

# Hodge Hill Family Practice

## Quality Report

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Date of inspection visit: 9 June 2015  
Date of publication: 16/07/2015

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

### Ratings

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

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Hodge Hill Family Practice on 9 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for older people; people with long-term conditions; families, children and young people; working age people; people whose circumstances may make them vulnerable and people experiencing poor mental health.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- The practice had good facilities and was well equipped to treat patients and meet their needs. Cleanliness and infection control was well maintained at the practice.

- Patients' needs were assessed and care was planned and delivered following best practice guidance. We found that the practice audits were mostly driven by the medicines management team at the CCG (Clinical Commissioning Group). The practice recognised the need to conduct more clinical audits and they shared a summary of other audits due to be carried out at the practice.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned for. However, there was some inconsistency regarding awareness of lead roles within the practice. For example, some staff were unaware of the lead for safeguarding.
- Patients said they were treated with compassion, dignity and respect.
- Information about services and how to complain was available and easy to understand.
- There was a clear leadership structure and staff felt supported by management. Patients and staff told us how continuity of care was improving with permanent GPs in place; however we found that patients over the age of 75 did not have a named GP.

# Summary of findings

There were areas of practice where the provider needs to make improvements.

Importantly the provider should:

- Ensure processes are robust with regards to the management and dissemination of national patient safety alerts and ensure communication is consistent amongst clinical staff at the practice.
- Ensure risks to patients are assessed and recorded in relation to health and safety.
- Continue to strengthen a programme of clinical audits in the practice, ensuring that full cycle audits are completed with improvements recorded.

- Ensure support is offered to families who have suffered bereavement and ensure information is available for carers to offer support and signpost carers to local support services.
- Ensure a consistent approach is applied when applying learning points to complaints made regarding locum GPs who may fail to respond to complaints once they have left the practice.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. We found a lack of consistency with regards to the dissemination of national patient safety alerts across the practice. We found that the alerts process was not robust in terms of consistent communication to ensure all GPs, locums and nurses were receiving and acting on relevant patient safety alerts. Risks to patients were well managed, although we noted that the practice did not have risk assessments to assess the risk of health and safety. The practice used fully qualified locum GPs to provide cover for annual leave, sickness and training commitments. We saw that locums were accessed through a locum agency and we saw that appropriate recruitment checks were in place prior to providing locum cover at the practice. Staff and patients told us how the continuity of care was improving with permanent GPs in place and that they felt better about the improvements made around continuity of care so far.

Good



### Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams. We found that the practices audits were mostly driven by the medicines management team at the CCG (Clinical Commissioning Group). The practice recognised the need to conduct more clinical audits and they shared with us a summary of other audits due to be carried out at the practice.

Good



### Are services caring?

The practice is rated as good for providing caring services. The patients we spoke with on the day of our inspection and the comment cards highlighted that staff responded compassionately

Good



# Summary of findings

when they needed help and provided support when required. Patients were unhappy when seeing different GPs at the practice, stating that they would sometimes have to repeat their condition details to different locum GPs. However, patients had positive things to say about the current GPs in post, stating that they listened well and that they didn't feel rushed by them. One patient described the treatment received by one of the GPs as five star care. However, we found that the practice was not proactive in providing support to their caring population, 15.2% of the practices patient population were carers, we also found that the practice did not have a process in place for families who had suffered bereavement. We saw that staff treated patients with kindness and respect, and maintained confidentiality. Ratings were higher than the CCG average with regards to reception staff at the practice and this reflected the CQC comment cards where reception staff were described as caring and helpful.

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a GP, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Practice meetings were held every six weeks and we saw that within the meeting minutes, learning from some complaints was shared with staff. However, we were unable to identify the learning on complaints that were made with regards to locum GPs as responses were not always tracked back from the locums once the locum had left the practice. The management team assured us that complaint details were always shared with the locum agency however locum responses were not logged within the complaint details that the practice provided to us.

Good



## Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. Staff reported that they felt all areas of the practice had improved in the last six months and that leadership and management had improved considerably. The practice had a number of policies and procedures to govern activity and held regular practice meetings which included governance, quality and patient safety as part of the agenda. There

Good



# Summary of findings

were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The practice had a large virtual patient participation group (PPG) which was led by a PPG chair who regularly met with the practice. The PPG chair told us how the practice had made staffing improvements by recruiting permanent GPs and appointing a practice manager to support the practice team. Staff had received inductions, regular performance reviews and attended staff meetings and events.

# Summary of findings

## The six population groups and what we found

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

### Older people

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. However, we found that patients over 75 years of age did not have a named GP. The practice told us that this was previously due to using a large number of locum GPs. Staff told us that this was an area they planned on addressing however we saw no documented plans in place to support this. The practice was strengthening the relationships with the local care homes. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Good



### People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the GPs and nurses worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



### Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Good



# Summary of findings

## **Working age people (including those recently retired and students)**

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered a full range of health promotion and screening that reflected the needs for this age group.

