Featherstone Medical Centre

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Featherstone Medical Practice on 12 May 2015. The overall rating for the practice is good. We found the practice to be good in the safe, effective, caring, responsive and well-led domains. The practice is rated good for the population groups:

- Older people
- People with long term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Our key findings were as follows:

- Systems were in place to ensure that all staff had access to relevant national patient safety alerts. Infection prevention and control systems were managed and staff had received appropriate training.
- Staff received support, appraisals and role specific training to ensure they carried out their roles effectively. GPs carried out clinical audits to check that patients received appropriate care and treatment.
- Staff were friendly, caring and respected patient confidentiality. Patients we spoke with said that all staff were compassionate, listened to what they had to say and treated them with respect. Patients told us they were satisfied with the care they received. Staff worked together as a team to ensure they provided safe, co-ordinated patient care.
- There was a register of all vulnerable patients who were reviewed regularly. Patients who had long term conditions were regularly reviewed. GPs carried out clinical audits and made changes to patients care and treatments to ensure best practice. Information and feedback from patients was used to develop good systems of care.
- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. This was evident when speaking with staff and patients during our inspection. There was a clear leadership structure with named staff in lead roles.

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as requires improvement for providing safe services. The practice had a good track record for safety. There was effective recording and analysis of significant events and lessons learnt were cascaded to all relevant staff for prevention of recurrences. There were robust safeguarding measures in place to help protect children and vulnerable adults. Systems were in place for the safe storage and use of medicines and vaccines within the practice. There were designated leads to oversee the hygiene standards within the practice to prevent infections. Staff recruitment checks had been carried out to clarify that staff were suitable to work with vulnerable people before they commenced employment.

Are services effective?

Good

The practice is rated as good for effective services. Practice staff took account of clinical guidelines such as National Institute for Health and Clinical Excellence (NICE) when providing care. Patients' needs were assessed and care was planned appropriately to meet their needs. There were effective arrangements to identify, review and monitor patients with long term conditions. Staff received training that was appropriate to their roles and ensured staff skills and knowledge were kept up to date. Staff appraisals were carried out which identified their personal development needs. Health promotion and prevention was actively encouraged within the practice. Multidisciplinary working is evident to ensure patient needs are appropriately met.

Are services caring?

Good

The practice is rated as good for caring services. We saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. Patients we spoke with confirmed this. The practice had access to interpreters. Practice staff spoke a number of languages to assist patients in understanding their needs. Patients told us they were happy with the standards of care they received. There were arrangements in place to provide patients with end of life care that respected patients' needs and wishes.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice made use of information to understand and respond to the needs of their local population. They had achieved Quality Outcomes Framework (QOF) points similar to or above the national average. QOF is a voluntary national performance target for managing some of the most common chronic diseases, for example

Summary of findings

asthma and diabetes. The practice was accessible to patients with mobility restrictions and other needs. There was a Patient Participation Group (PPG). The PPG is a way in which patients and GP practices can work together to improve the quality of the service. The practice carried out annual patient surveys and other specific clinical surveys. The outcomes from these resulted in changes having been made for improvements in patient care.

Are services well-led?

