

OHP-Poolway 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?

Requires improvement 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Requires Improvement

Are services well-led? – Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students) – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) – Good

We carried out an announced comprehensive inspection at OHP-Poolway Medical Centre on 10 November 2017 as part of our inspection programme.

At this inspection we found:

- The practice was faced with a number of challenges outside their control which had placed additional pressure on staff and the service. This included two practice relocations since registering with CQC and the long term leave of one of the partners. The latest relocation of services was in September 2017. These challenges had generally been well managed by the practice to ensure continuity of service provision.
- The practice had systems and processes in place to keep patients safe and safeguarded from abuse. This included safeguarding arrangements, management of infection control, medicines and for unforeseen events.
- At the time of our inspection, the tenancy agreement was due to be signed and the practice was working with the landlord to ensure the safety of the premises. Refurbishment was in progress and various risk assessments had been undertaken in relation to the premises. However, we found risk assessments in relation to fire safety were not sufficiently detailed and were in need of review.
- The practice was reliant on regular locum staff, The principal GP worked flexibly to ensure cover was provided.
- The practice ensured that care and treatment was delivered according to evidence-based guidelines. They worked with a range of health and care professionals in the delivery of patient care.

Summary of findings

- Patient outcomes in relation to the quality outcome framework showed the practice was performing in line with other practices locally and nationally for many long term conditions.
- Feedback from patients from the national GP patient survey and the CQC patient comment cards showed that they felt they were treated with compassion, kindness, dignity and respect and felt involved in their care and treatment. Patient satisfaction with consultations with clinical staff and helpfulness of reception staff was above local and national averages.
- However, patient feedback also indicated that they did not always find it easy to access care when they needed it. The practice had started making improvements such as the recent piloting of a new telephone systems.
- We found systems for record keeping to support the delivery of the service was not always effective for example the recording of action taken in response to safety alerts, information relating to staff including training and registration and meetings.
- Review systems and processes for recording incidents occurring within the practice (positive and negative) to support practice learning.
- Review systems for monitoring staff registration with professional bodies to ensure they remain up to date.
- Review fire safety in the premises to ensure an adequate assessment of risk has been undertaken and action taken in response.
- Improve record keeping in relation actions taken in response to staff training, staff information, practice meetings and safety alerts.
- Take action to address areas where the practice is an outlier in relation to patient outcomes and prescribing.
- Continue to take action for improving patient satisfaction in relation to access to appointments and monitor progress to ensure progress is being made.
- Make greater use of service improvement activity such as clinical audit to support service improvements.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

The areas where the provider **should** make improvements are:

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

OHP-Poolway 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 adviser and a practice nurse specialist adviser.

Background to OHP-Poolway Medical Centre

OHP – Poolway Medical Centre is a member of the provider organisation Our Health Partnership, a partnership of approximately 40 practices and 340,000 patients across the West Midlands area. The partnership aims to support the member practices in meeting the changing demands of primary care. The practice also sits within NHS Birmingham Cross City Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

The practice recently moved in to their current premises in the Kitts Green area of Birmingham in September 2017 after their previous premises were placed under a compulsory purchase order for redevelopment. At the time of our inspection, the practice was in the process of refurbishing the new premises.

The practice registered list size is approximately 2500 patients. Services to patients are provided under a General Medical Services (GMS) contract with NHS England. A GMS contract ensures practices provide essential services for people who are sick as well as, for example, chronic disease management and end of life care and is a nationally agreed contract. The practice also provides some enhanced services such as childhood vaccinations.

Based on data available from Public Health England, the practice population is slightly younger than local and national averages and is located in an area with higher than average levels of deprivation.

Practice staffing consists of two female GP partners (one of the GP partners is on long term leave) supported by a locum GP and locum Advanced Nurse Practitioner, one practice nurse, a practice manager and two reception staff.

