Moseley Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Moseley Medical Centre on 4 February 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. We also inspected the quality of care for six population groups these were, people with long term conditions, families, children and young people, working age people, older people, people in vulnerable groups and people experiencing poor mental health. We rated the care provided to these population groups as good.

Our key findings were as follows:

- There were systems in place to ensure patients received a safe service. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, reviewed and addressed.
- There were effective arrangements in place to identify, review and monitor patients with long term conditions. Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with dignity and respect and they were involved in their care and decisions about their treatment.
- The practice was responsive to the needs of the practice population. There were services aimed at specific patient groups. The complaints procedure was accessible to patients.
- There was visible leadership with defined roles and responsibilities and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

However, there were also areas of practice where the provider needs to make improvements.

In addition the provider should:

Summary of findings

- Develop a robust recruitment policy that ensures appropriate checks are undertaken prior to staff commencing their post including satisfactory written references.
- Update the audit of compliance with the Equality Act (2010) and ensure that practice implements the requirements including providing appropriate access for patients with a physical disability.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated 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. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated good for providing effective services. Data showed patient outcomes were about average in comparison to other practices nationally. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely.

Clinical audits were completed to ensure patients' care and treatment was effective. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles and further training needs had been identified and planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. There was evidence of effective multi-disciplinary working to ensure a coordinated approach to managing people with complex, long term conditions and those in high risk groups.

Are services caring?

Good

The practice is rated good for providing caring services. Data showed that patients rated the practice as average in comparison to other practices nationally for several aspects of care. Patients said they were treated with compassion, dignity and respect. Patients told us that staff listened and gave them sufficient time to discuss their concerns and they were involved in making decisions about their care and treatment. Information to help patients understand the services was available and easy to understand.

Are services responsive to people's needs?

Good

The practice had arrangements in place to respond to the needs of specific patient groups. There were vaccination clinics for babies and children and women were offered cervical cytology screening. Patients over the age of 75 years had a named GP to ensure their care was co-ordinated.

Patients were able to access urgent appointment usually on the same day.

Summary of findings

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated good for providing well-led services. It had a vision and strategy and staff were aware of their responsibilities in relation to this. There was visible leadership with defined roles and responsibilities and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings to discuss how the practice was progressing in areas such as the Quality Outcome Framework (QOF). The QOF is the annual reward and incentive programme for GP practices which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes. There 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. 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

Good

The practice is rated 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, personalised 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. It was responsive to the needs of older people, and offered home visits. The practice worked in conjunction with the multi-disciplinary team to identify and support older patients who were at high risk of hospital admissions.

People with long term conditions

Good

The practice is rated 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 named GP and an annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Patients with long term conditions were added to the appropriate registers so that they could be easily identified and offered regular reviews of their health needs.

Families, children and young people

Good

The practice is rated 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. Appointments were available outside of school hours. There was evidence of joint working arrangements with the midwives and health visitors and systems in place for information sharing.

Working age people (including those recently retired and students)

Good

The practice is rated 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

Summary of findings

care. The practice offered online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice was open extended hours to accommodate the needs of patients who worked.

People whose circumstances may make them vulnerable

Good

The practice is rated good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability and those with caring responsibilities. It had carried out annual health checks for people with a learning disability and offered longer appointments. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. Staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of contacting relevant agencies in normal working hours and out of hours.

The practice provided an enhanced service to avoid unplanned hospital admissions .This service focused on coordinated care for the most vulnerable patients and included emergency health care plans. The aim was to avoid admission to hospital by managing their health needs at home. An enhanced service is a service that is provided above the standard general medical services contract (GMS).

People experiencing poor mental health (including people with dementia)

Good

The practice is rated good for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had received an annual physical health check. Staff worked closely with local community mental health teams to ensure patients with a mental health need were reviewed, and that appropriate risk assessments and care plans were in place.