Good

The practice is rated as good for being well led. All staff worked closely together to innovate and promote continuous improvements. There was strong leadership with a clear vision and purpose. All staff were encouraged and involved with suggesting and implementing ongoing improvements that benefitted patients. Staff were clear who made decisions and followed appropriate paths of accountability. The practice had a number of policies and procedures in place to govern activity and regular governance meetings take place. There were systems in place to monitor and improve quality and identify risks to the service. We saw evidence that the practice seeks feedback from patients and staff and acts on it where appropriate.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for care of older people. Patients over 75 years old had a named GP to help co-ordinate their care. Patients over the age of 75 years were offered health checks. There were arrangements to review patients in their own home if they were unable to attend the practice. Care plans were in place for patients who were at risk or had complex health needs to monitor and review their health needs. Patients with complex care needs and at high risk of admission had been identified so that they could be appropriately supported to live at home and avoid admission to hospital. The practice worked with the palliative care team through monthly meetings to provide support to patients receiving end of life care.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Practice staff supported patients to receive co-ordinated, multidisciplinary care whilst retaining an oversight of their care. Patients with long term conditions were regularly reviewed and any changes in their care needs were cascaded to other involved professionals to ensure integrated care was provided at all times. Staff kept a register of patients with long term conditions and those who had carers so that they could be offered support. When needed, longer appointments and home visits were available.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Practice staff worked with health visitors and community midwives who provided ante-natal clinics at a nearby practice. There was a safeguarding policy in place for children and adults that included principles and definitions of the different types of safeguarding concerns. The GP who was the lead for safeguarding had received appropriate training. Clinical sessions included outside of school hours for children to attend the practice. The childhood vaccination programme was encouraged and undertaken by practice staff.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age people (including those recently retired and students). There were extended evening hours each Monday until 7pm. The

Summary of findings

practice was proactive in offering on-line services for making appointments and ordering repeat prescriptions. Patients were offered a 'choose and book' service when they were referred to hospital outpatient services. This system gave them greater flexibility about when and where they were referred to. The practice carried out NHS health checks for patients between the ages of 40 and 74.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. Practice staff discussed patients in vulnerable circumstances at joint meetings with relevant health and social care professionals to ensure they received appropriate care and support. The practice held a register of patients living in vulnerable circumstances including those with a learning disability and carried out regular health checks to ensure their needs were being met. There was a register of carers who cared for vulnerable patients to provide them with support. A GP explained how they sign posted carers to support agencies.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Care was tailored to patients' individual needs and circumstances, including their physical health needs. Annual health checks were offered to patients with serious mental health illnesses. GPs had the necessary skills and information to assess and treat or refer patients with poor mental health. Practice staff had recognised the need and provided health checks and support for patients who had dementia.

Summary of findings

What people who use the service say

We spoke with six 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 that they were given information about their health status in a way they could understand. They told us 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. They informed us they were satisfied with the opening times and their ability to book appointments.

We collected 21 patient comment cards on the day of the inspection. Most of the comments were positive regarding the care they received, appointments and helpfulness of staff. Two patients had made negative comments about the practice. These were in relation to communication and delays in waiting to be seen.

We looked at results of the GP patient survey dated 2014. Findings of the survey were based on the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. The latest results were:

- 70% of respondents would recommend the practice, the local CCG average was 76%,
- 70% were satisfied with the opening times, the local CCG average was 73%,
- 96% felt it was easy to get through by telephone, the local CCG average was 69%,
- 81% had good or very good experience for making an appointment, the local CCG average was 68%.

The practice had a Patient Participation Group (PPG). PPGs can be a way for patients and practice staff to work together to improve services and promote quality care. We spoke with the chairperson of the PPG. They told us they were influential in encouraging the practice to review and improve the service they provided. The person told us they had an open and good relationship with practice staff who responded positively to suggestions. For example the introduction of patient information folder for patients to refer to when they were waiting to be seen. The file contained a large amount of practice information and details about support groups for long term conditions.

Featherstone Medical Centre

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 Featherstone Medical Centre

The practice provides primary medical services to approximately 1900 patients in the local community.

Both partners are male and one of the three regular locums is a female GP. Two practice nurses and a health care assistant are employed. The practice manager is supported by four receptionist staff who worked varying hours.

The practice has a General Medical Service (GMS) contract with NHS England. A GMS contract means that patients are registered with the practice and not an individual GP (with the exception of those aged 75 years or more) but the practice will focus on delivery of quality clinical care and well managed services.

The practice offers a range of clinics and services including, asthma, child health and development, contraception, chronic obstructive pulmonary diseases (COPD) and minor surgery.

The practice opening times are Monday from 8.30am until 7pm, Tuesday and Friday from 8.30am until 6.30pm and until 1.30pm each Wednesday and Thursday.