The practice is open Monday to Friday from 8.15am to 1pm and between 2pm and 6.30pm except on a Wednesday when it closes at 1pm. When the practice is closed during core hours services are provided by Primecare through a direct line and in the out of hours period patients receive care through another out of hours provider, Birmingham and District General Practitioner Emergency Room (BADGER) via the NHS 111 telephone service.

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice had policies and procedures in place for safeguarding children and vulnerable adults, these were up to date and accessible to all staff. Information was also available which clearly outlined who staff should contact for further guidance if they had a safeguarding concern. Alerts on the patient record system ensured staff were aware if a patient was at risk of harm. Staff demonstrated they understood their responsibilities and were able to give examples where they had taken appropriate action in relation to concerns about a patient's welfare. All staff had undertaken safeguarding training and clinical staff were trained to child safeguarding level three. The practice worked with other agencies to support patients and protect them from neglect and abuse. The principal GP told us that they would attend safeguarding meetings or provide reports where necessary for other agencies.
- The practice manager advised us that there had not been any new staff recruited recently however, they did regularly use locum staff. We checked the personnel files for two clinical members of staff (one of which was a long term locum). During the inspection we saw some staff checks in place but information was not consistently available for example photographic proof of identification for one member of staff and Disclosure and Barring Service check (DBS) check for the other. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice manager assured us that this information was available but were unable to locate it because of the move. References as evidence of conduct in previous employment obtained by telephone were also not available. We saw that registration with professional bodies was checked at the time of recruitment but the practice did not have an established a process to monitor this on a regular basis to ensure registrations remained valid. During our inspection, the practice

manager undertook a search against the professional registers to update the information held. Following our inspection, the practice provided evidence of DBS checks and proof of identification that was previously unavailable.

- Notices were displayed throughout the practice which advised patients that chaperones were available if required. The practice manager told us that only clinical staff acted as chaperones and had undergone a DBS check.
- There was an effective system to manage infection prevention and control. We observed the premises to be visibly clean and tidy. At the time of our inspection, the practice was undergoing refurbishment. We saw the refurbishment of the clinical rooms had been completed and new flooring laid in the waiting area. The principal GP was the nominated infection prevention and control (IPC) lead who liaised with the local infection prevention teams. There were cleaning schedules and monitoring systems in place for the premises and for items of clinical equipment. A recent infection control audit carried out by the local Clinical Commissioning group in November 2017 scored the practice at 92% compliant with infection control. The main areas highlighted for improvement related to the environment where work was still in progress.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. We saw evidence that electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety however, formal arrangements to ensure continuity of clinical cover over the long term were not consistently in place to set out working expectations.

- There were arrangements for planning and monitoring the number and mix of staff needed. The practice was reliant on locum staff to support the principal GP due to the long term absence of the second GP partner. Where possible the practice tried to use the same two locums who usually worked regular sessions. We saw a formal agreement for one of the locum staff but not the other. The principal GP told us they would work flexibly with the locum staff to ensure cover was always provided.

Are services safe?

The practice manager also told us that they would support reception staff during absences of leave or sickness. Practice staff advised us that the second GP partner was anticipated to return to work at the practice early in 2018 and that Our Health Partnership were supporting them to recruit a salaried GP.

- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. A template for suspected sepsis in line with evidence based guidance was available for clinicians to use. Emergency medicines and equipment including a defibrillator (with child and adult pads) and oxygen were available. These were routinely checked to ensure they were ready for use. There was an instant messaging system in place for alerting all staff to an emergency.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. This had been updated for the new premises. The plan contained details of emergency contacts. Copies were kept off site should the premises become inaccessible. A new telephone system had recently been installed that would allow continuity of the telephone service from another site should the practice needed to relocate.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe.
- The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff.
- Patient information such as test results and hospital discharge information was acted on in a timely way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There were dedicated forms for sharing information with the out of hours provider and a dedicated telephone line for community staff to speak with practice staff.
- Referral letters seen included the necessary information.
- Patient records and information was held securely.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.
- Staff prescribed medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.
- The practice kept prescription stationery securely and monitored its use.
- There was evidence of actions taken to support antimicrobial stewardship. Clinical staff had access to the local antimicrobial guidelines, microbiology and public health contact details for further advice and guidance.
- Patient Group Directions were in place to allow the practice nurse to administer medicines in line with legislation.

