

# Dr Eamon McQuillan

## 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

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## Overall summary

### Letter from the Chief Inspector of General Practice

This inspection was undertaken to ensure improvements made leading to the good rating from the inspection in August 2016 had been sustained. It was an announced comprehensive inspection on 21 July 2017. Overall the practice continues to be rated as Good.

Our key findings were as follows:

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice had clearly defined and embedded systems to minimise risks to patient safety. These included safeguarding, infection prevention and control and medicines management.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.

- Information about services and how to complain was available.
- Feedback from patients through the National GP patient survey (published July 2017) showed patients found it easy to make an appointment and access the service. Urgent appointments were available the same day. There was continuity of care.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported.
- The practice sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour.

There were also areas of practice where the provider should make improvements.

The provider should:

- Review and continue to take action to improve the uptake of national screening programmes for breast and bowel cancer.

# Summary of findings

**Professor Steve Field (CBE FRCP FFPH FRCGP)**

Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events.
- Lesson were shared with staff to ensure action was taken to improve safety in the practice.
- When there were unintended or unexpected safety incidents, patients received appropriate support and information.
- The practice had clearly defined, embedded systems and practice-specific processes in place to keep people safe and safeguarded from abuse.
- Risks to patients were assessed, embedded and well managed.

Good



### Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were in most areas comparable to the national average.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Prescribing data showed the practice was performing well in relation to antibiotics and hypnotics compared to other practices locally and nationally.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs, including those with end of life care needs.
- Uptake of national screening programmes for cervical screening was comparable to local and national averages but lower for breast and bowel cancer.

Good



### Are services caring?

The practice is rated as good for providing caring services.

- Data from the most recent national GP patient survey showed patients rated the practice higher than others for many aspects of care.

Good



# Summary of findings

- Feedback received from patients through the CQC comment cards told us that patients were treated with compassion, dignity and respect and that they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. The practice actively participated in the Aspiring for Clinical Excellence programme with the CCG aimed at driving improvements in general practice.
- Results from the national GP patient survey and feedback from our CQC comment cards told us that patients found it easy to make an appointment and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available. Practice staff told us that they had not received any complaints in the last 12 months.

Good



## Are services well-led?

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The practice performed well against QOF and in relation to patient satisfaction.
- The practice had sustained improvement seen at our last inspection in August 2016.
- The provider was aware of the requirements of the duty of candour.

Good



# Summary of findings

- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice sought feedback from staff and patients.

# Summary of findings

## The six population groups and what we found

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

### Older people

The practice is rated as good for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice had a low rate of emergency and unplanned admissions compared to others in the locality.
- The practice had carried out falls risk assessments on 79 out of 81 patients over the age of 76 years. Those identified as high or medium risk had a care plan in place. High risk patients were offered a referral to the falls prevention clinic for further assistance, 15 out of 22 eligible patients took up this offer.
- Patients are able to receive continuity of care from the principal GP.
- Multi-disciplinary team meetings are regularly held to discuss and manage the care of older patients with complex and palliative care needs.
- The practice would accept prescription requests via the telephone for those who had difficulty attending the practice.
- The practice was accessible to patients with mobility difficulties. A hearing loop was also available for those with a hearing impairment.

Good



### People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

- Clinical staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority. The practice had a low rate of emergency and unplanned admissions compared to others in the locality.
- Nationally reported outcome data for patients with diabetes was comparable to the CCG and national average overall (93% compared with the CCG average of 92% and national average of 90%). The practice also had lower exception reporting for diabetes indicators at 8% compared to the CCG average of 11% and national average of 12%.
- Longer appointments and home visits were available for patients who needed them.

Good



# Summary of findings

- There was a recall system in place for patients with long term conditions to attend regular reviews to check that their health and medicine needs were being met.
- Patients had access to the electronic prescription service, which enabled them to collect the medication from a pharmacy of choice without needing to attend the practice.

## Families, children and young people

The practice is rated as good for the care of families, children and young people.

- 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 attended accident and emergency (A&E) attendances or did not attend for their appointments.
- Immunisation rates were relatively high for all standard childhood immunisations. The practice provided information to promote the uptake of the MMR vaccine where concerns were raised.
- Appointments were available outside of school hours and the premises were suitable for children and babies. Baby changing facilities were available and practice staff said they would provide a room for breast-feeding if needed.
- The practice worked with midwives and health visitors to support this population group. For example, the midwife held an antenatal clinic at the practice on alternate weeks.