The out-of-hours services were provided by South Doc and Primecare on behalf of the 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

- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before our inspection, 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 12 May 2015. During our inspection we spoke with a range of staff including one GP, a practice nurse, the practice manager and two reception staff. We spoke with the visiting drug misuse professional who worked in conjunction with the senior GP each week. We spoke with six patients who used the service and observed, how patients were being cared for and staff interactions with them. We looked at care and treatment records of patients. Relevant documentation was also checked. Patients had completed 21 comment cards giving their opinion about the service they received. We spoke with the chairperson of the Patient Participation Group (PPG) who told us their experience not only as a member of the PPG but also as a patient of the service. The PPG is a way in which patients and the practice can work together to improve the service.

Good

Are services safe?

Our findings

Safe Track Record

We spoke with six patents about their experience at the practice. None of the patients we spoke with reported any safety concerns to us.

Practice staff used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. The management team, clinical and non-clinical staff told us that they shared information about significant events between each other so that all relevant staff learnt from incidents and reduced the likelihood of recurrences.

We reviewed safety records and incident reports for the previous 12 months. We spoke with clinical and non-clinical staff about incidents that had occurred. They demonstrated knowledge of them and an open culture between each staff grade to show that efforts were made to consistently reduce the risks to patients.

Learning and improvement from safety incidents

There was a system in place for reporting, recording and monitoring significant events. A recent significant event had been recorded where there had been a delay in prescribing a medicine. A system was put in place that provided written guidance and a template was developed for each GP to use for prescribing a specific type of medicine to ensure that these medicines were prescribed when needed.

Clinical staff spoken with confirmed that significant events, incidents and complaints were discussed regularly with staff and they were able to give some examples. We saw recordings to confirm this.

National patient safety alerts were disseminated by the practice manager to relevant staff. Safety alerts were discussed with staff to ensure all were aware of any that were relevant to the practice and where action needed to be taken. All staff spoken with knew where patient safety alerts were kept so they could refer to them.

Reliable safety systems and processes including safeguarding

The practice had a lead GP appointed for safeguarding vulnerable adults and children. All clinical staff had had been trained to the appropriate level in safeguarding to enable them to fulfil their roles. Practice training records made available to us showed that all non-clinical staff had also received relevant role specific training on safeguarding. All staff we spoke with were aware who the lead was and who to speak with if they had concerns about patient safety.

We saw that there was a policy regarding the protection of vulnerable children and adults. The practice manager acknowledged that the policy did not contain enough information to provide adequate staff guidance and assured us they would further develop it.

Staff were aware of their responsibilities regarding information sharing and documentation of safeguarding concerns and were aware that they should contact the relevant agencies in or out of hours. Contact details of agencies were easily accessible to staff in the reception area.

Community staff including health visitors were invited to attend the regular clinical meetings so that patients who were considered to be at risk could be discussed. There was close co-operation with health visitors which helped to identify children at risk and help keep them safe. An alert was included on the file of those who were at risk so that they could be easily identified.

We saw that a chaperone policy was in place. Chaperone duties were usually undertaken by nursing staff or the health care assistant but if not available reception staff would carry out the role. A chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure. Non-clinical staff had received chaperone training so that they were aware of the role and responsibilities of a chaperone. The practice manager had carried out risk assessments of non-clinical staff who carried out chaperone duties to establish if a Disclosure and Barring Scheme (DBS) check was necessary. We saw chaperone notices were displayed in all clinical rooms and the waiting area of the practice. Some patients we spoke with were aware that they could have a chaperone if needed.

Medicines Management

Good

Are services safe?

Patients were able to order repeat prescriptions on line, by fax, by email, in person or via their local pharmacy. Patients we spoke with said they were happy with the system. 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.

We found that vaccines were stored within the recommended safe temperature range in a lockable fridge. Temperature checks were taken and recorded each day. Medicines were kept within locked cupboards.

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

GPs kept medicines for use in an emergency in their bags for when they visited patients in their own homes. For example, treatment for anaphylaxis (allergic reactions). The medicines had been routinely checked and recordings made to ensure they remained safe for use and within their expiry date.

