Dr Karim Ladha

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 completed a comprehensive inspection at The Dovecote Surgery on 10 February 2015. Overall the practice is rated as good.

We found that the practice was good for providing a safe, effective, caring, responsive and well led service. We found the practice provided good care to people with long term conditions, families, children and young people, older people, people in vulnerable groups and people experiencing poor mental health.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from incidents were maximised.
- Patients were protected from the risk of abuse and avoidable harm. The staff we spoke with understood their roles and responsibilities and there were policies and procedures in place for safeguarding vulnerable adults and children.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- Patients received care and treatment which achieved good outcomes, promoted a good quality of life and was based on the best available evidence. Systems were in place to review the care needs of those patients with complex needs or those in vulnerable circumstances.
- The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in patients care and treatment.

Summary of findings

- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. This was evident when speaking with staff and patients during our inspection. There was a clear leadership structure with named staff in lead roles. Staff were aware who they should speak with if they needed guidance or advice. Staff reported that they worked well as a team and could approach the practice manager or GPs if they needed to discuss anything.

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

Importantly the provider should:

- Implement systems to identify patients at the practice with caring responsibilities including young patients with caring responsibilities.
- Implement robust systems to identify and manage risks to patients and others who use the service regarding the premises, including a fire risk assessment.
- Ensure equipment such as oxygen is available to deal with a medical emergency or provide an assessment of risk to demonstrate why this equipment is not required.
- Provide evidence to demonstrate that a legionella risk assessment has been carried out to identify all risks and ensure that the practice is managing any risks identified.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing a safe service. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. However there was no emergency oxygen on the premises and no fire risk assessment, although staff had received fire training and fire safety equipment was in place. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing an effective service. Data showed patient outcomes were at or above average for the locality. NICE guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. Appraisals and personal development plans were in place for all staff. Multidisciplinary working was embedded and working well.

Are services caring?

Good

The practice is rated as good for providing a caring service. Data showed patients rated the practice highly for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing a responsive service. The practice reviewed the needs of their local population and engaged with the Clinical Commissioning Group (CCG) to secure service improvements, where these were identified. Patients reported having access to a named GP and continuity of care, with urgent appointments available on the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

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Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision and a strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff told us they felt supported by management. The practice had a number of policies and procedures to govern activity. There were some systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). 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 as good for the care of older people. Systems were in place to ensure that those patients in this population group at risk of abuse or those who needed extra support were signposted to other services, referred to appropriate agencies and these patients were discussed at practice meetings and multi-disciplinary team meetings.

The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs. We saw evidence to demonstrate that patients were signposted to local support groups to enable them to maintain a good quality of life.

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. All older patients over 65 were contacted with offer of flu vaccinations. The practice took part in the national vaccination programmes for example shingles and flu and actively contacted patients to offer the service. Systems were in place to ensure that medication reviews were undertaken on a regular basis for patients in this population group and within five working days following any discharge from hospital. Care plans were also reviewed and updated as required.

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.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. When needed longer appointments and home visits were available. All these patients had a named GP and structured reviews (six monthly and annually) to check their health and medication needs were being met. GP led diabetic clinics included reviews of medication to ensure conditions were being managed appropriately. Emphasis was given to important aspects of a patient's management of their health needs as well as providing advice of latest guidelines and recommendations. 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.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying

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and following-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. However, the practice did not have information regarding young carers to enable appropriate support to be provided.

All children received child health checks and these were integrated with the first immunisation scheduled and maternal follow up. Immunisation rates were high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives and health visitors. The practice provided health promotion advice and signposting to support organisations for children and young people with mental health problems for example Birmingham Healthy minds.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students, had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering health promotion in partnership with Birmingham Healthy Lifestyle Services with formal referrals and self-referrals being available. The smoking status of patients was identified and where appropriate smoking cessation was suggested. The blood pressure of working age people was checked during appointments, and we saw that 92% of these checks were recorded as having taken place.

A variety of appointment types were available, including pre-bookable, same day and urgent/emergency appointments. Extended opening hours and telephone consultations enabled patients who had work commitments to have access to the practice.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice had carried out annual health checks for patients with learning disabilities and all of these patients had received a follow-up. The patient's family, carers and the learning disability nurse attended pre-arranged health check consultations. The practice worked in conjunction with the

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Community Learning Disability Service. Carer support and advice was made available with the practice facilitating any community support services. The practice offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

The practice worked to support the health of the local population, the practice issued food vouchers to patients and signposted them to the local food bank. Chlamydia packs were available in the toilets and a sign in the surgery notified patients of their availability. Computer systems alerted GPs if patients registered at the practice with drug and/or alcohol addiction did not attend recommended health promotion activities such as smoking cessation or cervical cytology and these patients were contacted by practice staff to arrange alternative appointments.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. Care was tailored to meet individual needs and examples of this were discussed.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations including Birmingham Healthy Minds, Change and the Health Exchange Service. Patients were provided support within the practice until formal Improving Access to Psychological Therapies (IAPT) service was available and follow-up was continued by the practice until no longer required.

The practice had a system in place to ensure regular monitoring of prescribing for patients with mental health issues. Computer flags alerted staff if a patient requested a repeat prescription too early or

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did not request a repeat prescription. Anti-depressant medication was not prescribed on repeat prescriptions; this maintained the provision of regular medication reviews at each request for a prescription.