Good



## **People whose circumstances may make them vulnerable**

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and care plans were in place for 83% of these patients. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Good



## **People experiencing poor mental health (including people with dementia)**

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Ninety Seven percent of people experiencing poor mental health had received an annual physical health check; this was higher than the national average of 83%. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had received training on how to care for people with mental health needs and dementia.

Good



# Summary of findings

## What people who use the service say

During our inspection we spoke with four patients. Three patients attending the practice for appointments and one patient from the patient participation group (PPG) who had agreed to speak with us on the day of

inspection. We also looked at comment cards left by patients at the practice. Patients completed CQC comment cards to tell us what they thought about the practice, we found that the majority of the comment cards contained positive comments about the practice some of which detailed positive experiences with regards to the care and treatment provided by the GPs and nurses. The main theme related to a previous lack of

continuity of care however comments acknowledged the improvements made by the practice in appointing three permanent GPs. Patients reported that the practice was clean, staff were described as helpful and patients reported that they were treated with dignity. We spoke with a member of the PPG during our inspection. The PPG member informed us of the improvements and changes that had been made since a newly appointed practice manager was in post. The PPG member also told us that he expected the work of the PPG would strengthen at the practice now that a newly appointed practice manager was in post.

## Areas for improvement

### Action the service SHOULD take to improve

Ensure processes are robust with regards to the management and dissemination of national patient safety alerts and ensure communication is consistent amongst clinical staff at the practice.

Ensure risks to patients are assessed in relation to health and safety.

Continue to strengthen a programme of clinical audits in the practice, ensuring that full cycle audits are completed with improvements recorded.

Ensure support is offered to families who have suffered bereavement and ensure information is available for carers to offer support and signpost carers to local support services.

Ensure a consistent approach is applied when applying learning points to complaints made regarding locum GPs who may fail to respond to complaints once they have left the practice.

# Hodge Hill Family Practice

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The lead inspector was accompanied by a GP specialist advisor, a practice manager specialist advisor and support was provided by two further CQC inspectors.

### Background to Hodge Hill Family Practice

Hodge Hill Family Practice is situated in Birmingham. The practice operate as part of a larger organisation called Phoenix Primary Care who provide services under an alternative primary medical services (APMS) contract and has expanded its contracted obligations to provide enhanced services to patients. An enhanced service is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients. The increased range of services provided included in house diabetes care and phlebotomy (taking of blood samples).

The practice building is purpose built, with treatment areas on the second floor. The building has car parking, with allocated spaces and access for those with a disability.

There are just over 3,500 patients of all ages registered and cared for at the practice, including a younger than national average practice population.

The practice team consists of one female and two male GPs and two nurses. The administrative team take care of the day to day running of the practice and consist of a practice manager and four reception/secretarial team members.

Appointments were available from 8.30am to 6pm on all weekdays and the practice offered extended hours on Thursdays until 8pm and on Saturdays from 9am to 2pm. Appointments could be booked in person or via telephone. The practice does not routinely provide an out-of-hours service to their own patients but they have alternative arrangements for patients to be seen when the practice is closed.

### Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out a comprehensive inspection of the 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?

# Detailed findings

- 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
- 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)

We carried out an announced inspection on 9 June 2015 at the practice. During our inspection we spoke with two GP's and two nurses. We also spoke with four reception staff, as well as the practice manager and three patients. We spoke with the chair of the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We observed how patients were cared for. We reviewed 11 comment cards where patients and members of the public shared their views and experiences of the service.

# Are services safe?

## Our findings

### Safe track record

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We reviewed safety records and incident reports dating back to April 2014 to show that the practice had managed them consistently over time. The practice used a range of information to identify risks and improve patient safety including reported incidents as well as comments and complaints received from patients. Staff used incident forms and sent completed forms to the practice manager. We tracked five significant events and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, we saw that an incident had occurred regarding the prescribing of medicines. We saw that appropriate action had been taken and the issue was raised as a significant event. As a result of the incident, the practice implemented a system of recording and monitoring all prescriptions and developed an audit trail of the prescriptions passed to the pharmacy to avoid any further duplication.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed a log of 20 significant events that had occurred during the last 12 months and saw that significant events was a standing item on the practice meeting agenda. Practice meetings were held every six weeks, we saw that within the meeting minutes, learning was shared and this included learning points from incident and complaints. The practice had included the outcomes of significant events in meetings but the details of who was responsible for any actions were not always clear from the minutes or the significant event recording. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Nurses and one of the GPs demonstrated that following an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) dosage was either altered or stopped for patients on a particular type of antihistamine in line with guidance set by the MHRA. While the nurses managed their own national patient safety alerts we found

an inconsistency with regards to how the GPs received the alerts. One GP received alerts directly and another GP told us that no alerts had been communicated to them in the six months they had been working at the practice. When we raised this with the practice on the day they advised us that the practice manager was working across two email accounts and was in the process of signing up to the alerts in order to begin disseminating them on behalf of the practice.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of how to properly record any safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP as a lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary training to enable them to fulfil these roles. However when we asked, they were not familiar with cases on the register for patients who were at risk, such as children on the child protection register.