Cleanliness & Infection Control

We observed all areas of the practice to be clean, tidy and well maintained. The practice had an infection prevention and control policy (IPC) and there was a responsible lead. We saw evidence that staff had training in IPC to ensure they were up to date in all relevant areas. Aprons, gloves and other protective equipment were available in all treatment areas as was hand sanitizer and safe hand washing guidance.

The named IPC lead in the policy was the senior GP; however the practice nurse and practice manager carried out infection control audits each year for all areas of the practice.

We saw that cleaning schedules for all areas of the practice were in place. These had been signed when work had been completed.

We found that suitable arrangements were in place for the storage and the disposal of clinical waste and sharps. Sharps boxes were dated and signed with the date of use to enable staff to monitor how long they had been in place. A contract was in place to ensure the safe disposable of clinical waste.

We saw that there were good supplies of protective personal equipment (PPE) available, such as gloves and aprons. Staff we spoke with confirmed that there were always adequate stocks of PPE.

All clinical staff had attended training on infection control to equip them with the skills needed. Arrangements were in place for non-clinical staff to complete on-line training.

A legionella risk assessment had been carried out. Legionella is a germ found in the environment which can contaminate water systems in buildings. The risk assessment did not identify any risks.

Equipment

The clinical staff we spoke with told us they had sufficient equipment to enable them to carry out their duties including, assessments and treatments. The practice manager told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and we saw documentary evidence of this dated September 2014. We saw evidence of calibration of relevant equipment; for example a blood pressure monitor.

Staffing & Recruitment

The practice manager confirmed that most of the staff had worked at the practice for a number of years which provided stability within the staff team and ensured patients received continuity in their care.

There were systems in place to monitor and review staffing levels to ensure any shortages were addressed and did not impact on the delivery of the service. Non-clinical staff were able cover each other's annual leave. Nursing staff did not have cover during their absences but patient's appointments were arranged so that their care needs were not compromised. The two partner GPs provided cover for each other during absences. The regular locums would undertake extra clinical sessions and other locum GPs were used when needed.

We looked at seven staff files, including the file of the most recent member of staff employed at the practice. There was evidence that appropriate pre-employment checks were completed prior to staff commencing their post. This included photographic identity, references and a Disclosure and Barring Service (DBS) check at an appropriate level for the role and responsibilities. The DBS

Good

Are services safe?

check is a criminal records check that helps identify people who are unsuitable to work with children and vulnerable adults. Non-clinical staff had been risk assessed to ensure patient safety when this staff group spoke with patients.

Monitoring Safety & Responding to Risk

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

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk.

Staff had received regular fire safety training and participated in regular fire drills to maintain their knowledge of how to respond in an emergency. We saw that fire escape routes were kept clear to ensure safe exit for patients in the event of an emergency.

Arrangements to deal with emergencies and major incidents

Staff at the practice had received training in medical emergencies such as basic life support. The practice had a defibrillator on standby for dealing with medical emergencies. These were checked regularly to ensure they were fit for purpose.

Emergency medicines and equipment were kept in clinical rooms and staff knew where they were stored. We saw information that confirmed they were regularly checked and that the medicines remained in date and fit for administration.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and actions recorded to reduce and manage the risk. Risks identified included power failure, computer failure, and access to the building. Areas of responsibility for staff were identified along with risks and actions recorded to reduce the risk. The document also contained relevant contact details for staff to refer to.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We discussed effective patient management with a GP. They explained how they ensured best practice by following published national and local guidelines. For example, National Institute for Health and Care Excellence (NICE). We saw that any revised NICE guidelines were identified and shared with all clinicians appropriately.

Patients with long term conditions were reviewed by the GPs and practice nurses to assess and monitor their health condition so that any changes needed could be made. Practice nurses carried out immunisations of children and adults.