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What people who use the service say

As part of the inspection we sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received 40 completed comment cards; positive comments were received from 36 patients. Patients said that the staff were friendly, caring, the GPs and nurses listened and took their time and everyone was always helpful. However four patients commented that the care and treatment from GPs and nurses was good but they found it difficult to get through on the telephone or to get an appointment at a time that suited them.

On the day of our inspection we spoke with seven patients. Patients gave positive feedback about the service received and we were told that staff were friendly, caring and attentive. We were told that patients were treated with dignity and respect and GPs took their time, listened and were understanding of patients' needs.

We reviewed comments made on the NHS Choices website to see what feedback patients had given. During 2014 one patient had left positive comments about this practice, no negative feedback had been left in this timeframe.

We looked at results of the national GP patient survey carried out in 2014. Findings of the survey were based on comparison to the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. In some areas the practice performed below the CCG average:

- The proportion of respondents who find it easy to get through to this surgery by phone 55% (below CCG average)

In all other areas the practice performed in line with CCG average. This includes:

- 70% of respondents were satisfied with the surgery's opening hours
- 76% of respondents with a preferred GP usually get to see or speak to that GP
- 95% of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care
- 97% of respondents said the last GP they saw or spoke to was good at treating them with care and concern

These results were based on 109 surveys that were returned from a total of 298 sent out; a response rate of 37%.

Areas for improvement

Action the service SHOULD take to improve

- Implement systems to identify patients at the practice with caring responsibilities including young patients with caring responsibilities.
- Implement robust systems to identify and manage risks to patients and others who use the service regarding the premises including a fire risk assessment.
- Ensure equipment such as oxygen is available to deal with a medical emergency or provide an assessment of risk to demonstrate why this equipment is not required.
- Provide evidence to demonstrate that a legionella risk assessment has been carried out to identify all risks and ensure that the practice is managing any risks identified.

Dr Karim Ladha

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector; the team included a GP and a practice nurse.

Background to Dr Karim Ladha

Dr Karim Ladha (The Dovecote Surgery) is based in the Birmingham Cross City Clinical Commissioning Group (CCG) area. The practice provides primary medical services to approximately 1,900 patients in the local community. The population covered is mixed with a high percentage of Asian patients registered at this practice.

The lead GP at the Dovecote Surgery is male. Two female locums also work at the practice on a regular basis. Additional staff included a practice manager, a practice nurse (female), and health care assistant (female). There were two administrative staff that supported the practice.

The practice offers a range of clinics and services including, asthma, child health and development, family planning and diabetes.

The practice opening hours are 9am to 12.30pm and 4.30pm to 6.30pm on Monday, Wednesday and Friday. The practice closes early on a Thursday and the hours of opening are 9.30am to 12.30pm, During the daytime when the practice is closed telephone lines are covered by Southdoc. Extended opening hours are provided on a Tuesday and appointments are available upon request from 7am to 8am, 10am to 12.30pm and 4.30pm to 6pm.

The practice has opted out of providing out-of-hours services to their own patients. This service is provided by Primecare, who are an external out of hours service provider contracted by the CCG.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of 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.

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 we hold about the practice and asked other organisations to share what they knew. We reviewed comment cards where patients and members of the public shared their views and experiences of the service. We carried out an announced visit on 10 February 2015. During our visit we spoke with a

range of staff including a GP, nurse, practice manager and administration staff and we spoke with patients who used the service. We also spent some time observing how staff interacted with patients but did not observe any aspects of patients care or treatment. We spoke with seven members of the Patient Participation Group (PPG) who told us their experience not only as a member of the PPG but also as a patient of the service. The PPG is a way in which patients and the practice can work together to improve the service.

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

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Systems were in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last 12 months. The practice had followed up seven incidents and these were made available to us. Detailed information was recorded on significant event forms including how the event affected the patient, the practice or the practitioner. Identified learning points were recorded as well as the date discussed with staff at the practice. We saw that systems were in place to ensure that significant events were reviewed on a regular basis.

Learning and improvement from safety incidents

Procedures were in place for reporting safety incidents or safeguarding concerns. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. Staff told us they were actively encouraged and supported to raise any concerns that they might have. We saw that incident report forms contained detailed information including action points and identified learning. We looked at the minutes of meetings where these were discussed for the last three months. We saw that significant events were discussed at each meeting. It was not obvious from documentation seen that significant events and learning points identified had been fully discussed with staff on each occasion. However, staff spoken with confirmed that they were discussed at monthly practice meetings. A receptionist and practice nurse spoken with discussed recent significant events, for example poor communication relating to cause of death had been reported. Staff were keen to learn from these incidents and improve systems and practices. Staff said that the practice was very open and all information was shared.

We saw that a significant event audit had taken place with the aim of improving care for patients. Significant event audits enabled the practice to learn from patient safety incidents and events and helped staff consider both strengths and weaknesses in the care they provided.

National patient safety alerts were received by the GP and disseminated to all practice staff. Staff we spoke with told us that when alerts relevant to the practice were received they were discussed at practice meetings to ensure all staff were aware, particularly where action needed to be taken. We saw, for example, that Ebola had been discussed at a practice meeting following an alert.