There was a system to highlight vulnerable patients on the practice's electronic records and staff were able to demonstrate how the flagging system worked. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. While staff were aware of how to correctly spot and report safeguarding concerns, some staff we spoke with were unaware of whom the safeguarding lead was and two staff members told us that they thought the practice manager was the lead for safeguarding.

There was a chaperone policy, which staff could access through their shared policy system. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination

## Are services safe?

or procedure. Signs informing patients of their right to have a chaperone present during an intimate examination were on display in the practice. Nursing and reception staff told us they had received chaperone training and they clearly explained to us what their responsibilities were to keep patients safe from the risk of abuse, including where to stand to be able to observe the examination. Disclosure and Barring Service checks (DBS) were in place for all staff members, including chaperones. DBS checks are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

### Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medicines were stored at the appropriate temperature. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice nurse administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We saw up-to-date copies of all the PGDs and evidence that the practice nurses had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. There was a protocol for repeat prescribing which was in line with national guidance and was followed in the practice. The protocol complied with the legal framework and covered all required areas. The practice had systems in place to monitor how these

medicines were collected and they also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required. Patients could order their repeat prescriptions in person, online or by telephone.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, we saw that a review of antibiotic prescribing had been carried out and prescribing had been altered for specific patient groups, this was to ensure broad-spectrum antibiotics were avoided in line with guidance set by the National Institute for Health and Care Excellence (NICE). NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

### Cleanliness and infection control

We spoke to three patients during our inspection, all of these patients told us they found the practice to be clean and tidy and they had no concerns about cleanliness or infection control.

We found the practice to be visibly clean with hand washing facilities and hand gel available for staff and patients. We saw that suitable foot operated bins were provided for general and clinical waste. There were disposable privacy curtains in treatment rooms and staff had recorded the date these had been changed on the labels provided for this. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. Hand washing sinks with touch-free hand soap, hand gel and hand towel dispensers were available in toilets and treatment rooms. Notices about hand hygiene techniques were displayed in staff and patient toilets.

We saw there were cleaning schedules in place and cleaning records were kept. Cleaning equipment and products were kept securely and information about safe

## Are services safe?

use of cleaning materials was readily available. Clinical equipment was cleaned by the practice nurses and the GPs who were responsible for making sure equipment in the treatment rooms was kept clean.

An infection control policy and supporting procedures were available for staff to refer to which enabled them to plan and implement measures to control infection. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. The practice had a policy for the management, testing and investigation of legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings. We saw that appropriate action had been taken to address any risks identified and we saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients

The two practice nurses shared the role of infection control leads at the practice; the nurses had undertaken further training to enable them to provide advice on the practice infection control policy. We saw that the cleanliness and infection control of the practice was well maintained. An infection control audit was completed in February 2015 with no remedial actions required, the practice also shared plans with us regarding audit and training updates which were due to take place in August 2015.

### Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw records that demonstrated all medical devices had been calibrated and that all portable electrical equipment had been tested in February 2015 to ensure they were safe to use. The calibrated equipment included the oximeter equipment used for measuring oxygen levels in the blood and blood pressure measuring devices.

### Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The practice told us that references were kept at the organisations head office however we were able to check four staff records which contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification,

qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice was able to obtain copies of references to reflect the staff files we checked during our inspection.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there was always enough staff on duty to keep patients safe. Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for different staffing groups to ensure that enough staff were on duty. The practice told us how they could utilise staff from the other practices within the Phoenix Primary Care Group to cover administrative and reception duties if required and managers from the other practices would also provide cover on occasions where the practice manager was on annual leave. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

The practice recognised the need to recruit permanent GPs and was mostly using locums to provide GP cover prior to recruiting GPs in November and December 2014, as well as recruiting a further GP who joined the practice in January 2015. A locum GP is a fully qualified doctor who provides temporary cover to fill a vacancy or cover sick leave, staff holidays or training commitments. Staff told us how continuity of care was improving with permanent GPs in place and the practice nurses told us that patients had expressed to them that they were getting to know the permanent GPs, and that they felt better about the improvements made around continuity of care so far.