The GPs, practice nurses and the health care assistant had the facility to offer longer appointments where they thought this would be helpful. Due to the size of the practice staff knew the patients and those with long term conditions and they knew when longer appointments were needed. Staff could therefore ensure more in-depth assessments were carried out to ensure patients received appropriate treatment.

Unplanned hospital admissions were 192.5 patients per 1000 patients and the local CCG average was 242.4 patients per thousand. A and E attendances were 65.5 per 1000 patients compared with the CCG average of 79.1 per 1000 patients. These statistics better than the CCG averages. Systems were in place to minimise the number of patients who went to or were admitted to their local hospital where appropriate. Clinical staff monitored the number of patients who had been admitted to hospital as emergencies and the number who attended the Accident and Emergency (A and E) department.

Care plans had been put in place for patients who required higher levels of care or were considered to be at risk. The care plans were reviewed regularly and shared with community professionals to promote co-ordinated care.

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

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. QOF is a national performance measurement tool for managing patient outcomes. We were shown the latest QOF achievements that told us practice staff were average or above average for meeting all of the national standards. For example, 100% of patients with asthma, epilepsy and dementia had been reviewed. These were above the national target. There was an uptake of 95.5% for reviews of patients who had diabetes, which matched the national target. The exception rating for the practice was in line with the local CCG average.

There was a system in place for carrying out clinical audits. One audit concerned the education of patients who had insulin dependent diabetes and their safety when driving a car. The audit revealed that five patients did not have sufficient knowledge about their health and safety. These patients received information by telephone and were given written guidance for them to refer to as needed. The audit stated that it would be repeated later this year to check patient knowledge about their condition. Other audits we saw included actions and dates of when they would be repeated.

The senior GP carried out minor surgery, which included excision of a lump and joint injections. The GP undertook minor surgical procedures in line with NICE guidance. They were appropriately trained and kept their skills up to date. There was a minor surgery audit carried out for the year between November 2013 and 2014. A total of 28 patients had completed questionnaires about their satisfaction with the procedure, their understanding of it and whether they had any complications. Most questionnaires gave positive feedback. The results were no post-operative infections, unexpected referrals, repeat procedures or complications.

GPs were supported by Clinical Commissioning Group pharmacist who regularly attended the practice. The pharmacist provided advice about medicines that GPs prescribed for patients.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and

Good

Are services effective?

(for example, treatment is effective)

saw that all staff had attended training courses that were relevant to their roles. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses.

We saw that relevant checks were completed to ensure clinical staff were up to date with their professional registration, for example nurses were registered with the Nursing and Midwifery Council (NMC). The NMC was set up to protect the public by ensuring that nurses and midwives provide high standards of care to their patients and clients. The practice also kept a record to demonstrate that GPs were registered on the performers list. 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 (GMC) can the GP continue to practice and remain on the performers list with NHS England.

All staff had annual appraisals that identified any learning needs from which action plans were documented. We saw that the practice nurses' and health care assistants' appraisals were carried out by clinical staff. This was so that that their clinical practices and competencies could be discussed and appropriately evaluated.

Working with colleagues and other services

Staff worked well with other professionals including community nurses and health visitors. Arrangements were in place for the shared care of patients. Shared care is where the prescribing responsibility for treatments which were initiated by hospital staff are transferred to the GP. The hospital consultant retains clinical responsibility for the patient and the GP acts on their advice. Shared care arrangements may be helpful to support the discharge of patients back into the community and help provide continuity of care. Attendance at multidisciplinary meetings assisted in patients receiving co-ordinated care.

Meetings were held every three months with community nurses and case manager present. Health visitors were invited to attend these meetings. This promoted a partnership for ensuring patients received appropriate and joined up care.

The practice received summaries for patients who had accessed the out-of-hours (OOH) services. These patients were reviewed and followed up where necessary by the GPs at the practice. Correspondence received from other services was dealt with by the senior GP on the day it was received.

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. Where necessary referrals would be made to hospitals and other services such as physiotherapy.

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. Staff were fully trained on the system, and commented positively about the system's security for confidentiality and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The system included a facility to flag up patients who required closer monitoring such as children at risk.