Track record on safety

- There were risk assessments in relation to safety issues.
- The practice had recently moved into their current premises and were due to sign off the long term tenancy agreement. As part of the process a maintenance schedule had been drawn up of work needed. We saw risk assessments had recently been undertaken in relation to the premises including legionella and asbestos. We saw evidence of checks on fire equipment. However the fire risk assessment in place (dated 2011) had not been reviewed and updated as appropriate since the previous tenants. Following the inspection the provider sent us a fire risk assessment that they had completed internally. However, this was a list of what they were doing in relation to fire safety rather than an adequate assessment of the fire risks within the premises.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong. However there were relatively few recorded incidents to support learning.

- There was a system for recording and acting on significant events and incidents. Staff understood their

Are services safe?

duty to raise concerns and report incidents and near misses and had access to reporting forms. The practice had reported eight incidents from the last year, we saw that six of these related to concerns about other organisations rather than incidents relating to the practice itself. The practice shared with us an example of an incident involving an aggressive patient, systems were reviewed to ensure staff knew what to do should a similar incident occur.

- There were systems for reviewing and investigating when things went wrong. The practice had undertaken a review of their significant events however this was last done in September 2016.
- The principal GP told us that they discussed significant events across practices within the local commissioning network so that learning could be shared more widely. As part of the membership with Our Health Partnership a new IT system had recently been introduced for the reporting of incidents across practices within the wider partnership for shared learning.

- There was a system for receiving and acting on safety alerts. As part of the new IT system from OHP safety alerts were shared with the member practices who were required to confirm that they had been acted on. Practice staff assured us that they did act on safety alerts however documentary evidence of the action taken was not clearly available. In one example we saw evidence that a search had taken place to identify patients on a certain medicine with associated risks but it was not evidenced how these patients had been followed up and the outcome of the search. The practice manager also told us of another alert they had acted on but were not aware of any system for recording the action taken.
- The practice learned from external safety events as well as patient and medicine safety alerts. We saw an example of a local safety alert that had been recorded and discussed as a significant event.

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing, examples of care plans seen demonstrated this.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- Templates were used to ensure consistent care was given.
- We saw no evidence of discrimination when making care and treatment decisions.
- The percentage of new cancer cases (among patients registered at the practice) who were referred using the urgent two week wait referral pathway was 46% which was comparable to the CCG average of 49% and national average of 51%.

However,

- Prescribing of antibiotics was slightly higher than the national average although the prescribing of broad range antibiotics was lower than the national average. The principal GP felt this might be due to prescribing of rescue packs for reducing Chronic Obstructive Pulmonary Disease (COPD) emergency admissions. The practice had issued 35 rescue packs between September 2016 to September 2017.
- The practice also had a higher rate of hypnotics prescribing than the national average. The practice felt this was due to the higher prevalence of depression in the practice population compared to the CCG average. Patients were often continued prescribing hypnotics after specialist initiation. Staff told us that they have addressed this through their hypnotic policy which focuses on short term courses and patient education on the risks and that this has led to a reduction in hypnotic prescribing in the last year..

Older people:

- The practice maintained registers of patients who were frail so that it could provide support as necessary. There were 64 patients on this register.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Patients with a care plan in place such as those at risk of falls were given access to a priority telephone line to the practice so that they could access support quickly.
- Patients aged over 75 were invited for a health check. Over the last 12 months 71 had been carried out.