CCG alerts regarding drug users and missing persons were sent to the practice. Staff spoken with confirmed that all staff were informed and signed documentation to confirm that they had read the alert.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Training records made available to us demonstrated that all staff had received the level of safeguarding training relevant to their role. The GP and practice nurse had undertaken training at an advanced level and administration staff had undertaken basic training as appropriate to their role.

We saw that staff had access to information regarding safeguarding and we were told that the GP was the appointed safeguarding lead. Staff spoken with were aware who they should speak with if they had a safeguarding concern. Staff confirmed that they had access to information such as policies, contact details and guidance on how to make a safeguarding referral. Safeguarding vulnerable adults, children and domestic abuse contact details were available in paper format in each treatment room and reception and were available on each computer desktop. Information on computer also linked to various other websites such as Birmingham Children's safeguarding to provide further information for staff. We saw that staff had easy access to a wealth of information regarding safeguarding vulnerable adults and children.

We were told that there were currently no adults or children subject to a safeguarding referral registered at the practice. We were shown the systems in place to highlight those patients where safety concerns had been identified. Patient records would be coded; this generated an alert when this patient's records were reviewed. This alert helped staff easily identify that sensitive information may be recorded on this patient's file which GPs and other relevant staff need to be made aware of, for example children with child protection plans.

Good

Are services safe?

We looked at the minutes of three practice meetings and saw that safeguarding was a standard agenda item and would be discussed as issues arose. We saw evidence of this for a patient whose care was discussed at a practice meeting and a multi-disciplinary team meeting. We were told that the GP had not attended any external multidisciplinary meetings regarding safeguarding recently as they did not relate to any patients registered at the practice. Any relevant minutes of multidisciplinary meetings would be sent to the practice and scanned on to the appropriate patient's records so that GPs had easy access to information. We were told that the practice had a good relationship with health visitors who would also forward information to the practice regarding their patients.

A chaperone policy was in place and all staff had received informal, in-house training regarding this policy and the duties of a chaperone. The practice nurse or health care assistant (HCA) would act as a chaperone; if these staff were not available the practice manager or reception staff would undertake this role. Administrative staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks, however the practice nurse and HCA had not although the practice were in the process of obtaining these. (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). During the inspection we saw information sent through on email which confirmed that the DBS check had been completed. The policy seen clearly recorded the duties of a chaperone including where to stand to be able to observe the examination. A chaperone could also be requested for any home visits undertaken by the GP. Female GPs worked at the practice each Tuesday and Wednesday morning this gave patients the ability to book an appointment with a same sex GP if they preferred.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on the practice's electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We were told about the systems in place to ensure all important information received into the practice was passed on to the relevant member of staff and records coded appropriately.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by practice staff. The practice nurse was monitoring and recording fridge temperatures twice per day. When the practice nurse was not available a member of reception staff had been trained to undertake this duty. We were told of an occasion when the vaccine fridge had lost power, the practice nurse described the action taken which included safe disposal of the vaccines as they were considered to be unusable.

The day prior to our inspection it was identified that the lock to one of the medication fridges was broken and therefore medication could not be safely stored. We saw that all vaccines had been transferred to another lockable vaccination fridge at the practice. The practice manager was aware of this and had commenced the process of having the lock repaired or replaced.

Systems were in place for stock management and rotation. We saw that records were kept to demonstrate stock received and expiry dates. Staff had also signed records to demonstrate when they had used stock and for stock rotation. Stock rotation helped to ensure that products with the shortest expiry dates were used first so that wastage of medicines could be kept to a minimum.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol covered areas such as, how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

Cleanliness & Infection Control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Good

Are services safe?

We looked at how infection prevention and control procedures were managed at the practice. The practice nurse confirmed that she was the lead for infection control. Infection prevention and control measures in place included the use of personal protective equipment (PPE), clearly labelled sharps bins and spillage kits.

Spill kits are used to clean up any spillage of blood or bodily fluids such as vomit, urine or other body substances. These spills need to be treated promptly to reduce the potential for spread of infection with other patients, staff or visitors. We saw that one spill kit was available and we were told that another kit had been ordered. Staff were aware where the spill kit was stored and when they should be used.

We saw that PPE, including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how and when they would use these. Sharps bins seen had been clearly labelled and staff spoken with were aware of when they should be disposed of. “Sharps” is a medical term for devices with sharp points or edges that can puncture or cut skin such as needles or syringes. Sharps bins are used to safely store used sharps prior to disposal.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. All staff undertook yearly hand hygiene training; records showed that this training was last undertaken in February 2015.

We discussed the arrangements for managing clinical waste. We saw that there was a policy for management of clinical waste. Consignment notices demonstrated that clinical waste was being removed from the premises by an appropriate contractor. We saw that clinical waste was appropriately stored before being removed from the premises.

We discussed infection control audits with the practice nurse, we were not shown any infection control audits and were told that none had been completed recently. It was therefore difficult for the practice to demonstrate that they complied with infection control standards or had taken mitigating action where they did not meet these standards.

Following our inspection we were sent a copy of an in-depth infection prevention and control audit completed in February 2015. Issues for action have been identified and actions taken to address these issues recorded.