There was a system in place to ensure the out of hours service had access to up to date treatment plans of patients who were receiving specialist support or palliative care.

There was a practice website with information for patients including signposting, services available and latest news. Patients could access the full range of information on the website. Information leaflets, and electronic screen and posters informed patients about local services were available in the waiting area.

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 and they were asked to sign a consent form to confirm this.

Good

Are services effective?

(for example, treatment is effective)

Clinicians were aware of the requirements within the Mental Capacity Act 2005. This was used for adults who lacked ability to make informed decisions. Staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity.

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 & Prevention

We saw that all new patients were offered a health check. New patients who had received prescribed medicines from previous clinicians were given an appointment with a GP to review the medicine dosage and if it was still appropriate.

The GPs had achieved 100% for childhood surveillance. This indicated that child development checks had been offered that were consistent with national guidelines. The practice had achieved 95% for mumps, measles and rubella vaccinations first dose and 85% for the second dose. There had been an uptake of 96.2% of five year old children who had whooping cough (pertussis) vaccinations. These were in line with the local CCG averages.

All patients who had cancer had been regularly reviewed and the uptake for cervical screening was 94.3%, which was 0.3% below the CCG average.

All patients who were recorded they smoked (62) had been given advice by clinical staff.

Patients who did not attend for health reviews for their long term conditions were sent a reminder 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.

Annual health checks were offered to all patients who were aged 65 years or more and data held at the practice told us they had all received a review.

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. We saw some health and welfare information displayed in the waiting area. For example, breast screening, shingles vaccinations for patients aged 70 years and safe alcohol consumption. Contact details were on display for healthy lifestyle and weight loss advice.

A range of tests were offered by practice staff including spirometry (breathing test) blood pressure monitoring and cervical screening to regularly monitor the patient's health status.

We spoke with a member of the Patient Participation Group (PPG). PPG's work with practice staff in a way to improve services and promote quality. The PPG regularly arranged speakers and patients were invited to attend. Speakers included a pharmacist, age concern and a physiotherapist. The purpose of these was to give patients guidance about health awareness. We were told that these were well attended by patients.

The waiting room had a dedicated notice board that displayed information about the sugar content in various foods and drinks. Bags of sugar were on display that gave examples of the sugar contents of named foods and drinks. At the side of the reception desk there were tubs of fat on display so that patients could view the fat content of various foods. These were in place to improve patient awareness for the need to have a balanced diet.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & 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 for private discussions. 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 clinical room doors were closed during consultations and that conversations taking place in these rooms could not be easily overheard. We observed staff knocking on doors and waiting to be called into the room before entering.

We spoke with six patients and collected 21 comment cards during the inspection. Our discussions with patients on the day of the inspection and feedback from comment cards told us patients felt that staff were caring and their privacy and dignity was respected.

Patients confirmed they knew their rights about requesting a chaperone. They told us this service was offered to them by clinical staff.

The National Patient Survey for GP practices informed us that 386 surveys were sent to patients and 125 (32%) were returned. We looked at results of the GP patient survey dated 2014. Findings of the survey were based on the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. The latest results were:

- 82% of respondents said they were able to be seen or speak with a GP or nurse the same or next day, the CCG average was 57%,
- 79% said that the last time they saw a GP they were treated with care and concern, the CCG average was 85%,
- 99% stated they had confidence in the nurse, the CCG average was 85%,
- 97% stated they had confidence in the GP, the CCG average was 92%,
- 87% of respondents stated that their overall experience was good; the CCG average was 83%.

Care planning and involvement in decisions about care and treatment

We found that patient care was a priority and was embraced by the whole practice team. Providing the GP was holding clinical sessions on the day, patients were able to choose and request to be seen by a particular GP.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views. GP national survey showed that 81% of respondents stated that the last GP they saw or spoke to was good at involving them in decisions about their care. The local CCG average was 71% achievement.