People with long-term conditions:

- The practice had a high disease prevalence for many long term conditions compared with the CCG and national averages. For example, 8% of the practice list size had a diagnosis of asthma, 5% had a diagnosis of COPD, 11% had a diagnosis of diabetes and 16% a diagnosis of hypertension.
- Despite the high disease prevalence nationally available data (2016/17) on patient outcomes for long term conditions such as asthma, COPD, diabetes, hypertension and atrial fibrillation was comparable to CCG and national averages.
- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met.
- Performance for diabetes related indicators overall was 92% compared to the CCG average of 94% and national average of 91%. We identified one area in which the practice was an outlier, this related to the percentage of patients with diabetes whose last blood pressure reading was 140/80 or less. The practice achieved 55% compared to the CCG average of 77% and the national average of 78%.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Care plans and advice for the management of worsening conditions was provided to the most complex patients such as those with COPD, asthma and diabetes. A priority line was set up for these patients to call if they needed support. Staff told us they would receive a same day call back from a clinician

Families, children and young people:

Are services effective?

(for example, treatment is effective)

- Childhood immunisations were carried out in line with the national childhood vaccination programme. The uptake rates for childhood immunisations for under two year olds was meeting the national standard of 90% or above.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. Medication reviews were carried out at the time of booking and consultant advice sought.
- The practice was able to provide examples of support provided to premature babies and their families on discharge from hospital.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 83%, which was in line with the 80% coverage target for the national screening programme.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- We reviewed data for uptake of other national cancer screening programmes. This showed the uptake for breast cancer screening was in line with CCG and national averages but below for bowel cancer screening. The practice manager told us that they were working to bowel cancer screening hub to encourage further uptake of bowel screening.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice made use of the ReSPECT form for recording advance care planning for emergency care for patients at end of life.
- The practice held a register of patients living in vulnerable circumstances such as those with a learning disability. The practice had 21 patients on the learning disability register of which 16 had received a health check in the last year.

- The practice did not have any patients with no fixed abode registered but told us that they would use the practice address if necessary so that they could register.

People experiencing poor mental health (including people with dementia):

- The practice had a high prevalence of depression compared to the CCG and national averages at 23% of the practice list.
- Nationally available data for 2016/17 showed 86% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to the CCG average of 85% and national average of 84%.
- Nationally available data for 2016/17 showed 100% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is higher than the CCG average of 92% and the national average national average of 90%. Practice exception reporting was also lower for this indicator.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. We saw several examples of consultations where the patient's physical health needs had been reviewed alongside mental health needs.
- The practice had systems to follow up patients who attended accident and emergency where they may have experienced poor health and we saw an example of this.
- The practice had recently met with the Community Mental Health team and were trying to establish six monthly meetings.

Monitoring care and treatment

The practice undertook some quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

- The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were for 2016/17. This data showed the practice had achieved 99% of the total number of points available, which was comparable with the clinical commissioning group (CCG) average of 97% and the national average of 96%.

Are services effective?

(for example, treatment is effective)

Overall exception reporting by the practice was 10% which was comparable to the CCG average of 11% and the national average of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- The practice shared with us examples of clinical audits that they had recently undertaken. This included two full cycle audits relating to the management of asthma and antibiotic prescribing. The asthma audit showed improved prescribing of inhaled corticosteroids in the management of asthma. The audit of antibiotic prescribing showed limited improvement. For example, there was improvement in relation to the use of antibiotics in line with local guidance from 40% to 64%. However there were also areas where the practice scores had deteriorated for example the use prophylactic antibiotics reviewed at each annual medication review was down from 100% to 83%. Practice staff told us that they were working to improve antibiotic prescribing but no specific plans of action were in place.