Summary of findings

What people who use the service say

We looked at results of the 2013- 2014 national GP patient survey. Findings of the survey were based on comparison to other practices nationally. The results showed that overall the practice performance in most areas relating to access was average. This included patients' experience of getting through to the practice by phone, opening times and patients overall experience of their GP practice. However, the practice was below the national average for the number of respondents who would recommend the practice to someone new to the area.

As part of the inspection we sent the practice comment cards so that patients had the opportunity to give us feedback. We received 16 completed cards, the feedback we received was overall positive. On the day of the inspection we spoke with four patients including three members of the patient participation group (PPG). PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. Patients described staff as caring and helpful and said their privacy and dignity was respected.

We reviewed comments made on the NHS Choices website to see what feedback patients had given. There were 13 comments posted on the website in the last year and there was a mixture of positive and negative feedback. The practice had not replied any of the comments.

Areas for improvement

Action the service SHOULD take to improve

- Develop a robust recruitment policy that ensures appropriate checks are undertaken prior to staff commencing their post including satisfactory written references.
- Update the audit of compliance with the Equality Act (2010) and ensure that practice implements the requirements including providing appropriate access for patients with a physical disability.

Moseley Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and included a specialist advisor GP and a specialist advisor practice manager with experience of primary care services.

Background to Moseley Medical Centre

Moseley Medical Centre is a two GP partnership practice based in an adapted residential property that has undergone refurbishment. The registered patient list size is approximately 2600 patients.

The practice has a General Medical Services contract (GMS) with NHS England. A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract. The practice also provides some enhanced services. An enhanced service is a service that is provided above the standard general medical services contract (GMS).

Moseley Medical Centre is open Mondays and Fridays between 9am to 7pm with extended opening hours on Tuesdays and Thursdays when the practice is open from 9am to 7.15pm. The practice is closed at 2pm on Wednesdays.

The practice has opted out of providing out-of-hours services to their own patients. When the practice is closed including on Wednesday afternoon, the telephone answerphone message provided patients with the option of calling the out of hours service provider 'Badger'.

The staffing establishment at Moseley Medical Centre includes clinical staff comprising two GP partners who are also the registered providers (male and female), one salaried GP (male), two practice nurses (female) and one health care assistant (female). There are three administrative staff, a practice manager, a business manager and a human resources manager.

We reviewed the most recent data available to us from Public Health England which showed that the practice is located in a deprived area of Birmingham. Data showed that the practice has a below average practice population aged 65 years and over in comparison to other practices across England. The practice achieved 98.4% points for the Quality and Outcomes Framework (QOF) for the financial year 2012-2013 out of a total of 100% of available points. This was above the national average. The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This provider had not been inspected before and that was why we included them.

Detailed findings

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

Before visiting, we reviewed a range of information that we hold about the practice. We also asked other organisations to share what they knew. We sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received16 completed comment cards where patients shared their views and experiences of the service. We carried out an announced inspection on 4 February 2015. During our inspection we spoke with a range of staff including the management team, clinical and non clinical staff. We spoke with patients who used the service and observed the way the service was delivered.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- 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)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. We reviewed minutes of meetings where significant events, near misses and complaints discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report any incidents that had occurred.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. A significant event is any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice. We saw that five significant events had occurred in the last seven months. As a result action had been taken to minimise the risk of future reoccurrence. For example, following an incident where a piece of equipment could not be located a system had been developed to log all equipment held at practice. There was evidence that significant events were discussed and shared with staff in meetings.

National patient safety alerts were reviewed and acted on by the lead GP and shared with staff. Patient safety alerts were issued when potentially harmful situations were identified and needed to be acted on.

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 training relevant to their role. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. There was evidence of regular meetings with the health visiting team to ensure information sharing, identification and follow up of at risk children.