The practice nurse we spoke with told us they explained treatments and tests to patients before carrying out any procedure. They told us that patients were kept informed of what was going to happen at each step so that they knew what to expect.

Patients we spoke with confirmed they had been given advice and choices about where they could be referred to assist them in making decisions for secondary assessment and care.

Patient/carer support to cope emotionally with care and treatment

The respective GP contacted bereaved families and offered a range of services they felt to be appropriate for the family to access. There were also bereavement counselling services available and GPs could make referrals to them. Families were sent a sympathy card from practice staff.

We saw information was on display in the waiting area for patients to pick up and take away with them. They informed patients of various support groups and how to contact them.

There was a poster in the waiting area and the electronic screen provided information about people who acted as

Good

Are services caring?

carers. The practice held a register of carers and at the time of our inspection there were 27 persons on the register. This enabled staff to offer carers additional support and referral to carer groups and support organisations.

Good

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 main patient population they treated. For example, screening services were in place to detect and monitor the symptoms of long term conditions such as asthma and hypertension. There were nurse led services such as diabetes. There were immunisation clinics for babies and children and women were offered cervical screening. Patients over the age of 75 years had an accountable GP to ensure their care was co-ordinated.

The practice had a mental health register for patients who required annual health checks. We saw that all of the 25 patients on the register had been reviewed. Patients who had a learning disability were also registered and clinical staff had completed the annual reviews for these patients. The practice manager showed us the new improved system they had introduced for reviews of patients who had a learning disability. Of the eight patients registered three had been re-called and received the more in-depth review and the other five patients had been sent re-call letters.

The senior GP told us they sometimes held an extra clinical session to ensure that patients who had long term conditions were reviewed when needed.

There was a palliative care register and quarterly multidisciplinary meetings were held to discuss patient and their families care and support needs. All patients on the palliative care register had been regularly reviewed. The local CCG expectation was 100% achievement.

A health professional held regular substance and alcohol misuse clinics at the practice. They worked in conjunction with the senior partner who had received appropriate training in prescribing for these patients. The senior GP told us about a recent success they had achieved concerning a patient who had been successfully treated.

Both the GPs were male. The senior partner ensured that a female locum was regularly employed at the practice which gave patients the option of receiving gender specific care and treatment.

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. GPs attended CCG meetings where actions were agreed to implement service improvements and manage delivery challenges to its population. For example, clinical staff maintained regular liaison with a pharmacist to ensure patients received appropriately prescribed medicines.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). For example, the PPG had been involved with the development of the new patient leaflet.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The practice had recognised the needs of different groups in the planning of its services and had made arrangements for meeting their needs.

Access to the service

Good

Are services responsive to people's needs?

(for example, to feedback?)

Appointments were available from 9am until 11.50am each day, from 4pm until 7pm Mondays and from 4pm until 6pm Tuesdays and Fridays. Nurse sessions were 9am until 1pm and 4pm until 7.15pm Mondays, 9am until 1pm Wednesdays and 2.15pm until 6.30pm Fridays.

Patients we spoke with told us they could book an appointment when they felt they needed to. We did not receive any negative comments in the comment cards about patients' ability to make an appointment. Reception staff told us they never turn a patient away who was requesting an appointment. Children and emergency requests were seen on the same day.

Patients were able to book and order repeat prescriptions online from their own homes. This was useful for working age patients as well as those who had difficulty with their mobility.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This out of hour's service was provided by an external service contracted by the CCG. Details of the out of hour's provider were available on the practice leaflet and in the practice.

Listening and learning from concerns & 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.

There was a practice leaflet that informed patients of how to make a complaint and what they could expect. It included the contact details of NHS England and the local ombudsman if the complainant was not satisfied with the outcome of the investigation.

We saw that the practice had received five complaints during the previous 12 months. They had dealt with them appropriately and written responses had been sent to complainants. Lessons learned had been documented to prevent recurrences. For example, a patient who was not happy with the service they received had requested a copy of their records. The practice manager sought advice from the local CCG. The recordings indicated that the practice manager had a better understanding of the process for dealing with future requests.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. This information was included in the Statement of Purpose and a copy was on display in the waiting area.