Good



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

The practice is rated as good for the care of working age people (including those recently retired and students).

- The practice did not offer extended opening hours. However, telephone appointments were available with the GP where appropriate. The practice was proactive in offering online services for making appointments and repeat prescriptions.
- Text messaging was used to remind patients of appointments and ease of cancellation.
- A range of health promotion and screening that reflects the needs for this age group was available.
- Uptake of cervical screening was comparable to CCG and national averages. National data for 2015/16 showed the practice uptake was 76%, compared with the CCG average of 79% and the national average of 81%.

Good



# Summary of findings

- However, there was low uptake of national screening programmes for breast and bowel cancer. The practice had tried to promote the uptake of bowel cancer screening through information on the practice website.
- Health checks were offered to patients aged 40 to 74 years.
- Health trainer attended the practice on a weekly basis to provide lifestyle advice and support.
- Other services provided for this age group include travel advice and vaccinations on the NHS, chlamydia self-testing.

## People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held register of patients living in vulnerable circumstances including those with a learning disability, with palliative care needs and carers.
- The practice had recently signed up to provide an enhanced service to provide annual reviews for patients with a learning disability.
- Learning disability passports were issued as part of a CCG initiative. These enabled patients to record and share important information including their likes and dislikes as they passed through different services.
- The practice offered longer appointments to patients who required them, such as patients with a learning disability.
- The practice supported patients to access the service. This included the provision of interpreter services and hearing loop.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies. Staff had also undertaken training in female genital mutilation awareness.
- The practice's computer system alerted the GP if a patient was also a carer. There were 24 patients on the practice's register for carers; this was 1.4% of the practice list. Patients on the carers register were offered additional support.

Good



# Summary of findings

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

Good



- Nationally available data for 2015/16 showed 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, compared to the CCG and national average of 84%. There was no exception reporting.
- National reported data for 2015/16 showed 71% of patients with poor mental health had a comprehensive, agreed care plan documented, in the preceding 12 months, which was below the CCG average 88% and national average 89%. Exception reporting at 7% was also below CCG averages at 10% and the national average of 13%. Unverified data for 2016/17 showed a small increase to 73%. We saw that the numbers involved in this indicator were relatively small 11 patients. Staff told us that they had difficulties getting these patients to attend.
- The practice met with the community mental health teams every six months to discuss those with severe poor mental health.
- Staff had undertaken Mental Capacity Act training.

# Summary of findings

## What people who use the service say

The latest national GP patient survey results were published in July 2017. The results showed the practice was performing consistently above local and national averages in terms of patient satisfaction. A total of 364 survey forms were distributed and 74 (20%) were returned. This represented 4% of the practice's patient list.

- 93% of patients described the overall experience of this GP practice as good compared with the CCG average of 81% and the national average of 85%.
- 95% of patients described their experience of making an appointment as good compared with the CCG average of 66% and the national average of 73%.
- 88% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 73% and the national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 16 comment cards which were all positive about the standard of care received. Patients described staff as kind, friendly and helpful. They told us that they were treated with dignity and respect and would recommend the service to others.

## Areas for improvement

### Action the service SHOULD take to improve

The provider should:

- Review and continue to take action to improve the uptake of national screening programmes for breast and bowel cancer.

# Dr Eamon McQuillan

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was consisted of a CQC Lead Inspector and a GP specialist adviser.

## Background to Dr Eamon McQuillan

Dr Eamon McQuillan's Surgery (also known as Bloomsbury Medical Centre) is part the 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.

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.

The practice is located in a residential property that has been adapted for the purpose of providing primary medical services. Clinical services are provided on the ground floor of the premises. There is limited parking available at the practice however, parking is permitted on the street and well served by local transport.

The practice registered list size is approximately 1,800 patients. Based on data available from Public Health England, the practice is located within the 10% most

deprived areas nationally. The practice population is slightly younger than the national average. The practice has a high proportion of patients whose first language is not English which they estimate at approximately 40%.

Practice staff consist of the principal GP (male), a practice nurse (female), a practice manager, and two reception staff.

The practice is open between 9.00am and 6.30pm Monday to Friday except for Thursday afternoon when the practice closes at 1.30pm. Appointments take place from 9.50am to 11.00am every morning and 4.10pm to 5.20pm daily (except on Thursdays). Extended hours surgeries are not offered at the practice. When the practice is closed during the out of hours period between 6.30pm and 8am on weekdays and all weekends and bank holidays the service is provided by another out of hours provider Birmingham and District General Practitioner Emergency Rooms (BADGER). Patients are directed to this service via the practice answerphone. BADGER also provides cover on a Thursday afternoon when the practice is closed.