The practice continued to use locum GPs to provide cover for annual leave, sickness and training commitments. We saw that locums were accessed through a locum agency and we saw that appropriate recruitment checks were in place prior to providing locum cover at the practice. The practice told us that they would access preferred locums who were familiar with the practices patients, practice staff and practice protocols. The practice kept a book of 60 preferred locums to choose from. The practice selected from their preferred locum list on a weekly basis in order to

## Are services safe?

cover the practice when the GP's would visit the local care homes to conduct ward-rounds. Ward-rounds would take place every Monday, Wednesday and Thursday from 1pm to 5pm and the ward-round shifts would rotate across the three GPs. A regular locum would therefore be booked to cover the GP conducting the ward-round.

### Monitoring safety and responding to risk

We saw policies in place to support health and safety, health and safety information was displayed for staff to see and staff were aware of how to report risks and who to report them to. We saw a fire log book which contained evidence of fire risk assessments and fire testing to ensure that the fire alarm was in working order and that staff and patients were not at risk. We saw that risk assessments for the Control of Substances Hazardous to Health (COSHH) had also been completed. COSHH implemented to protect workers against ill health and injury caused by exposure to hazardous substances - from mild eye irritation through to chronic lung disease. COSHH requires employers to eliminate or reduce exposure to known hazardous substances in a practical way.

The practice told us that regular health and safety checks of the building were carried out by the practice team and also by the site owners however the practice did not document the health and safety checks they carried out, for example, we saw no evidence of health and safety risk assessments during our inspection.

The practice had arrangements for identifying those patients who may be at risk. There were practice registers in place for patients in high risk groups such as those with long term conditions, mental health needs, dementia or learning disabilities. The practice computer system was used to inform staff of individual patients who might be particularly vulnerable. Reception staff also had this

information to help them prioritise potentially urgent cases such as vulnerable patients and patients experiencing poor mental health. Staff were aware of how to report risks and who to report them to.

### Arrangements to deal with emergencies and major incidents

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We saw that there was a warning sign on the door of the room where the oxygen was stored to alert the fire service of the presence of oxygen if a fire were to occur at the practice. Emergency equipment was available including access to oxygen and an automated external defibrillator (AED, used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and diabetes. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs shared responsibility across specialist clinical areas such as asthma, mental health and family planning. The practice nurses supported this work and also specialised in the management of all chronic diseases including diabetes. Nurses also provided childhood immunisations, sexual health advice, phlebotomy (taking of blood), cytology, health checks and smoking cessation. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The GPs and nursing staff were familiar with current best practice guidance and guidelines from the National Institute for Health and Care Excellence (NICE). National Institute for Health and Care Excellence (NICE) – the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment. We saw that the GPs and nurses used clinical templates in the management of patients care and treatment. This assisted them to assess the needs of patients with long term conditions, older patients and patients experiencing poor mental health. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them.

The practice had a register in place for all patients with long term conditions, this included patients with poor mental health, dementia, learning disabilities, palliative care patients and patients from vulnerable groups such as patients with a drug or alcohol dependence. The practice offered annual reviews for all patients with long term conditions, we saw the latest data for the practice and this showed that annual reviews had been carried out for 97.7% of the practice's patients with dementia. The GPs we spoke with told us that the practice provided cognition testing for patients at risk of developing or displaying symptoms of dementia. We saw evidence to support this data on the day of our inspection as well as the templates used for cognition testing.

We saw practice records that showed annual reviews of medication were in place and we saw that for the year so far, medication reviews had been carried out for patients

with asthma, dementia, diabetes and chronic obstructive pulmonary disease (COPD) - the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. The GPs used national standards for the referral of patients with suspected cancers so that they were referred and seen within two weeks. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within six weeks by their GP according to need.

All information about patients received from accident and emergency departments was reviewed by the practice nurses and the GPs; we saw that discussions around the reviews were also documented in the practice meeting minutes. Staff told us this provided a clinical evaluation of the information and enabled the practice to assess if the patient would require any further follow up or support. Out-of hour's reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received.

### Management, monitoring and improving outcomes for people

The practice held specialist clinics for diabetes, heart disease and asthma and the practice nurse supported this work. We saw training certificates which demonstrated that the practice nurse had received the additional training they required for the review of patients with long term conditions such as coronary heart disease and chronic obstructive pulmonary disease (COPD).

Staff across the practice had key roles in monitoring and improving outcomes for patients. If patients with long term conditions were too unwell to attend the practice for their routine checks the GP visited them at home. We saw evidence of care plans in place for patients with long term conditions and there were also care plans in place for patients experiencing poor mental health; the practice had care plans in place for 96% of these patients which was higher than the Clinical Commissioning Group average of 86.09%

The practice used the Quality and Outcomes Framework (QOF) to measure its performance and the management of

# Are services effective?

## (for example, treatment is effective)

QOF was shared by the GPs. The Quality and Outcomes Framework (QOF) is a voluntary incentive scheme for GP practices in the UK. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The QOF data for this practice showed it was performing in line with national standards with a practice value of 94.2%.