Effective staffing

We reviewed staff training records to assess whether staff had the skills, knowledge and experience to carry out their roles. We found training records were not easy to follow as there was no overall systems for monitoring that staff were up to date or clear expectations as to what training staff needed to complete. We found:

- Staff had access to training such as e-learning training modules. However, there were gaps in the training records reviewed. For example, records showed only one member of staff had completed fire safety training, none of the reception staff had completed information governance training and only one of the reception staff had undertaken infection control training. We were also unable to verify that the long term locum GP had up to date basic life support and anaphylaxis training. However, we did not identify any issues during the inspection which indicated staff did not have skills or knowledge in these areas.
- We saw evidence of role specific training for example for staff administering vaccines and taking samples for the cervical screening programme and in relation to long

term conditions. The principal GP told us that they and the practice nurse were currently undertaking training to improve end of life care through the gold standard framework accreditation training scheme.

- Staff appraisals had been carried recently to discuss learning and development needs. However, we were also unable to verify that there was a systematic approach to staff appraisals to ensure they were carried out on a regular basis. The practice manager advised us that they undertook annual appraisals in September but this had been delayed due to the relocation of premises.
- During our inspection we saw that that there was a locum checklist to go through with clinical staff working on a temporary basis but no locum pack. Following the inspection the practice manager forwarded the locum pack to us.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice held multidisciplinary meetings on a quarterly basis to discuss some of the practices most vulnerable patients such as those with end of life care needs. Minutes of these meetings were seen.
- Results from tests and other patient information was reviewed by the principal GP. We saw that these were managed in a timely way.
- Practice staff told us that referrals made as part of the two week wait were followed up to ensure they were actioned properly.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

Are services effective?

(for example, treatment is effective)

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- The practice manager told us that they had undertaken smoking cessation training and were able to offer this as an in-house service. The practice also made use of local schemes available to support patients in leading healthier lifestyles.
- Flu and shingles vaccinations were available to eligible patients.
- The practice offered opportunistic screening for atrial fibrillation (heart condition).
- Information leaflets were available for patients to take away for example drug and alcohol support and mental health wellbeing.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. For example, advice was given to patients with long term conditions should their condition deteriorate.
- Clinical staff discussed changes to care or treatment with patients and their carers as necessary.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making for patients who may lack mental capacity and for children and young people. The practice had a Mental Capacity Act policy which clearly documented expectations with recording capacity assessments.
- Information relating to the Mental Capacity Act was displayed in the clinical rooms along with information about independent mental capacity advocates should a patient need support.
- The practice had systems for seeking consent for procedures carried out at the practice. For example, consent forms were used for joint injections which included details of the risks associated with the procedure explained.
- The practice made use of ReSPECT (Recommended summary plan for emergency care and treatment) for planning future emergency care where the patient may not be able to make or express choices in the future.

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff were sensitive to patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- As clinical staff were all female staff told us that there was a regular male locum GP they would use for approximately two sessions each month if patients specifically wanted to see a male GP.

All of the 37 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they found staff polite, helpful and caring. They also told us that they felt listened to. This was in line with other feedback received by the practice such as the NHS Friends and Family Test. Results from the Friends and Family Test for September 2017 showed that all of the 11 patients who responded would recommend the practice.

Results from the July 2017 annual national GP patient survey also showed patients felt they were treated with compassion, dignity and respect. A total of 364 surveys were sent out and 102 (28%) were returned. This represented approximately 4% of the practice population. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 93% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 93% of patients who responded said the GP gave them enough time compared with the CCG average of 86% and the national average of 86%.

- 98% of patients who responded said they had confidence and trust in the last GP they saw compared with the CCG average of 96% and the national average of 95%.
- 95% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared with the CCG average of 85% and the national average of 86%.
- 95% of patients who responded said the nurse was good at listening to them compared to with the CCG average of 90% and the national average of 91%.
- 95% of patients who responded said the nurse gave them enough time compared with the CCG average of 91% and the national average of 92%.
- 100% of patients who responded said they had confidence and trust in the last nurse they saw compared with the CCG average of 97% and the national average of 97%.
- 98% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared with the CCG average of 88% and the national average of 91%.
- 89% of patients who responded said they found the receptionists at the practice helpful compared with the CCG average of 83% and the national average of 87%.