## Why we carried out this inspection

We undertook a comprehensive inspection of Dr Eamon McQuillan's practice on 21 July 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

The practice had previously been rated as inadequate following an inspection in September 2015 and placed into special measures for a period of six months. At the September 2015 inspection the practice was found to be in breach of regulation 12 safe care and treatment and regulation 17 good governance of the Health & Social Care

# Detailed findings

Act 2008 (Regulated Activities) Regulations 2014. A follow up inspection was undertaken in August 2016 in which significant improvements had been made, the practice was rated as good and removed from special measures.

We undertook a further announced comprehensive inspection of Dr Eamon McQuillan's on 21 July 2017 to assess whether the improvements made in August 2016 had been sustained.

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations including the CCG to share what they knew. We carried out an announced visit on 21 July 2017. During our visit we:

- Spoke with a range of clinical and non-clinical staff (including the GP, practice nurse, practice manager and reception staff).
- Observed how patients were being cared for in the reception area.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

- Reviewed documentation made available to us in relation to the running of the service.

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 were provided for specific groups of people and what good care looked 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).

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.

# Are services safe?

## Our findings

### Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- There had been three significant events reported since the start of 2017. We reviewed a summary of significant events and minutes from practice meetings, which demonstrated that these had been investigated, acted on and learning shared. For example, the practice had incidents in which medicine changes made by the local hospital had been unclear. In all cases the practice had followed these up before prescribing.
- The systems in place for reporting supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- The practice told us that that when things went wrong with care and treatment, patients would be informed and apology given. However, they had not received any incidents or complaints in the last 12 months where this had been required.
- Significant events were a standing item on the practice meeting agenda for discussion and learning.
- Safety alerts received such as those from the Medicines and Healthcare products Regulatory Agency (MHRA) were routinely discussed at practice meetings and copies kept on the practice computers for staff to access. Practice staff told us of recent alerts which they had actioned such as a Department of Health alert on the risks of socket covers. Another example related to a medicine used in the management of epilepsy where potential risks were identified.

### Overview of safety systems and process

The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. The practice had safeguarding policies in place and the principal GP was the safeguarding lead for the practice. Safeguarding information and contact details for further support and guidance should a member of staff have concerns about a patient's welfare was available. This

included support for those at risk of domestic violence. Staff spoken with demonstrated they understood their responsibilities regarding safeguarding children and vulnerable adults and had received training relevant to their role. Clinical staff were trained to child safeguarding level three. The principal GP told us that they would provide reports for other agencies where necessary. An alert on the patient record system ensured staff were aware if patients they were seeing were at risk of harm.

- Notices were displayed throughout the practice advised patients that they could request a chaperone during their consultation if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (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 maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be visibly clean and tidy. The practice nurse was the infection prevention and control (IPC) clinical 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. Staff had access to personal protective equipment. Staff had access to IPC policies and procedures and had received infection control training. We saw that there had been an infection control audit carried out in November 2016 in which the practice had achieved a score of 98%. There was an action plan in place to address improvements identified as a result of the audit and an action plan showed actions identified had been completed. However, we noticed during the inspection that two of the sharps bins had been opened for longer than three months. Following the inspection the practice provided evidence to show that they had been replaced.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security, and disposal).

- There were processes for handling repeat prescriptions, which included the review of high risk medicines. We

## Are services safe?

looked at a sample of patient records and found patients on high risk medicines were appropriately monitored. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. Any uncollected prescriptions were regularly monitored and followed up as appropriate.

- We saw appropriate and organised storage of vaccines within the medicines fridge. Temperatures of the medicine fridge were monitored to ensure vaccines were stored in accordance with the manufacturer's instructions.
- The practice worked with the local clinical commissioning group medicine management teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

We reviewed three personnel files (including a locum GP) and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

### Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available ,
- There was an up to date fire risk assessment for the premises and fire equipment had been checked. We saw evidence of regular alarm testing and fire drills. Staff had received fire safety training.
- Electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order. Checks had been carried out within the last 12 months.