The practice had appointed a GP with a lead role in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and that they could speak with them if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy and a poster informing patients about the service visible on the waiting room noticeboard. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Reception staff would act as a chaperone if nursing staff were not available and had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. We saw that non-clinical staff had a Disclosure and Barring Service (DBS) check or risk assessment in place which took into account potential risks such as if they would be left unattended with a patient. A DBS check helps 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

There was one dedicated secure fridge where vaccines were stored. There were systems in place to ensure that regular checks of the fridge temperatures were undertaken and recorded. This provided assurance that the vaccines were stored within the recommended temperature ranges and were safe and effective to use. Regular checks were undertaken of the fridge temperature and we saw all except one occasion where the maximum temperature had exceeded the recommended range by one degree. Our conversation with the member of staff who completed the check indicated that they were not sure what the acceptable maximum should be. We discussed this with the GPs and management team at the time of our inspection who identified that the temperature had been

exceeded during re-stocking of vaccines. They had taken immediate action to address the issue including seeking advice from the manufacturer and undertaking a risk assessment to prevent reoccurrence.

The practice routinely used electronic prescribing and systems were in place to ensure all prescriptions including paper prescriptions could be accounted for.

There were robust arrangements in place for repeat prescribing so that patients were reviewed appropriately to ensure their medications remained relevant to their health needs. There was an alert system which informed patients and staff that medication reviews were due.

A pharmacist from the local Clinical Commissioning Group (CCG) was attached to the practice which enabled medicine management systems to be monitored and reviewed through auditing. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

The most recent national data available to us for 2013-2014 showed us that the practice prescribing rates for some medicines for example, the prescribing of non-steroidal anti-inflammatory medicines were in line with the national average. The practice rates for antibacterial prescriptions were better than the national average.

Cleanliness and infection control

On the day of our inspection we observed that the practice was visibly clean and tidy. There were systems in place to reduce the risk of cross infection. This included the availability of personal protective equipment and posters promoting good hand hygiene.

There was an infection control policy and a named lead for infection control with responsibility for overseeing infection control procedures. We saw evidence that a large number of staff had received training in infection prevention and control so that they were up to date with good practice. Further training was planned for staff who were due updates.

We found that suitable arrangements were in place for the storage and the disposal of clinical waste and sharps. Sharps boxes were dated and signed to help staff monitor how long they had been in place. A contract was in place to ensure the safe disposal of clinical waste. The practice employed cleaners for the general cleaning of the environment and there were records to demonstrate the cleaning undertaken. Spot checks were undertaken by the management team to ensure standards of cleaning were being maintained.

An infection prevention and control audit had been completed by the practice in December 2014 and there was evidence that some of the actions identified from the audit had been addressed and others were in progress. For example, hand sanitisers were made available in reception areas and there were wall mounted hand wash dispensers in clinical rooms

The practice had completed a Legionella risk assessment. Legionella is a term for particular bacteria which can contaminate water systems in buildings.

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. All portable electrical equipment was routinely tested and a schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example blood pressure measuring devices.

Staffing and recruitment

Records we looked at contained some evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). A DBS check helps 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. The practice had a recruitment policy that set out the standards followed when recruiting staff.

We also saw that there were some minor gaps in the recruitment process. We looked at the files of the most recently employed clinical and non-clinical staff. For the clinical member of staff appropriate records were in place. For the non clinical member of staff we saw that they had a DBS check from another employer although a risk assessment was in place which considered potential risks associated with using a portable DBS check. We also saw that this member of staff did not have written references in

Good

Are services safe?

place; we were told that the person was known to the GPs and as such only verbal references were obtained. The practices recruitment policy stated that two references would be required although it did not state if verbal references were acceptable. The practice recruitment policy included details of when a DBS check would be necessary for staff for example, if providing regulated activities to children and vulnerable adults. However, it did not make reference to accepting portable DBS checks.

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 all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. This included a health and safety policy and a risk assessment.

Staff had received training in fire safety and there was evidence that regular fire drills took place to ensure staff were prepared in the event of a fire emergency. An annual fire risk assessment was completed in October 2014.