Specific examples to demonstrate this included:

- Performance for diabetes related indicators; overall performance was similar to the national average. Specifically, the percentage of patients with diabetes with a record of a foot examination within the last 12 months was 89.73% for the practice and this was higher than the CCG average of 88.38%
- The percentage of patients with hypertension having regular blood pressure tests was 83.72%, this was slightly higher than the national average of 83.13%
- Performance for mental health related QOF indicators was higher than the national average. For example, the practice scored 100% for the percentage of patients experiencing poor mental health who have had a recording of alcohol consumption within the last 12 months; this was higher than the CCG average of 88.65%.
- The practice had carried out reviews for 97.67% within the last 12 months for their patients diagnosed with dementia, this was higher than the CCG average of 83.83%

We found that the practice audits were mostly driven by the medicines management team at the CCG (Clinical Commissioning Group). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. The practice had not completed audits on secondary referral rates, including A&E rates. However, the staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. The practice recognised the need to conduct more clinical audits and they shared a summary of other audits due to be carried out at the practice. The summary included an audit for diagnosis rates to be audited on patients with asthma with review of inhaler usage. Staff spoke positively about the culture in the practice and around future audits and quality improvement.

The practice was able to share two prescribing audits with us that had been undertaken within the last 12 months. An example was an audit of antibiotic prescribing specifically in patients with respiratory tract infections. The practice shared the audit data with us during our inspection which showed how antibiotic prescribing had reduced over a 12 month period. The clinical effectiveness and cost effectiveness of antibiotic management and strategies for respiratory tract infections were also reviewed as part of the audit. Prescribing was also adjusted where required, in line with NICE guidelines. The practice also completed an audit for the prescribing of newer medicines for patients with diabetes in line with NICE guidance. The audit highlighted the need for the practice to be more proactive with treatment reviews for patients on hypoglycaemic medicines and to ensure treatment is discontinued in patients where appropriate.

There was a protocol for repeat prescribing which followed national guidance and prescribing rates were in line with national figures. The protocol required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had made use of the gold standards framework (GSF) for end of life care. It had a palliative care register and had regular GSF meetings to discuss the care and support needs of patients and their families. We found that one of the GPs did not work on the days when the meetings were held, there was a gap in communication in terms of sharing the information from these meetings with the GP as the GP told us they did not receive the minutes of these.

We found that the practice nurses managed their own national patient safety alerts. However, we received mixed feedback with regards to how the GPs received the alerts. One GP told us that no alerts had been communicated to them since joining the practice six months ago.

### Effective staffing

# Are services effective?

(for example, treatment is effective)

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending essential courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Staff undertook annual appraisals that identified learning needs from which action plans were documented, the two staff that hadn't had appraisals had them booked in for completion in July 2015. Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example, one nurse told us that the practice had supported them with specialist training in the care and treatment of chronic obstructive pulmonary disease. The practice nurses also attended the nurse forums led by the CCG (Clinical Commissioning Group).

Practice staff had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, nurses were trained on administration of vaccines, cervical cytology and phlebotomy, as well as receiving appropriate training to fulfil their roles in the management of patients with long term conditions.

## Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and support patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The GPs were heavily involved in managing the reading, administration and acting on any issues arising from these communications. Out-of hour's reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were

usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required.

The practice held monthly multidisciplinary team meetings to discuss patients with complex needs. For example, people from vulnerable groups and patients with end of life care needs. These meetings were attended by district nurses, health visitors and the midwife. The district nurses and health visitors were based on site and therefore staff could easily access these services on a regular basis. During our inspection we observed a case where a health visitor needed to consult with one of the GPs at the practice. The practice receptionist on duty was able to assist the health visitor by signposting them to the relevant GP, the health visitor was directly put through to the GP and was able to follow up with a face to face conversation where they were able to discuss a particular patient. The practice nurses also had regular contact with school nurses as well as district nurses. Palliative care meetings did not take place within the practice however staff told us that this was because they had regular contact with the district nursing service based on site in order to discuss any patients requiring palliative care.

The practice regularly engaged with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. The practice took part in local benchmarking to ensure they were performing in line with similar practices in the CCG.

## Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made their referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients'

# Are services effective?

(for example, treatment is effective)

care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

## Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. The practice had not needed to use restraint, but staff were aware of the distinction between lawful and unlawful restraint.

The practice had a policy to support staff in fulfilling the requirements of the Mental Capacity Act 2005. The Mental Capacity Act provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. This reflected national and local guidance and provided links to government and voluntary organisation information to support best practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

The practice consent policy provided guidance for GPs and nurses with duties involving children and young people under 16 in respect of the need to consider Gillick competence. The Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. All clinical staff demonstrated a clear understanding of the Gillick competency test.