- The practice had a variety of other risk assessments in place to monitor the safety of the premises such as the control of substances hazardous to health (COSHH) and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). COSHH safety information was readily available when needed.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff worked regular shifts but during leave would cover for each other. For example, reception staff worked part time and were able to cover for each other during periods of leave. In the absence of the principal GP locum cover was provided.

### Arrangements to deal with emergencies and major incidents

The practice had adequate arrangement in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers and panic alarms in the consultation and treatment rooms, which alerted staff to any emergency.
- All staff received annual basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. These were routinely checked by the practice nurse to ensure they were ready for use. A first aid kit and accident book were also available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and staff knew of their location. Medicines checked were in date. The practice had a system in place to alert them when medicines needed replacing. We noticed two recommended emergency medicines were not available however, this was addressed immediately.
- The practice had a business continuity plan for major incidents such as power failure or building damage. The plan contained emergency contact numbers for staff and services that might be needed.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. NICE guidance was discussed in clinical meetings and we saw evidence of this.
- We saw that practice staff were proactive in seeking guidance from secondary care if needed.
- Guidance from the resuscitation council was displayed in treatment room.

### Management, monitoring and improving outcomes for people

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 2015/16. This showed the practice had achieved 92% of the total number of points available, which was comparable to the CCG and national average of 95%. Overall exception reporting by the practice was 9% compared to the CCG and national average of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Data from 2015/16 showed:

- Performance for diabetes related indicators was comparable to the CCG and national averages. For example, the percentage of patients, on the register, whose last HbA1c (measure of diabetic control) was 64 mmol/mol or less was 76% compared with the CCG average of 80% and the national average of 78%. Exception reporting for this indicator was 1% compared to the CCG average of 12% and national average of 13%.
- Performance for mental health related indicators was below CCG and national averages at 78%. The CCG average was 92% and national average 93%. The

practice exception reporting for mental health indicators was lower at 6% compared to the CCG average of 10% and national average of 11%. We looked at this data in more detail and found the number of patients was relatively small (15 patients). There were a small number of patients that they had difficulty getting to attend the practice for reviews. The practice met with the community mental health team to discuss patients on the mental health register.

There was evidence of quality improvement including clinical audit:

- The practice shared with us two completed audits carried out in the last 12 months where improvements made were implemented and monitored. For example, one audit seen looked at the safe use of antipsychotic medicine and another looked at the management of patients with atrial fibrillation. On re-audit both showed improvements to the care and treatment of patients and as a result of one of the audit a patient was identified as needing further care and treatment and referred to hospital.
- Prescribing data for (2015/16) showed the practice performed well compared to other practices locally and nationally as a low prescriber of hypnotics and antibiotics including broad spectrum antibiotics.
- The practice was involved in CCG led schemes to reduce medicines waste and deliver cost improvements.
- The practice was among the lowest in the local commissioning network of 11 practices for accident and emergency attendances and hospital admissions.

### Effective staffing

Staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. New staff also received a staff handbook to support them in their work and had access to online training. A locum pack was also available for locum GPs working at the practice on a temporary basis. This included information about the IT systems and referrals.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. The practice nurse had recently attended training in chronic obstructive pulmonary disease (COPD).

# Are services effective?

## (for example, treatment is effective)

- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and guidance.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. Staff found the practice supportive of training.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- The practice nurse told us that they attended practice nurse forums to support them in their work.

### Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. We saw that patient information received such as hospital letters and test results were processed and acted upon in a timely way.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. We saw minutes of multidisciplinary team meetings. These took place regularly to discuss and plan the care and treatment of some of the practices most vulnerable patients including those with complex care, palliative care and mental health care needs.

Patients were in most cases referred to secondary care through the e-referral system. We noticed during the inspection that the practice did not keep a log of two week wait suspected cancer referrals. Following our inspection the practice sent evidence to show a system had been set up.

### Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Clinical staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and guidelines for capacity to consent in children and young people. Reference to this was included in the practice's consent policy.
- Staff had undertaken Mental Capacity Act training.

### Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support for example, patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring lifestyle advice. Patients were signposted to relevant services. Patient health information was available in the patient waiting area. A health trainer attended the practice on a weekly basis to provide lifestyle advice and support.

The practice's uptake for the cervical screening programme (2015/16) was 76%, which was comparable to the CCG average of 79% and the national average of 81%. There was low exception reporting for cervical screening at 0.3%. The practice did not have a failsafe system for ensuring results were received for all samples sent for the cervical screening programme. Following the inspection the practice sent evidence to demonstrate that they systems were now in place.