The practice had data log sheets for the control of substances hazardous to health (COSHH) to ensure an accurate record of all COSSH products.

Arrangements to deal with emergencies and major incident

There were arrangements to deal with foreseeable medical emergencies. Most of the staff had received training in responding to a medical emergency although some staff were due updates to ensure their knowledge and skills were in line with current best practice. There were emergency medicines and equipment available so that staff could respond safely in the event of a medical emergency. The practice had oxygen and automated external defibrillator (AED). This is a piece of life saving equipment that can be used in the event of a medical emergency. All of the staff asked (including receptionists) knew the location of the emergency medicines and equipment. Staff told us that emergency medicines and equipment were checked daily to ensure that they were in good working order and we saw that records were in place. The emergency medicines and equipment we looked at were all in date.

We saw that the patient waiting area was some distance from the reception occupied by staff. We asked how staff would identify a deteriorating patient. The managers told us that staff occupied the office located in the patient waiting area which was surrounded by glass windows so they were able to see patients and there were CCTV cameras in operation in communal areas.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. For example, power failure and adverse weather. The document also contained relevant contact details for staff to refer to and was easily accessible to all staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. There were examples of the practice implementing best practice in line with NICE. For example, for the management and treatment of patients with diabetes and a heart condition which results in an irregular heart rate.

Monthly staff meetings and protected learning time provided the opportunity to discuss and share best practice.

The GPs at the practice had lead roles in specialist clinical areas such as diabetes, women's health and safeguarding. The practice nurses supported this work, which allowed the practice to focus on specific conditions.

The practice had a system in place for identifying and reviewing patients with long term conditions. Data that we reviewed showed that the practice was in line with the national average in a number of areas such as diabetes and mental health.

All GPs we spoke with used national standards for any urgent referrals to secondary care for example for suspected cancer.

Discrimination was avoided when making care and treatment decisions. Interviews with the 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.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients as part of the Quality and Outcomes Framework (QOF). The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes. The most recent data available to us showed that the practice achieved 98.4% points for the Quality and Outcomes Framework (QOF) for the financial year 2012-2013 out of a total of 100% of available points.This was above the national average. The practice QOF score in areas such as diabetes and mental health was average in comparison to other practices nationally.

The practice had a system in place for completing clinical audit cycles. The practice had completed seven clinical audits in the last year. Of these audits five were completed cycles which showed improvements made to patients care and treatment and demonstrated learning and reflection. For example, an audit to ensure patients were prescribed an alternative more appropriate medicine for their health condition based on NICE guidance. The other two audits were still in progress.

The team was making use of clinical audit tools and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved.

At the time of the inspection the practice did not have any patients receiving end of life care. However, the practice had previously implemented the gold standards framework for end of life care (GSF). This framework helps doctors, nurses and care assistants provide a good standard of care for patients who may be in the last years of life. This included a palliative care register and regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

One of the GPs in the surgery undertook joint injections which are used to treat inflammation caused by for example, arthritis, they were appropriately trained and kept up to date.

Effective staffing

The practice had an established team that included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with courses such as basic life support, safeguarding children and vulnerable adults, fire safety and infection control and further training was planned for staff who were due updates. Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those

Good

Are services effective?

(for example, treatment is effective)

with extended roles such as reviewing patients with long-term conditions such as diabetes and respiratory conditions were also able to demonstrate that they had appropriate training to fulfil these roles.

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).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training, for example the practice nurse had completed a spirometry course.

There were monthly practice meetings which included staff such as administrative and clinical staff which enabled important information to be shared with staff as well providing an opportunity or staff to discuss any issues.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and support those 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. There were systems in place to ensure that the results of tests and investigations were reviewed and acted on as clinically necessary by a GP. The practice had an effective referral system to secondary care services such as the hospital.