## Health promotion and prevention

The practice held a number of clinics which could be accessed by appointment and also offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for child immunisations in the 12 month age group was in line with the CCG average, there was a clear policy for following up non-attenders by the named practice nurse.

It was practice policy to offer a health check to all new patients registering with the practice. The GPs were informed of all health concerns detected and these were followed up in a timely way. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 45% of patients in this age group took up the offer of the health check.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 598 of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to 99.5% of these patients, this was higher than the national average of 95.29%, 2% of their patients had stopped smoking. Similar mechanisms of identifying 'at risk' groups were used for patients who were receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 88.59%, which was above the national average of 81.89%. The practice nurses had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening, 89% of the practice's patients had been screened for breast cancer for the year so far. During our inspection we spoke with the chair of the Patient Population Group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. The PPG chair was also involved in health promotion at the practice and hosted a yearly Macmillan cancer day with staff at the practice to raise awareness, promote healthy lifestyle and to promote the PPG on behalf of the practice.

The nurse told us that they held flu clinics and actively targeted their patients who were over 65, patients with a long term health condition, carers and patients with learning disabilities. The nurse also told us that they administered flu vaccinations at the local care homes where patients were registered with the practice. The practice informed us that 85% of patients had received a flu vaccination which was in line with the national CCG average.

The practice also held daily clinics for blood pressure, heart disease and stroke, asthma and hypertension and weight clinics. The practice nurse told us that any abnormal blood

## Are services effective? (for example, treatment is effective)

pressure findings were followed up with a GP. High blood pressure is a known risk factor in serious illnesses such as stroke, and coronary heart disease. Performance for blood pressure checks for patients with hypertension was slightly above the CCG average of 83.13%, the latest figures for the practice was 83.72%, these figures reflect blood pressure checks between September 2014 and May 2015.

The practice had numerous ways of identifying patients who needed additional support, the practice kept a register of all patients experiencing poor mental health; all 36 of them had care plans in place and were offered an annual physical health check.

# Are services caring?

## Our findings

### **Respect, dignity, compassion and empathy**

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in January 2015. The evidence showed patients were generally satisfied with how they were treated, 79% of the respondents described their overall experience of the practice as good. This was lower than the CCG average of 83% however the practice had relatively high percentages for having confidence and trust in the GPs and the nurses at the practice. Ninety eight percent of the survey respondents said that they had confidence and trust in the last GP they saw or spoke to at the practice, this was slightly higher than the CCG average of 97%. Ninety six percent of the respondents said that they had confidence and trust in the last nurse they saw or spoke to at the practice and this was also higher than the CCG average of 95%.

Ratings were slightly lower than the CCG average with regards to treating patients with care and concern, 84% of respondents said that the last GP they saw or spoke to was good at treating them with care and concern, this was lower than the CCG average of 85%. Eighty four percent of respondents said that the last nurse they saw or spoke to was good at treating them with care and concern, this was also lower than the CCG average of 89%. Patients completed CQC comment cards to tell us what they thought about the practice; we found that 10 of the 11 comment cards contained positive comments about the practice and five of these contained specific comments of how nurses were kind and understanding and how one of the GPs at the practice was particularly good at listening to patients.

Ratings were higher than the CCG average with regards to reception staff at the practice, with 84.7% of the respondents rating the receptionists as helpful; this was higher than the CCG average of 83.8%. This was reflected in the CQC comment cards where reception staff were described as caring and helpful and this also reflected the comments provided by the chair of the patient participation group (PPG). The chair of the PPG told us how the practice team had worked hard to keep the practice running smoothly during times when the practice management team was changing; the chair described the practice team as brilliant and hard working.

We spoke with three patients during our inspection and we received a mixture of positive and negative comments regarding the practice. Patients made positive comments regarding having permanent GPs in place and they told us that they would like the practice to continue to recruit further permanent GPs because they felt that the continuity of care was improving. Patients were unhappy when seeing different GPs at the practice, stating that they would sometimes have to repeat their condition details to different locum GPs. However, patients had positive things to say about the current GPs in post, stating that they listened well and that they didn't feel rushed by them. One patient described the treatment received by one of the GPs as five star care.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. There was a barrier in place to inform patients of where to stand and queue when waiting to speak with reception; this helped to ensure patients could not be overheard when speaking at the reception desk. Staff told us that they would take patients to a private room if they wished to speak in private. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

There was a clearly visible notice in the patient reception areas stating the practice's zero tolerance for abusive behaviour. Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

### **Care planning and involvement in decisions about care and treatment**

The latest patient survey information we reviewed showed results were lower than the CCG average with regards to GPs and nurses involving patients in decisions about their care; the practice scored 71% with regards to GP