The practice had not had a legionella risk assessment undertaken as they had been advised by the company who serviced their gas appliances that this was not necessary. (Legionella - is a term for particular bacteria which can contaminate water systems in buildings). We were told that as part of cleaning duties flushing of infrequently used water outlets, such as the shower on the first floor, took place. This was completed to reduce the risk of infection from legionella bacteria which may grow in parts of water systems that are not regularly used, such as water standing in the pipes immediately leading to outlets. Regular flushing of taps/outlets in these areas is required to prevent the possibility of growth by Legionella.

Equipment

Staff we spoke with told us they had sufficient 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 displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and the fridge thermometer.

We saw records to demonstrate that firefighting equipment such as smoke alarms and fire extinguishers had been subject to regular checks and routine maintenance. Fire extinguishers displayed stickers indicating the date of last testing.

Staffing & Recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that recruitment checks had been undertaken prior to employment, for example, proof of identification, CV and details of qualifications. The practice manager was unable to find written references for the member of administration staff employed approximately two years ago. We were told

that this staff member had been recommended to them by another local practice and that an email reference had been received. However, we did not see this on the day of our inspection.

We saw evidence that all staff apart from the practice nurse and HCA had received criminal records checks through the disclosure and barring service. We were told that these checks had recently been undertaken for the practice nurse and health care assistant. We were shown an email received during our inspection confirming that these checks had been completed.

Systems were in place for managing expected and unexpected staff absences which helped to ensure that sufficient staff were on duty at all times. There was an arrangement in place for members of administration staff to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

We saw evidence to demonstrate that appropriate checks had been undertaken for locum GPs who worked at the practice. This included disclosure and barring service checks (DBS), proof of qualifications and evidence to demonstrate that the GP was on the performers list. All GPs need to be registered with the NHS England Area Team Medical Performers List. If they are not on the Performers list then they are not authorised to work.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of equipment, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy and we saw hazard report sheets in treatment and consultation rooms. This enabled staff to report any hazards identified. The practice manager told us that they completed a visual assessment of the premises and took appropriate action, however there was no documentation to demonstrate this.

We saw that locum GPs who worked at the practice had signed to confirm that they had read the practice's health and safety policy. Two administrative staff had undertaken health and safety training.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly. There was no oxygen on the premises to be used in an emergency situation and there was no risk assessment to determine whether oxygen was required and what the alternative arrangements were in the absence of oxygen.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

A fire risk assessment had not been undertaken. The fire risk assessment should identify any risk of fire and include details of actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken. Following our inspection we were sent minutes of a meeting held regarding fire safety which confirmed the actions taken to ensure fire safety equipment was serviced and maintained and systems in place to ensure patient and staff safety.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE). The GP was aware of the need to stay updated regarding changes to guidelines. We saw that NICE guidelines and Medicines and Healthcare Products Regulatory Agency (MHRA) guidelines were used to inform clinical audits completed recently.

Patients had their needs assessed and care planned in accordance with best practice. We were told about the systems in place regarding chronic disease management and the templates used to develop care plans for patients. Records seen demonstrated that they had been adapted to each individual to ensure holistic care was provided and captured NICE guidance. The practice nurse told us that patients were given ownership of their care plan and were involved in the long term management of their care and said that self-management plans were in place.

We were told about the systems in place to avoid unplanned hospital admissions. Patients had been identified by the CCG dependent upon the number of times they had visited the hospital within the previous 12 months. Care plans had been developed by the GP in corroboration with the patient. We were told that care plans had been reviewed on a monthly basis. The GP was responsible for ensuring that all care plans were in place and reviews completed. Patients were either visited at their home or if they were able they visited the practice. Action plans were put in place for all patients at a high risk of admission to hospital. These patients had direct telephone access to the practice manager in case of emergency.

We saw records to demonstrate that all older aged patients had a medication review undertaken on a regular basis. Systems were in place to inform all practice staff when a patient was admitted to hospital, we saw that upon discharge care plans were reviewed and updated as needed. Medication reviews were completed within five working days of discharge from hospital. Systems were in place to ensure that appropriate secondary care services were also accessed. For example following discharge from hospital due to a fall the GP referred one patient for physiotherapy, podiatry and a social worker was allocated.

Systems were in place to ensure that those patients suffering with depression were reviewed regularly. The GP told us that they used the PHQ-9 tool to assess patients for depression. The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression. We saw two examples of patients being diagnosed by the GP and then having a further two consultations within a two week period. Repeat prescriptions would not be available for anti-depressant medication and the repeat prescribing protocol confirmed this. This helped to ensure that patients suffering with depression received a regular review of their condition.

We were told that there were a very low number of patients with a learning disability registered at the practice and there were no specific care plans in place for these patients. However records seen showed that a health check took place, for example of heart rate, weight and blood pressure. A flag was put on computer records to alert staff of the need to contact these patients for regular health checks. Records seen demonstrated that all of these patients at received at least an annual health check.

We were told that there were no patients registered at the practice who had no fixed abode. Patients with drug or alcohol dependency were referred to Aquarius. Aquarius is a counselling service for patients with drug, alcohol or gambling addiction.

The GP told us that care plans were in place for 82% of patients with mental health illness and work was in progress to develop and agree the remaining care plans. We saw an example of how care was tailored to meet individual needs when a patient who would not leave their house, received home visits by the GP and was referred to and seen by secondary care services within one day of referral. All of the patients registered at the practice had received a health check including blood pressure monitoring and cervical cytology if required within the last twelve months. Systems were in place to identify if a patient with mental health illness requested a repeat prescription early or did not request a repeat prescription; this ensured that the medication usage of these patients was monitored to keep them safe.

