decisions for patients who lacked capacity to make decisions for themselves.

The practice population was both culturally and ethnically diverse. The practice demonstrated sensitivity for patients whose first language was not English. They provided an interpreting service through Birmingham Integrated Language and Communication Services to ensure that patients fully understood their conditions and how to manage them. Some staff employed by the practice were multi-lingual and were also able to support patients where appropriate.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

We spoke with one of the GPs about how they managed patients experiencing a mental health crisis. The GP advised us that they had good support from the local NHS mental health service and would refer patients to them for an assessment if they had any concerns. Staff told us that arrangements were in progress to pilot a walk in mental health counselling clinic at the practice.

Staff told us that annual mental health check-ups were offered to patients with mental health concerns. Patients were also offered appointments with the in house counselling service provided by Birmingham Healthy Minds each week at the practice.

Staff told us that they were aware of the need to be understanding and be extra patient when responding to patients with mental health needs. We were told that patients with mental health needs were given 20 minute appointments as they may need longer time with the GP. We saw an example where this occurred during the inspection.

Carers of patients experiencing poor mental health were also monitored and kept under review so that support was provided when the need arose.