## Are services caring?

involvement which was lower than the CCG average of 81%. The practice scored 81% with regards to nurse involvement which was slightly lower than the CCG average of 83%. Ninety two percent of respondents rated the practice higher than the CCG average with regards to consultations with the nurses; 92% said that the last nurse they saw or spoke to was good at giving them enough time, this was higher than the CCG average of 91%. Ninety two percent of respondents said that the last nurse they saw or spoke to was good at listening to them, this was higher than the CCG average of 90%. However, the practice scored lower than the CCG average with regards to GPs listening and explaining test results and also regarding having enough time with the GPs. The practice scored 80% with regards to the respondents who felt that the last GP they saw or spoke to was good at giving them enough time, this was lower than the CCG average of 87%. Eighty four percent of respondents said that the last GP they saw or spoke to was good at listening to them, this was lower than the CCG average of 88% and 80% felt that the last GP they saw or spoke to was good at explaining tests and treatments. This was below the CCG average of 87%.

### **Patient/carer support to cope emotionally with care and treatment**

The patients we spoke with on the day of our inspection and the comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

The practice had leaflets on display in the reception area for carers, the leaflets contained information on care services and how to get help when looking after someone, we found that the content of this particular leaflet signposted carers to Walsall and Wolverhampton carer support rather than local support services within the Birmingham area. The practice did not maintain a register of carers and the latest data we viewed showed that 15.2% of the practice's patients had caring responsibilities.

The practice did not have a process in place for families who had suffered bereavement.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice offered extended appointments when reviewing patients who needed additional time. An example of this was patients with a learning disability. A GP told us this was to ensure they had sufficient time to discuss issues so the patient would not feel rushed, also to accommodate the assessment of health conditions that patients in this group were at a higher risk of developing.

Home visits were available on request for patients who were housebound, terminally ill or too ill to attend the practice. We spoke with a patient who told us that they were grateful for how the practice GPs were able to attend to their relative at home when they were too ill to visit the practice.

The practice provided care and support to several housebound elderly patients and patients living in local care homes. During our inspection we found that patients over 75 years of age did not have a named GP to provide continuity of care. The practice told us that this was previously due to using a large number of locum GPs. Staff told us that this was an area they planned on addressing however we saw no documented plans in place to support this.

### Tackling inequity and promoting equality

Staff told us that translation services were available for patients who did not have English as a first language, some staff spoke additional languages including Urdu and Punjabi. We saw notices in the reception areas informing patients of the translation services available.

The practice ran from a modern purpose built premises that had been adapted to meet the needs of patients with disabilities. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Doorways and corridors were wide enough to allow prams and wheelchairs to turn and access all rooms. We saw patients with walking aids mobilising through the practice without hindrance. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. Facilities for patients with mobility

difficulties included accessible parking spaces, step free access to the electronic front door of the practice and accessible toilets. The practice did not have a hearing loop in place for patients with hearing impairments.

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

### Access to the service

Appointments were available from 8.30am to 6pm on all weekdays and the practice offered extended hours on Thursdays until 8pm and on Saturdays from 9am to 2pm. Appointments could be booked in person or via telephone.

Emergency cover was provided by an out-of-hours service when the practice was closed, patients could access this service through 111. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Comprehensive information was available to patients about appointments on the practice website and on the practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Longer appointments were also available for patients who needed them and those with long-term conditions. Home visits were made to several local care homes to those patients who needed one. The practice no longer offered telephone consultations as an alternative method of consultation. The practice told us that this was due to a training need as they found that some calls were not appropriate for telephone consultations, for example, general non-medical queries that the practice could assist with. The practice told us that they would train staff in the future to ensure that calls are routed correctly for triage and telephone consultations.

The latest patient survey information showed that the practice scored 91% for convenience of appointment times which is in line with the CCG average. Eighty seven percent of the respondents were satisfied with the practice opening times, this was higher than the national average of 76%.

# Are services responsive to people's needs?

(for example, to feedback?)

Patients were generally satisfied with the appointments system and confirmed that the system was improving since having permanent GPs at the practice. Patients confirmed that they could see another GP or a locum doctor if there was a wait to see the doctor of their choice however patients preferred to have continuity of care by seeing familiar GPs. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The latest patient survey information showed that the practice scored higher than the CCG average of 62% for appointment waiting times, 73% of respondents said that they usually waited 15 minutes or less after their appointment time to be seen and 54% of respondents felt that they didn't normally have to wait too long to be seen in the practice, this was slightly higher than the CCG average of 53%. We noticed a theme across the CQC comment cards and comments from patients spoken to on the day of inspection with regards to appointment waiting times. One patient told us that they waited one hour for an appointment when a locum GP was running late and another patient commented that they were waiting for their appointment for 45 minutes. The theme picked up was regarding communication from the practice when clinics are running late, patients said they were not kept informed when having to wait for long periods.