Good

Are services effective?

(for example, treatment is effective)

The GP undertook a regular diabetic clinic. We saw evidence to demonstrate that patients on diabetic medications were assessed at least six monthly to ensure all patients received a regular review of their condition and, if appropriate, newer interventions/medications were considered to aid management.

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

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. For example one member of reception staff was responsible for ensuring that all children registered at the practice received their routine childhood immunisations. The member of staff conducted a regular search on the computer system, invited the child via their parent to attend an appointment and updated records when this had been given. We were told that the practice had 100% attendance rate for their childhood immunisations.

Other key roles included data input, clinical review scheduling, child protection alerts management and medicines management.

The health care assistant conducted anti-coagulation clinics for practice patients and the wider community. We were told that text messages were sent to patients who did not attend for their appointment. The practice's rate for patients who did not attend their appointment was 1% which was low in comparison with the locality rate of 11%.

The practice showed us two completed clinical audits where the practice was able to demonstrate the changes resulting since the initial audit. The GPs told us that National Institute for Health and Clinical Excellence (NICE) guidelines or Medicines and Healthcare products Regulator Agency (MHRA) guidelines were used to inform clinical audits. We discussed two recent clinical audits and saw records. An audit regarding the use of a medication following MHRA guidelines and an audit of another medication following NICE guidelines. Following the audit the GPs carried out medication reviews for patients who were prescribed these medicines, discussions were held with patients and GPs altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information they collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. For example, 88.3% of patients with diabetes had a dietary review within the last 12 months; this was above the CCG average of 80%. The blood pressure of working age people was checked during appointments and we saw records to confirm that checks had taken place for 92% of these patients registered at the practice. The GP told us that the practice always reached high QOF targets which demonstrated that the practice had systems in place to monitor patients with a long term condition. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually).

The practice manager told us that a disease register had been set up on the practice's computer system. The disease register gave the number and percentage of patients with certain conditions such as diabetes, coronary heart disease, epilepsy and chronic kidney disease who are registered with the each practice.

Systems were in place to ensure all patients with a long term condition received routine health checks such as those patients with diabetes, asthma and chronic obstructive pulmonary disease (COPD). We saw that the large majority of patients on the practice's register suffering from these long term conditions had received a six monthly and annual review; we were told that work was still in progress regarding this.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support, infection control and safeguarding.

We discussed training with the practice nurse and health care assistant. We were told that the GP was proactive and encouraged staff to undertake training. We were told that

spirometry had recently been introduced and the practice nurse had undertaken training by the equipment provider and then worked alongside the GP until they were competent to undertake this task. We saw that the practice nurse had defined duties that they were expected to perform. Training records seen demonstrated that this staff member was trained to fulfil these duties, for example seasonal flu vaccinations.

The lead GP at this practice was an insulin initiator and was therefore undertaking training for management of patients who took insulin. The GP saw practice patients and those from the wider community who had diabetes and provided training to other staff regarding this.

The practice manager told us about the new training system being implemented which would also develop a detailed training matrix. We were told about the time set aside each Tuesday which could be utilised for practice meetings, multi-disciplinary meetings or protected learning time.

Before our inspection we were sent a copy of the documentation used for the induction process for new administration staff. This was a comprehensive document which covered all aspects of the duties of reception/ administration staff.

We discussed the appraisal systems in place and reviewed a random sample of appraisal records.

We were told that all staff undertook annual appraisals and staff spoken with confirmed this. We saw that appraisal meetings were conducted by both the practice manager and GP. Pre-appraisal documentation requested, for example, staff views on job satisfaction and future employment plans within the practice. We saw that learning needs were identified during the appraisal process.

We were told that locum GPs were used at this practice to cover times of sickness or annual leave. Systems were in place to ensure that locums used were appropriately qualified and pre-employment checks undertaken. We saw that locums received information about the practice's policies and procedures and signed to confirm that they had read them. We were told that any comments or concerns made by patients regarding locums would be taken into consideration before the locum was re-booked to work at the practice.

Working with colleagues and other services

Test results, hospital discharge summaries and information from the out of hours service came to the practice either by post or electronically via the computer system. A member of staff processed this information and forwarded it to the GP, highlighting any issues that required immediate attention. The GP seeing these documents and results was responsible for the action required.

We were given various examples of collaborative working with external services such as health trainers, health visitors, district nurses and Macmillan nurses. Multi-disciplinary team meetings were held on a monthly basis to discuss the needs of patients with complex needs, for example those with end of life care needs. These meetings were attended by practice staff such as the GP, practice manager, practice nurse and a member of reception staff. The practice manager felt it was important for reception staff to attend as they were the first point of contact with patients and had formed a good relationship with them. We saw minutes of palliative care meetings which confirmed this. The GP gave examples of recent multi-disciplinary approaches to working. One example related to a housebound patient. This patient's needs were discussed and a holistic approach taken, including involvement by health trainers and physiotherapy.

We were told that the practice had been involved in the pilot study for the angina plan. The practice nurse was an angina facilitator and we were told that they had good links with the Queen Elizabeth Hospital, cardiology department. The Angina Plan is a self-management programme for people with chronic stable angina. Patients would work through the angina plan with the practice nurse. The aim of this was to help patients live a more active life, be less anxious and have less angina.