Multidisciplinary working was in place, meetings were held with health care professionals such as the district nurses and health visitors. We spoke with the health visiting and district nursing team who told us that they felt this system worked well and remarked on the usefulness of the meetings as a means of sharing important information about high risk patients and those with complex care needs.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The practice had completed the required 2% of care plans for patients at most risk of unplanned hospital admissions and regularly reviewed them.

Information sharing

The practice had arrangements in place to share information with local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner.

The practice referred patients appropriately to secondary and other community care services such as district nurses. The practice used the Choose and Book system for making the majority of patient referrals. The Choose and Book system enables patients to choose at which hospital they would prefer to be seen.

Our discussion with health care professionals and evidence from meeting minutes reviewed on the day demonstrated that information was shared in a timely manner.

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. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. The practice had a consent policy in place and there was a template to record capacity assessment which would be uploaded on to the patients medical records to provide an audit trail.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated 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. Clinical staff demonstrated an understanding of Gillick competencies. (These helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health promotion and prevention

Information leaflets and posters relating to health promotion and prevention were available in the patient waiting area. There was also information that signposted

Good

Are services effective?

(for example, treatment is effective)

patients to support groups and organisations such as services for people who were carers. We saw a television in the patient waiting area which was used to disseminate health promotion and prevention advice.

The practice offered advice and support in areas such as smoking cessation, weight management, family planning and sexual health referring patients to secondary services where necessary. NHS health checks were available for people aged between 40 years and 74 years and the practice offered a range of health promotion and screening services which reflected the needs of this patient group. Flu vaccinations were offered to high risk groups such as older patients and those with caring responsibilities.

The practice had a policy and procedure in place for new patients registering with the practice. A new patient check was completed by the health care assistant. The GPs were informed of all health concerns detected and these were followed up in a timely way.

There was a national recall system in place for cervical screening in which patients were invited to attend the practice. Cervical screening was undertaken by the practice nurse. This ensured women received this important health check including their results in a timely manner. Findings were audited to ensure good practice was being followed.

Good

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 GP patient survey 2013- 2014. The results of the national GP survey highlighted the practice was average in most areas in comparison to other practices nationally. For example, data showed the practice was rated average for the proportion of respondents who stated that the last time they saw or spoke to a GP or nurse, they were good or very good at treating them with care and concern.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 16 completed cards and these were positive about the service patients experienced. Patients said staff treated them with dignity and respect. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room and that their privacy and dignity was maintained during examinations, investigations and treatments. We also noted that consultation and treatment room doors were closed during consultations.

The layout of the patient waiting area meant that patient's confidentiality was not always maintained. Patients could be overheard when talking to staff in two of the consulting rooms. The GPs told us that the television in the patient waiting area was used to help mute the conversations in the consulting rooms so that they could not be overheard by patients waiting outside. We saw that an office was located in the patient waiting area with glass screen surrounding it which did not make it sound proof. The GPs told us that this office was only used for administrative work and no sensitive information was discussed. We observed staff were careful in what they discussed with patients approaching the reception desk and a poster informing patients that they could discuss any issues in private, away from the main reception desk.

Patients were offered a chaperone for intimate examinations and procedures and our discussions with staff demonstrated that they were aware of the importance of maintaining patient dignity and respect during such procedures. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.

There were male and female GPs employed at the practice. This gave patients the option of receiving gender specific care and treatment.

Care planning and involvement in decisions about care and treatment

Data from the national GP patient survey 2013-2014 showed that patients rated the practice in line with other practices nationally in response to questions about their involvement in planning and making decisions about their care and treatment. For example, the numbers of respondents who said the last time they saw a GP or nurse, they were good or very good at involving them in decisions about their care. This was aligned with feedback we received on the day of the inspection. Patients told us that they were involved in their care and decisions about their treatment.

Patient/carer support to cope emotionally with care and treatment

There was information in the patient waiting area for carers which included details of how to access support groups and organisation to ensure this vulnerable group understood the various avenues of support available to them. The practice also had a register for identifying people who were carers to ensure their needs were identified and support could be offered.