The uptake of national screening programmes for bowel and breast cancer screening was lower than the CCG and national averages. For example,

- 54% of females aged 50-70 years of age had been screened for breast cancer in the last 36 months compared to the CCG average of 69% and the national average of 73%.
- 40% of patients aged 60-69 years, had been screened for bowel cancer in the last 30 months compared to the CCG average of 50% and the national average of 58%.

Practice staff told us that they had met with a member of cancer research team to look at how they might promote uptake of the national cancer screening programmes. As a result a video had been added to the practice website to promote and provide further information on bowel cancer screening.

Data available for 2015/16 on childhood immunisation rates for vaccinations given to under two year olds had achieved the national standards of 90% overall. Childhood

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

immunisation rates for the MMR vaccinations given at 5 years were comparable to the CCG and national averages. For example: uptake of dose 1 MMR was 100% compared to the CCG average of 95% and national average of 94%. Uptake of dose 2 MMR was 86% compared to the CCG average of 83% and national average of 88%. Practice staff told us that there was a reluctance among some patients for the MMR vaccine and that they were trying to educate patients of the risks and providing written information.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and

NHS health checks for patients aged 40–74. Appropriate follow ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

The practice had carried out falls risk assessments on 79 out of 81 patients over the age of 76 years. Those identified as high or medium risk had a care plan in place. High risk patients were offered a referral to the falls prevention clinic for further assistance , 15 out of 22 eligible patients took up this offer.

# Are services caring?

## Our findings

### Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- 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.
- Glass screens were available at reception to help minimise the risk of conversations being overheard.
- The practice did not have a female GP but patients were able to see the nurse or the GP in conjunction with the nurse. There were plans for a female GP to undertake a weekly session from September 2017.

All of the 16 patient Care Quality Commission comment cards we received were very positive about the service experienced. Patients described staff as kind, friendly and helpful. They told us that they were treated with dignity and respect and would recommend the service to others. Five patients told us the GP was good or excellent.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was consistently above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 93% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 91% of patients said the GP gave them enough time compared to the CCG and national average of 86%.
- 100% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 87% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and the national average of 86%.

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

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

Feedback received from patients through the CQC comment cards indicated that patients felt involved in decision making about the care and treatment they received. Patients told us that they felt listened to.

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 consistently above local and national averages. For example:

- 91% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 87% and the national average of 86%.
- 91% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national average of 82%.
- 98% of patients 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%.
- 95% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

## Are services caring?

- Practice staff told us there was a high proportion of patients on the practice list whose first language was not English. Interpretation services were available for patients who did not have English as a first language.
- The practice website could be translated into a variety of languages.
- There was a hearing loop available for those with a hearing impairment.
- The E-Referral service was used with patients as appropriate. (E-Referral service is a national electronic referral service, which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

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

Patient information leaflets and notices were available in the patient waiting area, which told patients how to access various support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 24 patients as carers (approximately 1.4% of the practice list). There was a carers pack available to signpost carers to support available and the practice would refer patients for a carers needs assessment with their agreement. The practice had a carers support policy which set out the support the practice could provide for example, flexible appointments and flu vaccinations. Carers information was also available on the practice website.

Staff told us that if families had experienced bereavement, a condolence card was sent to offer support if needed.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

The practice understood the needs of its population and engaged with the local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice participated in the Aspiring to Clinical Excellence (ACE) programme led by the CCG aimed at improving services and patient outcomes as well as delivering consistency in primary care services.

### Responding to and meeting people's needs

- Home visits were available for patients whose clinical needs resulted in difficulty attending the practice.
- There were longer appointments available for those who needed them.
- Same day appointments were available for patients with medical problems that require same day consultation.
- The premises were accessible to patients with mobility difficulties and included ramp access. There was limed parking at the practice but street parking was permitted outside the practice. Staff told us that patients could bring the car up to the door in necessary.
- The practice had baby changing facilities and staff would offer a room for patients who wished to breast feed.
- There were accessible facilities, which included a hearing loop and interpretation services. Some of the staff spoke a second language.
- Patients were able to receive travel vaccines available on the NHS.
- The practice participated in a CCG led initiative for ambulance triage. A scheme in which the GPs provide advice to paramedics and facilitate support for patients within primary care as an alternative to accident and emergency.
- Clinics with the midwife and a health trainer to provide lifestyle advice were available at the practice for the convenience of patients.