Involvement in decisions about care and treatment

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were above local and national averages for consultations with GPs and in line with local and national averages for consultations with nurses:

- 94% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 87% and the national average of 86%.
- 93% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared with the CCG and national averages of 82%.
- 87% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 88% and the national average of 90%.

Are services caring?

- 83% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 84% and the national average of 85%.

Staff helped patients to be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- The practice had a form which enabled patients to identify their communication needs so that the practice could assist where possible.
- Interpretation services were available for patients who did not have English as a first language. Some of the clinical staff were also multilingual.
- The practice had a hearing loop available for patients who have difficulty hearing.
- Clinical staff had access to online information resources to help support patients.

The practice proactively identified patients who were carers. Patients who were carers were invited to notify the

practice of this using a form available from reception. The practice had identified 98 patients as carers (approximately 4% of the practice list). Carers were provided with information about local support available and referred for a carers need assessment. Information about carer support available was also displayed in the waiting area.

Staff told us that if families had experienced bereavement, the GP contacted them, a letter was also sent with information about support available.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Paper records were held securely while awaiting purpose build facilities to be put in place within the new premises.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as requires improvement for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The facilities and premises were appropriate for the services delivered. The practice had only recently moved into the premises. Refurbishment of the premises was in progress and had been completed in the clinical areas. The practice had undertaken an Equality Act assessments and there were plans to make further changes to the premises to make the reception area more accessible.
- The practice made reasonable adjustments when patients found it hard to access services. Consulting rooms were all available on the ground floor. There was automatic door access and ramps to ensure easy access for patients using wheelchairs and pushchairs.

Older people:

- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. Phlebotomy appointments were available as home visits if a patient's medical condition meant it was difficult for them to attend the practice.
- The practice offered an electronic prescription service which enabled prescriptions to be sent electronically from the GP practice to a patients chosen pharmacy for patient convenience.
- The practice participated in the ambulance triage scheme in which GPs provide advice to paramedics and facilitate support for patients with primary care as an alternative to accident and emergency. The practice told us that this was helping to prevent approximately two admissions per month.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met.

- The practice worked with specialist consultants and nurses from the local hospital to support the more complex patients with diabetes and chronic obstructive pulmonary disease through the use of virtual clinics. The practice also provided insulin initiation clinics for the convenience of patients.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life were coordinated with other services. Regular meetings with community teams took place to manage the needs of patients with complex medical issues.
- There were services available at the practice to support the diagnosis and monitoring of patients with long term conditions including spirometry, ambulatory blood pressure monitoring and phlebotomy.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Regular meetings were held with the health visitor to discuss patients at risk and we saw minutes from those meetings.
- Practice staff told us that all babies and children under five would be seen the same day and all children under 16 years who were acutely unwell.
- The practice offered various clinics for this population group including antenatal, postnatal and baby clinics.
- Baby changing facilities were available in the premises along with the promotion of breast feeding.

Working age people (including those recently retired and students):

- The practice staff told us that 14% of patients had signed up to using online bookings. At the time of inspection the practice was not currently offering online bookings due to the recent relocation of premises. However, staff told us that the last appointments each day were reserved for patients who worked and that there was some flexibility with this.
- Patients were able to receive travel vaccinations that were available on the NHS.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

Are services responsive to people's needs?

(for example, to feedback?)

- The practice undertook annual learning disability reviews and we saw examples of these.
- The Citizens Advice Bureau ran clinics from this and other local practices on a rotational basis to provide advice and support on a variety of issues.
- Practice staff told us that they had patients registered from local refuges and that patients could use the practice address to register if necessary.