Staff told us that if families had suffered bereavement, the GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

The GPs at the practice also occasionally attended the funeral of patients who had passed away, and we saw that the GPs had recently attended a funeral of a patient.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The practice delivered core services to meet the needs of the patient population they treated. For example, screening services were in place to detect and monitor the symptoms of long term conditions such as diabetes. Patients over the age of 75 years had a named GP to ensure their care was co-ordinated. There were vaccination clinics for babies and children at risk groups, and women were offered cervical screening.

National data showed that the practice performance in areas such as cervical screening, flu vaccinations for at risk groups including those over 65 years were in line with national average. There was evidence to support that the practice was monitoring its performance and taking action to ensure improvements were made. For, example, the practice was below the national average for the ratio of reported versus expected prevalence for Chronic Obstructive Pulmonary Disease (COPD).The practice was aware of this data and one of the GP partners was looking at how this could be improved. One of the GPs at the practice had a lead role for diabetes and was trained to initiate insulin for diabetic patients; this included reviewing patients from other practices. The practice had an ECG monitor, this enabled the results of the patients ECG to be interpreted instantly.

There was evidence that practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patients.

Tackling inequity and promoting equality

Staff told us that translation services were available for patients who did not have English as a first language. However, there was no information on display informing patients that this service was available.

There were baby changing facilities at the practice which would be helpful for parents with babies and young children.

There were no automatic doors to the main entrance into the building and no ramp access. A poster was displayed informing parents with pushchairs to ring the bell for assistance. We saw that there was a wheelchair lift outside the premises to enable patients with a physical disability to access the practice however, this was out of order on the day of our inspection. The GP partner told us that they currently had no patients who required the use of a wheelchair and if they did they would undertake a home visit. They told us that the repairs to the lift were costly and there were no clear plans for when the repair would be completed. The practice had completed an audit to assess compliance with the Equality Act (2010). This Act ensures providers of services do not treat disabled people less favourably, and must make reasonable adjustments so that there are no physical barriers to prevent disabled people using their service. However, the audit was not up to date as it did not reflect that the wheelchair lifts was out of order or that there doors were not automatic.

There were arrangements in place to enable patients with no fixed address or those requiring temporary registration to be seen or to be registered at the practice. The practice had a policy in place for new patients registering with the practice which included registering patients who were not in the practice area. However, the policy did not make any reference to patients with no fixed address .The practice manager told us that, at the time of our inspection, there were no patients registered at the practice with no fixed abode and any new patients wanting to register would be able to do so.

Access to the service

Moseley Medical Centre was open Mondays and Fridays between 9am to 7pm with extended opening hours on Tuesdays and Thursdays when the practice was opened from 9am and 7.15pm. The practice was closed at 2pm on Wednesdays. When the practice was closed including on Wednesday afternoon, the telephone answerphone message provided patients with the option of calling the out of hours service provider 'Badger'.

We looked at results of the most recent national GP patient survey 2013- 2014. Findings of the survey were based on comparison to other practices nationally. The results showed that overall the practice performance in most areas relating to access was average. This included patients' experience of getting through to the practice by phone, opening times and patients overall experience of their GP practice. The practice had undertaken its own internal survey and the results showed that patients were happy with access to the service. Feedback from completed CQC comment cards were also aligned with these views.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients could book appointments and order prescriptions on line. Telephone consultations were available with the GPs and nurses. Home visits were undertaken for those patients who were unable to attend the practice.

Listening and learning from concerns and complaints

Prior to our inspection we had received three complaints about the service between June 2014 and November 2014 although there were no particular themes identified the feedback we received suggested that the practices response to complaints was not robust. However, it was evident during the inspection that the practice had improved its management and response to complaints. The practice had a system in place for handling complaints and concerns. The practice had a complaints policy and a register which enabled the complaints process to be followed. An annual review was also undertaken to ensure complaints were being monitored and responded to in a timely manner.