We spoke with five 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. A premises audit had been carried out identifying areas needing investment/ improvements and senior staff were awaiting a report from the CCG estates department.

Governance Arrangements

The practice had a clear governance structure designed to provide assurance to patients and the local clinical Commissioning Group (CCG) that the service was operating safely and effectively.

There were specific identified lead roles for areas such as safeguarding and palliative (end of life) care. Responsibilities regarding care, safeguarding, infection control and management were shared among GPs, the practice nurses and the practice manager.

The practice staff did not hold practice meetings. They told us they disseminated information and changes amongst each other and that the system was not a problem because they regularly saw each other. Staff told us they could make suggestions for improvements and that they would be listened to by senior staff. A receptionist told us they had re-designed the appointment slips they gave to patients to make them look more professional. Another initiative was the introduction of a communication book.

The senior GP told us about the type of minor surgery they carried out. They did joint injections and had removed a serious skin growth. Under these circumstances the provider was advised they must register with the Care Quality Commission (CQC) for the regulated activity of surgical procedures. We were given assurance from the practice manager that an application would be submitted to CQC promptly.

Leadership, openness and transparency

We saw that there was a clear leadership structure which had named members of staff in lead roles. For example, there was a lead GP for safeguarding. Staff were aware that there were lead roles and knew who to speak with if they needed any guidance or had concerns. Staff we spoke with were clear about their own roles and responsibilities and said that the practice manager and GPs were approachable and offered assistance if required.

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.

Staff told us that they felt supported and also supported each other as necessary. We were told that staff worked well as a team and also that they felt appreciated for the work that they did. The provider organised social events in recognition of the input that staff made towards the day to day operations of the practice.

Practice seeks and acts on feedback from users, 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 latest PPG meeting; we were told by a PPG member they were held regularly and this was confirmed in the minutes we saw. The practice manager attended the meetings and sometimes a GP. The PPG member told us that they set the agenda and recorded the minutes. They told us they had a very good and open relationship with practice staff.

During our inspection we spoke with a PPG member. They were positive about their relationship with senior staff and their responses when suggestions for improvements were made. The PPG had responded positively to a complaint that a patient had made about the telephone system. Following the complaint about the telephone system the PPG carried out a survey in January 2014 by asking 50 patients to complete a questionnaire. The results did not find any concerns about the telephone system or the helpfulness of reception staff.

The practice was participating in the 'Friends and Family' survey where patients were asked to record if they would recommend the practice to others. The survey commenced in December 2014 and the results were fed back to the CCG each month. We saw the results for March 2015. There were

Are services well-led?

Good

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

29 patients who had indicated they were extremely likely to recommend the GP they had seen, 22 said they were likely to, three stated neither likely or unlikely, no patients had stated extremely unlikely and one patient had indicated they did not know.

Staff we spoke with told us they felt well supported and were able to express their views about the practice.

Management lead through learning & improvement

Staff told us that senior staff supported them to maintain their clinical professional development through training and mentoring. We looked at some staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

GP's held regular meetings to discuss each patient who had been admitted to hospital to monitor their progress and to determine if there were any lessons to be learnt.

Work towards achievement of ACE Excellence for six types of long term conditions was on-going by practice staff. These included an 85% achievement for electronic referrals, adding to the carers register and 100% uptake of many childhood vaccinations. This demonstrated that efforts were being made to provide high standards and consistent care and treatment to these patients. Aspiring to Clinical Excellence (ACE) is a programme offered to all Birmingham Cross City Clinical commissioning group (CCG) practices. ACE is aimed at reducing the level of variation in general practice by bringing all CCG member practices up to the same standards and delivering improved health outcomes for patients.

The practice had completed reviews of significant events and other incidents and shared them with staff to ensure the practice improved outcomes for patients. There had been seven recorded during the previous 12 months. For example, use of incorrect patient records and action taken to prevent a recurrence.