People experiencing poor mental health (including people with dementia):

- Clinical staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. They were able to show examples of care plans along with advice on what to do if symptoms relapsed.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health. We saw an example of patient follow up.
- Staff told us that they would offer extended appointments to patients with poor mental health if needed.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- The practice offered a range of pre-booked and same day access appointments as well as telephone consultations. Patients could obtain longer appointments if needed.
- Patients with the most urgent needs had their care and treatment prioritised. A message on the answerphone advised patients that if they had certain symptoms to call an ambulance.
- Patients with urgent needs or with queries were listed for a call back if no appointments were available.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was below local and national averages. A total of 364 surveys were sent out and 102 (28%) were returned. This represented approximately 4% of the practice population.

- 73% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 74% and the national average of 76%.
- 49% of patients who responded said they could get through easily to the practice by phone compared with the CCG average of 59% and the national average of 71%.
- 67% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 80% and national average of 84%.
- 64% of patients who responded said their last appointment was convenient compared with the CCG average of 75% and the national average of 81%.
- 55% of patients who responded described their experience of making an appointment as good compared with the CCG average of 66% and the national average of 73%.
- 41% of patients who responded said they don't normally have to wait too long to be seen compared with the CCG average of 51% and the national average of 58%.

Feedback we received from patients through the completed comment cards also raised issues in relation to access. For example, of the 37 cards received 11 patients said they had experienced difficulty obtaining appointments.

The practice shared with us an action plan based on the 2016 national GP patient survey results which had yet to be fully implemented. Implementation of the plan was reliant on the relocation of the practice for example, more space to recruit additional reception staff. Since the relocation of the practice a new telephone system had been installed and was being piloted. This enabled the practice to monitor calls such as how many times a patient had tried to ring and to identify when the peak periods for calls were. The telephone system had been in place for approximately one month so no analysis had yet been undertaken to demonstrate impact on improved telephone access and patient satisfaction..

The practice was also anticipating the return of one of the partners early in 2018 who was currently on long term leave. Practice staff told us that one of the difficulties faced with access was that patients wanted to see the principal GP. They told us that they had unfilled appointments. Data

Are services responsive to people's needs?

(for example, to feedback?)

provided by the practice showed 58 GP appointments were unfilled between August and October 2017. The practice manager told us that only one of the unfilled appointments was for the principal GP.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Details of the complaints system was available in a patient leaflet. This provided information about expected timescales and how to escalate the complaint should the patient be unhappy with the response received.
- The complaint policy and procedures were in line with recognised guidance. There was a practice lead for managing complaints received. The practice had six reported complaints that were received since April 2016. We reviewed the complaints and found that they were handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. We saw complaints had been discussed at an annual review with staff. Both written and verbal complaints were recorded to support learning.

Are services well-led?

Good 

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

Our findings

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care. The practice had faced a number of challenges which had been outside their control which had placed additional pressure on staff and the service.

- The leadership of the practice was knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges they faced and were trying to address them. The practice had been forced to move premises twice over recent years, the latest move was in September 2017. They also had one partner on long term leave. They also recognised the need to redevelop the patient participation group since relocating.
- Practice leaders were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a business plan in place to which focussed on developing and improving the current premises. The signing of the formal tenancy agreement for the premises was due to take place the week following our inspection.
- The practice had also recently joined Our Health Partnership (OHP) who were now the provider organisation for the practice. OHP aim to provide ongoing support to member practices to help meet the changing demands of primary care. A new IT system had been introduced through OHP with the aim of facilitating shared learning of incidents, safety alerts and best practice guidance among member practices.
- There were also plans to change the practice patient record systems so that they would be compatible with the OHP systems and templates.
- The practice worked closely with other practices within their local commissioning network to develop services

to meet health and social priorities. For example, funding provided by the CCG led Aspiring for Clinical Excellence (ACE) scheme had led to the development of initiatives to support patients with diabetes and chronic obstructive pulmonary disease through joint working with secondary care.

Culture

The practice had a culture of high-quality care.