There was a national recall system in place for cytology screening which was carried out by the practice nurse. This ensured women received this important health check including their results in a timely manner.

We saw that the practice effectively shared information with other services, for example the out of hours service. Systems were in place to ensure that special patient notes were sent to out of hours providers so that important information was shared. (Special patient notes is

information recorded about patients with complex health and social care needs used to alert or highlight any specific care requirements, long term care plans or any other item of useful information for the patient).

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice used the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they would be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

The practice had systems in place to provide staff with the information they needed. An electronic patient record system was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We were told that the practice had signed up for the Summary Care Record but could not commence this until the computer system had been updated and staff received further training. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information).

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. The practice nurse and GP had undertaken training regarding the Mental Capacity Act.

Patients with learning disabilities 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)

We discussed consent with the GP and practice nurse and were told that implied consent was obtained, for example when a patient rolled up their sleeve to have an injection. Appropriate codes were included on patient records to demonstrate the consent obtained. There was a practice policy for documenting consent for specific interventions.

Health Promotion & Prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant. The GP was informed of all health concerns detected and these were followed-up as soon as an appointment was available and if possible at the time of the health check. Those patients who required additional support were signposted to various services such as smoking cessation and weight loss services. We were shown records to demonstrate that the smoking status of patients was obtained and recorded. We saw that those patients who smoked had been advised to attend smoking cessation services which were held at a local pharmacy and patients were able to self-refer to this service. Those patients who were identified as requiring weight loss were referred to health trainers and were offered a six week voucher to attend a local slimming club. Health trainers help people to develop healthier behaviour and lifestyles. They offer practical support to change people's behaviour to achieve their own choices and goals.

New patient consultations were also offered to newly registered children to support the delivery of the healthy child programme. The healthy child programme is an initiative which, for example encourages care that keeps children healthy and safe and to protect children from serious diseases, through screening and immunisation.

We saw that the practice website updated patients regarding research about the benefits of stopping smoking, healthy eating, fighting off a virus and other information to promote a healthy lifestyle. This information could be translated into various languages via google translate which helped patient's whose first language was not English have access to this information. We saw that leaflets and posters signposting patients to support services and alternative therapies were also available in the reception area, for example healthy minds, aromatherapy, hypnosis and life coaching.

Systems were in place to ensure chronic disease management patients were involved in their care. The practice nurse told us that they tried to give patients

Good

Are services effective?

(for example, treatment is effective)

ownership of their care as they felt this had better results. Patients were always involved in the long term management of their care and we were told about the self-management plans in place.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and all had received an annual physical health check within the last 12 months.

The practice's performance for cervical screening was 90% and work was still being undertaken regarding this. We saw that all female patients with a mental illness had received cervical smear test. There was a clear policy for following up non-attenders by a member of reception staff. We were told that when patients were 10 minutes late for their appointment, a member of reception staff telephoned them to ensure that they were safe and well and to try and re-book another appointment.

We saw evidence to demonstrate that patients were signposted to local support groups to enable the patient to maintain a good quality of life, for example patients referred to Alzheimer's disease society memory clinic and a local coffee morning.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. We saw records to demonstrate that currently 95% of patients who were eligible had received the shingles vaccination and 98% of diabetic patients and all of those patients who were suffering from chronic obstructive pulmonary disease (COPD) had received the flu vaccination.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, 109 out of 298 patients surveyed responded to this survey undertaken in 2014. We saw that the practice was rated in line with the local CCG average relating to patients being treated with care and concern by the GP (97%). The practice was also in line with local averages regarding being involved in decisions about care (90%), having confidence and trust in the last GP the patient saw or spoke with (98%) and 96% of respondents said that the GP was good at listening to them.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 40 completed cards, 36 of which were positive about the service experienced. Patients commented that the GPs and nursing staff treated them with dignity and respect at all times, were caring and listened to what they had to say. Four patients commented that it could be difficult to get an appointment or get through on the telephone, however these patients said that when they got an appointment, the service was good and all of the staff were attentive and kind and accommodating.

We also spoke with seven patients on the day of our inspection who were also members of the patient participation group (PPG). All told us they were satisfied with the care and service provided. One patient told us that they saw the practice nurse once per month, when the practice nurse had any issues or concerns they spoke with the GP immediately and either got the advice required or ensured that the patient was seen immediately by the GP. We were told that the GP was caring, compassionate and treated patients as individuals and showed empathy towards patients when they or members of their family were suffering ill health.

Details of surveys undertaken by the practice's PPG were available on the practice website. The last survey was undertaken in 2014, 50 patients were surveyed and patients were generally satisfied with the service. Patients commented about access to the service, saying that they found it difficult to get through to the practice and suggestions for improvements were recorded by patients. A meeting of the PPG was held following completion of the survey and issues recorded in the minutes of this meeting, along with the suggested action to take. The minutes of this meeting were available on the practice website.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Reception staff were seen to be respectful and treated patients in a friendly, respectful manner.

The lead GP at the practice is male, however female GPs work at the practice each Tuesday and Wednesday morning to ensure that same sex consultations could be provided if this was the patient's wish.