### Access to the service

The practice was open between 9.00am and 6.30pm Monday to Friday except on a Thursday afternoon when it closed at 1pm. Appointments were available from 9.50am to 11.00am every morning and 4.10pm to 5.20pm daily (except on Thursdays). Extended hours surgeries were not offered at the practice. When the practice was closed during the out of hours period between 6.30pm and 8am

on weekdays and all weekends and bank holidays the service was provided by another out of hours provider Birmingham and District General Practitioner Emergency Rooms (BADGER). Patients were directed to this service via the practice answerphone. BADGER also provided cover on a Thursday afternoon when the practice was closed and between 8.00am and 9.00am each morning.

In addition to pre-bookable appointments that could be booked two months in advance, urgent same day appointments were also available for patients that needed them. Telephone consultations were also available, where appropriate.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was consistently above local and national averages.

- 85% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 74% and the national average of 76%.
- 94% of patients said they could get through easily to the practice by phone compared to the CCG average of 59% and the national average of 71%.
- 92% of patients 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 the national average of 84%.
- 97% of patients said their last appointment was convenient compared with the CCG average of 75% and the national average of 81%.
- 95% of patients described their experience of making an appointment as good compared with the CCG average of 66% and the national average of 73%.
- 75% of patients 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%.

We saw that the next available routine appointments with a GP or a nurse was within one working day or if urgent the same day as the inspection.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

# Are services responsive to people's needs?

(for example, to feedback?)

Reception staff knew to advise patients to contact emergency services if they were experiencing certain symptoms such as chest pain.

## **Listening and learning from concerns and complaints**

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.

- We saw that information was available to help patients understand the complaints system. There was a notice displayed in the waiting area advising patients what to do if they wished to make a complaint.
- The practice had systems and processes in place for recording both verbal and written complaints. However the practice told us that they had not received any complaints in the last 12 months.
- Complaints were a standing item for discussion on the practice meeting agenda.

# Are services well-led?

Good 

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

## Our findings

### Vision and strategy

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

- The practice had set out its commitment to their patients and what they expected from the patients in return.
- The practice had a clear vision of areas where it wished to improve.
- The practice had joined Our Health Partnership a super partnership of over forty practices covering a population of approximately half a million patients within the West Midlands. The partnership aimed to support sustainability within general practice through the sharing of back office functions and support. The change to registration was in progress.

### Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care.

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff. These were kept up to date.
- A comprehensive understanding of the performance of the practice was maintained. The practice was performing well in relation to QOF, the CCG led ACE programme and patient satisfaction. Performance was monitored and discussed with staff at the practice meetings.
- Clinical and internal audits were used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- Incidents, safety alerts and complaints were standing agenda item for discussion at the practice meetings enabling any learning to be shared.
- The practice had sustained the improvements seen at our previous inspection in August 2016.

### Leadership and culture

The practice leadership consisted of the principal GP and practice manager. On the day of inspection they

demonstrated they had the experience, capacity and capability to run the practice and ensure quality care. Practice staff demonstrated safe, high quality and compassionate care. Staff found the leadership team approachable and supportive.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The provider encouraged a culture of openness and honesty. Although, there had not been any recently reported incidents in which the practice had needed to contact the patient, there were systems to ensure that when things went wrong with care and treatment affected people would receive reasonable support, truthful information and an apology and for maintaining records of interactions with patients.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with community based staff such as district nurses, health visitors and members of the community mental health team.
- Staff told us the practice held regular practice meetings. Minutes of meetings were documented and available for practice staff to view.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at practice meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported.

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

The practice encouraged and valued feedback from patients and staff in the delivery of the service.

- The practice had a patient participation group (PPG). A PPG is a way in which the practice and patients can work together to help improve the quality of the service. There were approximately 11 active members of the PPG who met on a three monthly basis and we saw minutes of meetings to confirm this. There were notices

# Are services well-led?

Good 

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

in the waiting room advertising the next meeting and encouraging patients to attend. Minutes of meetings showed that members were happy with the service overall.

- The practice reviewed and responded to comments left by patients on the NHS choices website.
- The practice had gathered feedback from staff through practice meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff were able to add items to the practice agenda for discussion.

## Continuous improvement

The practice told us about some of the changes they were bringing into the practice to secure further improvements. This included the recruitment of a female GP, membership of Our Health Partnership to share back office functions and the development of formal checks for patients with a learning difficulty following signing up to an enhanced service.