- The practice focused on the needs of patients which was led by a dedicated and hardworking principal GP.
- The practice had a small team of staff who told us that they worked well together. The staff we spoke with felt respected, supported and valued within the team.
- Staff we spoke with told us they felt able to raise concerns and were encouraged to do so.
- Practice staff were aware of and had systems to ensure compliance with the requirements of the duty of candour. They told us that they would contact the patient if things went wrong with care and treatment but did not have any specific examples where they had needed to do this.
- However, we also found that processes for ensuring all staff were up to date with learning and development needs was not well embedded. Core training needs had not been clearly identified and monitored. It was also not evident that there was a systematic process for undertaking annual appraisals to identify learning needs, although the practice manager assured us that this was usually done in September but had been delayed due to the relocation of premises.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the service.

- Structures, processes and systems to support the governance and management of the practice were clearly set out.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care. The practice regularly met as part of a multidisciplinary team, worked with secondary care specialists and the ambulance service to help reduce admissions to secondary care.
- Staff we spoke with were clear on their roles and accountabilities including in respect of safeguarding.

Are services well-led?

Good 

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

- Practice policies, procedures and activities were in place to support safety and provide assurance that the service was operating as intended.
- Practice staff told us that they held monthly practice meetings. We saw minutes of the meetings which had included the attendance of locum staff. Although we saw issues such as audits and new policies discussed there was very little recorded detail from the meetings and for future reference of any decisions made. There was no clear structure to the practice meeting agenda to ensure key issues were always discussed or for following up matters arising.

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

- Securing long term premises and adapting these to meet the service needs was a significant risk to the practice. They were effectively working with the landlord to secure a contract and ensure risks associated with the premises were being addressed.
- In most areas we found risks were being managed appropriately. However we also found some areas where improvements were needed. This included risks relating to fire safety, staffing and staff training and development.
- The practice had processes to manage current and future performance. The practice made use of information available such as those relating to hospital attendances in order to prioritise areas for focus for example, respiratory conditions. Clinical audits had been carried out and there was some evidence of improvement from these, although areas for continued improvement were also identified.
- Practice leaders had oversight of MHRA alerts, incidents, and complaints, although records seen were limited and did not always demonstrate what action was taken.
- OHP formally took over as provider of Poolway Medical Centre in October 2017 and were implementing systems to support the practice in managing risks such as safety alerts, incidents and complaints.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to support performance and improve patient outcomes for example, QOF data was used to support the follow up of patients with long term conditions.
- The practice had looked at patient views about the service but had not yet been able to fully address these due to the practice relocation. However there were plans to revisit this.
- The practice submitted data or notifications to external organisations as required. For example in relation to safeguarding concerns.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. The practice had arrangements to ensure patient records were safe in the practice move while longer term solutions were secured.

Engagement with patients, the public, staff and external partners

The practice encouraged feedback from patients, the public, staff and external partners and engaged with them in the delivery of services.

- The practice manager told us that there was a patient participation group (PPG) with approximately nine active members of the group. However, due to the relocation they had yet to meet in the new premises. The last recorded PPG meeting was in July 2017 which had been focused on discussions about the move.
- The practice had used patient feedback from the 2016 National GP patient survey which had highlighted issues around access. They were currently piloting a new telephone system to help improve access.
- Feedback from the 2017 National GP patient survey and friends and family test showed positive feedback around consultations with clinical staff.

Continuous improvement and innovation

We saw some examples from the practice of continuous improvement and innovation. For example, through the local commissioning network and funding from the CCG the practice was working to improve care for patients with Chronic Obstructive Pulmonary Disease and Diabetes through joint working with secondary care consultants. The practice recognised a high prevalence of these conditions within their population.

Are services well-led?

Good 

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

We also saw positive examples of care planning and working with patients to support and educate them should their condition deteriorate and avoid unnecessary admissions to hospital.

The principal GP and practice nurse were also undertaking training to improve end of life care through the gold standard framework accreditation training scheme.