The practice's rates for missed appointments were up to 250 in one month. We asked the practice what processes they had in place to help to reduce these rates, the practice did not utilise a text messaging reminder service available through their IT system however they did write to patients who failed to cancel their appointments. The text messenger reminder option would remind patients of their

appointment times; we noticed a comment on one of the CQC comment cards where a patient had suggested that the practice implement a text messaging service for patients who wished to opt in for this.

## Listening and learning from concerns and complaints

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

The practice reviewed complaints annually to detect themes or trends and complaints were discussed at practice meetings. Practice meetings were held every six weeks, we saw that within the meeting minutes, learning was shared and this included learning points from some complaints. However, we were unable to identify the learning on complaints that were made with regards to locum GPs. Five of the 13 complaints logged within the last 12 months were made regarding the locum GPs at the practice. We were unable to identify action taken and lessons learnt from these particular complaints as responses were not always received from the locums once they were not actively working at the practice. The management team assured us that complaint details were always shared with the locum agency however locum responses were not logged within the complaint details that the practice provided to us.

We saw that information was available within the practice leaflet to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint. We spoke with one patient whose relative had made a complaint previously with regards to the treatment and manner of a locum GP. This also reflected a theme across the nature of complaints made at the practice.

# 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 the highest quality health care that is continuing, holistic and responsive to patients' needs and preferences. We spoke with seven members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

All staff at the practice were able to attend a corporate event which was held by the group every six months to discuss the groups' vision. Other items on the event agenda included sharing of key learning points, staff told us that they benefitted from attending these events as it was good to share ideas and see how improvements can be made from the examples set by other practices within the group.

### Governance arrangements

The practice had a range of policies and procedures and these were all available on the practice computer system where members of the team could access them. Most of the staff we spoke with were familiar with the practices policy system and staff were able to direct us to a number of electronic policies and procedures. The practice had a whistleblowing policy which was also available to all staff.

The practice had a programme of monthly business reports. The latest report was shared with us on the day of our inspection. We saw that the practice was regularly monitoring and reporting on quality and governance. For example, we saw that significant event and complaint figures were monitored on a monthly basis. The practice told us that the monthly business report was included in the practice meetings; we saw evidence to reflect this within the minutes of the meetings. The minutes of staff meetings also included evidence of QOF discussions and performance reviews.

### Leadership, openness and transparency

The management and GP team in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. We saw from minutes that team meetings were held every six weeks.

Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at

team meetings and were confident in doing so and felt supported if they did. Staff told us that the practice was supportive of their training needs and were encouraged to participate in e-learning which was available to them. We also noted that educational events were held every six months. Staff said they felt respected, valued and supported, particularly by the practice manager, GPs and nurses in the practice.

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

The practice had gathered feedback from patients through surveys, complaints received and the patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services.

We spoke with a member of the PPG during our inspection; the PPG member informed us that a PPG meeting had not taken place for several months. The PPG member felt that this was due to a reduction in members and also due to a mixture of changes in management at the practice. The practice recognised the need to maintain a PPG and therefore decided to proceed with a virtual patient participation group, giving the practice a total of 28 PPG members (including the PPG chairman). The chairman told us that he expected the work of the PPG would strengthen at the practice now that a newly appointed practice manager was in post.

The PPG member told us how they were exploring ways of encouraging more people to join as PPG members and that they hoped to approach and include the young population group at the practice. To support these plans the practice and the PPG had set up a dedicated PPG table in the reception waiting room. We saw that the PPG table contained healthy lifestyle information as well as posters and forms for patients who wished to join the PPG. However, we found that some of the PPG information contained mixed dates. For example, the poster for the recruitment of new PPG members noted that meetings took place every two months and the PPG newsletter from May 2015 noted that meetings took place every three months, the information shared by the practice noted that meetings took place every two to three months.

The practice had gathered feedback from patients through patient satisfaction surveys. We looked at the results of the annual GP patient survey and 28% of the respondents said

# Are services well-led?

Good 

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

that they always or almost always get to see or speak to the GP they prefer. This was lower than the CCG average of 57% and also lower than the national average of 60%. The practice acknowledged this theme and recruited three permanent GPs to improve continuity of care.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. We saw a suggestions box for patients to make suggestions in writing.

## **Management lead through learning and improvement**

Staff reported that they felt all areas of the practice had improved in the last six months and that leadership and management had improved considerably. These comments also reflected comments given by the PPG

chairman who told us how the practice had made staffing improvements by recruiting permanent GPs and appointing a practice manager to support the practice team.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was supportive of training and that the practice held regular educational events, including group professional development events held every six weeks. Guest speakers and clinical members of the board would attend the educational events along with clinical staff members across the groups' practices.

Regular practice meetings were taking place at the practice. Minutes of the meetings demonstrated that the practice had completed reviews of significant events and other incidents to ensure the practice improved outcomes for patients; shared learning was also documented within the minutes.