We saw that information was available to help patients understand the complaints system; this included a poster in the patient waiting area and a complaints leaflet.

The practice had received five complaints in the last 12 months, we found that these were handled satisfactorily and resolved. There was evidence that lessons learned from complaints were shared with staff with changes made.

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 vision to deliver high quality care and promote good outcomes for patients by working more closely with local practices. The practice was part of a Local Commissioning Network (LCN) which included five practices. The vision was to develop more innovative ways to work with other practices. Staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

Patients were cared for by staff who were aware of their roles and responsibilities for managing risk and improving quality. There was a governance structure in place for example, there were processes in place to keep staff informed and engaged in practice matters which included protected learning time and regular staff meetings. This provided the opportunity to discuss significant events, complaints and share good practice. The GPs at the practice had various lead roles in areas such as diabetes, safeguarding and women's health. This provided the opportunity for staff to develop specialist knowledge and expertise and for other staff to obtain support and advice.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at some of these policies and procedures and found that most had been reviewed and were up to date.

There were systems in place to monitor and review the practice performance for Quality and Outcomes Framework (QOF). This included discussions about the progress of QOF targets in team meetings to review and monitor performance. Data that we reviewed showed that the practice was a high performing QOF practice. The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, prescribing audits to help improve outcomes for patients on a particular medicine.

The GP partners at the practice attended meetings with the local Clinical Commissioning Group (CCG) NHS Birmingham Crosscity. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. This ensured they were up to date with any changes.

Leadership, openness and transparency

There was evidence that the practice worked alongside the patient participation group (PPG) and acted on patient feedback which had resulted in changes being made. PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. The practice manager and a GP partner attended PPG meetings to ensure they remained fully involved and aware of feedback from patients.

The management team at the practice consisted of the GP partners, practice manager, a human resources manager and a business manager. The GP partners told us that additional management support was brought in to develop a more robust governance system as this was recognised as an area for development. However, the human resource and business manager were working on a short term basis and the long term plan to ensure sustainability was not clear.

The practice had a whistleblowing policy which was available electronically on any computer within the practice. Whistleblowing is when staff is able to report suspected wrong doing at work confidentially, this is officially referred to as 'making a disclosure in the public interest'. Our discussions with staff indicated that they were confident to raise any concerns.

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

The practice had gathered feedback from patients through the patient participation group (PPG), patient surveys and complaints received. We spoke with three members of the PPG who told us that they met every three month. There was evidence that the PPG had acted on feedback from patients, for example, responding to complaints about the use of mobile phones in the patient waiting area.

We looked at results of the most recent national GP patient survey 2013- 2014. Findings of the survey were based on comparison to other practices nationally. The results showed that overall the practice performance in most areas relating to access was average. This included patients

Are services well-led?

Good

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

experience of getting through to the practice by phone, opening times and patients overall experience of their GP practice. The practice was below the national average for the number of respondents who would recommend the practice to someone new to the area. However, the practice had taken action to make improvements. This was demonstrated by findings from the practices own survey undertaken between October and November 2014. Results showed a higher proportion of patients who would recommend the practice to someone new to the area.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. 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.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that appraisals took place which included a personal development plan. Staff told us that the practice was supportive of training and that they had protected learning time.

There was a visible leadership structure and staff members who we spoke with were clear about their roles and responsibilities. They told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patient.

The practice was part of the Clinical Commissioning Groups (CCG) 'Aspiring to Clinical Excellence' (ACE) programme. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. ACE is a programme of improvement aimed at reducing the level of variation in general practice by bringing all CCG member practices up to the same standards and delivering improved health outcomes for patients. There are two levels; ACE Foundation and ACE Excellence. Achievement of ACE foundation is verified by a practice appraisal process. The practice had achieved both foundation and excellence level and were part of the original pilot for the excellence programme known as 'ACE Excellence Pioneer'.The practices achievement of ACE Excellence demonstrated that the practice was committed to delivering a quality service.