One member of administration staff was responsible for sending out letters of congratulations to new parents. Staff discussed examples of how they ensured that these letters were sent out appropriately, for example different letters were sent to the parents of premature babies and letters were held back for babies who were unwell in hospital.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example data from the national patient survey showed that 96% of respondents said that the GP was good at listening to them, 97% felt that the GP was good at explaining tests and treatments, 90% felt that the GP was good at involving them in decisions about their care, 97% felt that the GP was good at treating them with care and concern and 98% of respondents had confidence and trust in the last GP they saw. Similar results were achieved for the practice nurse. These results were in line with the CCG average. Patient feedback we received on the comment cards aligned with these views. Feedback from the patients spoken with on the day of our inspection was

positive and we were told that the practice was extremely caring and supportive. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Staff told us that translation services were available for patients who did not have English as a first language. The lead GP could also speak to patients in Gujarati, Hindi and Urdu. This helped to ensure that patients understood information given to them and were able to be involved in decisions about their care and treatment**.**

Care plans were in place for patients with a view to avoiding unnecessary hospital admissions. Records were coded appropriately and completed care plans were given to the patient. We saw that computerised records contained an alert to notify staff that the patient was included in the unplanned hospital admissions register. We were told that all of these patients (37) had a care plan in place which was subject to a monthly review. Systems were in place to ensure that patient's records were updated following any hospital admission or outpatient appointment.

We were told about the systems in place to notify the GP if a patient on the practice's palliative care list had been discharged from hospital. We were told that the GP would conduct a home visit and would liaise with the local hospice nurse as necessary. This helped to ensure that patients with complex, changing needs were kept under review.

Patient/carer support to cope emotionally with care and treatment

Information we reviewed from patient comment cards were positive about the emotional support provided by the practice. Patients commented that they had received excellent support from the practice during any illness and said that staff were supportive, caring and helpful. The patients we spoke with on the day of our inspection gave responses that were consistent with this information. For example, one patient said that they received support as a carer of a patient and other patients said that staff listened, treated them with respect and helped them understand things that affected their health and wellbeing.

We were told by the lead GP and the practice nurse about how the practice strived to ensure that care and treatment was provided in a way that met patients' needs and wishes. We were told that patients were involved in their care and given ownership. The practice nurse said that the surgery took a holistic approach ensuring that patient's emotional and mental health needs were catered for as well as their general health needs. We were told that patients would be signposted to external agencies that would be able to provide support. We saw patient records which confirmed this.

The GP discussed recent examples of how the practice had met individual patient's needs regarding their treatment, working closely with other services such as health trainers, physiotherapist and a nurse from the local hospice. All staff we spoke with displayed a caring and empathetic attitude. Patients with long term conditions were routinely assessed for anxiety and depression and we saw the template used to complete the assessment.

Staff told us families who had suffered bereavement were sent a letter by the GP offering them a patient consultation at a flexible time and location to meet the family's needs. People were also signposting to a support service. Information leaflets were available in the waiting area regarding local bereavement services available.

We were told that there was no carers register but this was being developed. We saw that the practice's computer system alerted the GP if a patient was also a carer. The practice manager said that carers would be offered the annual flu vaccinations and support to ensure that they remained healthy and continued providing care.

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 people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The practice were aware that 1,150 patients of the practice population were of working age or students as the computer system logged this. We were told that this information was gathered so that these patients could be offered early morning appointments and health checks before they started their working day.

Staff spoken with appeared to have a good understanding of the patients registered at the practice suffering from mental health illnesses. The practice manager demonstrated their knowledge of the signs which demonstrated deterioration in mental health for some patients. We were told that those patients with mental health needs were offered an appointment on the same day that they telephoned unless they requested an appointment on a different day. People experiencing poor mental health and those with long term conditions were offered longer appointments or home visits for those who were unable to attend the practice due to frailty or immobility. Patients experiencing poor mental health were offered flexible appointments including the first appointment of the day to avoid being seen at busy times or having to wait in the practice to be seen. Appointments were available outside of school hours for children and young people and patients who work during normal office hours.

The practice told us how it delivered services to meet the needs of its patient population. For example, screening services were in place to detect and monitor the symptoms of long term conditions such as asthma and diabetes. There were nurse led services such as the vaccinations, cervical smear tests as well as disease management services which aimed to review patients with common illness and aliments. Patients over the age of 75 years had an accountable GP to ensure their care was co-ordinated.

The practice was working towards implementing the gold standards framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

The practice worked collaboratively with other agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment. Special patient notes is information recorded about patients with complex health and social care needs used to alert or highlight any specific care requirements, long term care plans or any other useful information.

The Aspiring to Clinical Excellence (ACE) needs assessment recently undertaken identified areas that the practice needed to address to ensure that they met the needs of the local population. This included insulin initiation, Ambulatory Blood Pressure Monitoring (ABPM which involves monitoring your blood pressure whilst undertaking day to day life over a 24 hour period) and phlebotomy which were all implemented by the practice and now available to the practice population.

Tackle inequity and promote equality

The practice had access to online and telephone translation services and a GP who spoke three languages. The practice's website could also be translated into 80 different languages to ensure that patients had access to all information about the practice.

Two staff at the practice had attended a training course regarding understanding migrant populations and access to health care. This helped the practice to consider improved access to general health care and health promotion for these patients.

We were told about the new training package which had recently been purchased by the practice. Staff had recently received training and were now able to access the training. This package included e-learning regarding equality and diversity. We were told that all staff would be undertaking this training.

Although the practice was located in a converted house, adaptations had been completed to ensure that patients who had mobility difficulties or used a wheelchair were able to access the building. All treatment and consultation rooms were located on the ground floor and patients would have easy access to these rooms.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We were given examples that demonstrated that gender issues and sexual orientation were taken into account when planning services for patients.

We were told that patients with no fixed abode could walk into the practice and see a GP regarding any immediate medical need but they would not be registered at the practice. These patients would be signposted to the Homeless service in Birmingham.

Students were able to register as temporary patients outside of term time and we saw examples of this.

Access to the service

The practice was located in a converted semi-detached house. Ramped access with grab rails was available to the front of the building and all doors throughout the ground floor were wheelchair accessible. A disabled toilet and baby changing facilities were available. All treatment and consultation rooms were provided on the ground floor of the building and were extra wide to ensure that they were accessible to wheelchair users. The practice manager told us that they had completed a lot of work on the ground floor of the building to make the area disability friendly. However the practice would not meet disability discrimination act requirements as the staff areas on the first floor were only accessible by steep stairs.

Information was available to patients about appointments on the practice website. The practice website could be translated into 80 different languages. Other information such as how to arrange urgent appointments and telephone consultations was also available. Reception staff told us that patients were able to book appointments in person at the practice, over the telephone or those patients who were hard of hearing were able to email or fax the practice to arrange an appointment. An interpreting service was available for those patients whose first language was not English. We were told that the GP also spoke three languages as well as English and the health care assistant was able to use sign language if required.

Patients were able to book an appointment in advance, on the day that they telephoned and appointment slots were available each day to be filled by people who may need to see a GP in an emergency. Three telephone consultation appointments are made available every day, however this would be increased if needed and we saw evidence of this when five telephone appointments had been undertaken to meet the needs of the working age population.

Telephone consultations could be booked in advance. We were told that patients with mental health illness, children and those with palliative care needs were seen on the day that they telephoned, unless they requested an appointment on an alternative day.

We were told that those patients who did not attend their appointment were contacted within 10 minutes of their appointment time to check whether they were in need of assistance, or required another appointment. Text reminders for appointments could be made at the request of the patient.

This practice was open between the hours of 9am to 12.30pm on Monday, Wednesday, Thursday and Friday. The practice closed on a Thursday afternoon and was open between the hours of 4pm to 6pm on other week days. We were told that appointments were available early on a Tuesday morning but must be requested in advance as the surgery would not generally open until 10am on Tuesday mornings to enable staff meetings and training to take place. The practice website confirmed this. Patients unable to attend during normal surgery hours due to work commitments therefore had access to the practice at this time. Patients were also able to contact the nurse or GP for telephone advice. This helped those patients with work commitments to have access to the practice.

We were told about the arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Southdoc is an external out of hours provider who were contracted by the practice to provide telephone cover during the daytime when the surgery was closed. Primecare, an out of hours provider contracted by the Clinical Commissioning Group (CCG) provided the out of hours service to the practice from 6pm to 8am and during weekends when the practice was closed. If patients called the practice when it was closed, answerphone messages gave the telephone number they should ring depending on the circumstances and the time of day.

The results of the national GP patient survey for 2014 showed that the practice rated lower than the CCG average for the percentage of patients who found it easy to get through to someone at the GP surgery on the phone (55%). Four out of the 40 comments cards completed raised concerns about telephone access to the surgery and getting appointments. We saw that priority had been given to telephone systems, appointments and the practice website during the last practice satisfaction survey in 2014.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The main issue identified related to the telephone system. An action plan had been developed which stated that the practice were to have further discussions regarding managing the telephone system and limited resources of the Practice and take advice from the PPG.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. There was a designated responsible person who handled all complaints in the practice. We saw that the practice had a complaints leaflet which was available to patients and the practice leaflet guided patients to discuss complaints with reception staff or ask for a copy of the complaints leaflet.

We were told that the practice had not received any formal written complaints within the last 12 months. We saw evidence that verbal complaints had been received and we saw documentary evidence to demonstrate the action taken to address these. Records were available showing that monitoring was undertaken to ensure that these issues had been appropriately addressed and were unlikely to re-occur. We did not see any evidence to demonstrate that these verbal complaints were discussed at practice meetings. Complaints were not a standard agenda item.

Staff we spoke with were aware of the process for making a complaint and were aware of their responsibility to raise concerns and to report them. We were told that the practice manager would investigate complaints and involve the appropriate member of staff. Reception staff told us that they recorded verbal complaints in a book prior to passing information on to the practice manager for discussion and investigation.

We were not shown any evidence to demonstrate that a formal analysis of complaints received was undertaken to monitor trends. The practice had not received any written complaints within the last twelve months and we were told that two verbal complaints had been received. The practice manager said that written complaints were considered to be formal complaints which were logged and responded to accordingly. Verbal complaints were usually addressed on the day on which they were made. Patients spoken with on the day of inspection said that staff were approachable and friendly and they would raise any issue or concerns with them as needed. Patients were aware of the process to follow should they wish to make a complaint. None of the patients that we spoke with had cause for complaint and all were happy with the service provided.

We were told that a new complaint recording template was being developed to ensure that clear information was recorded regarding follow up of complaints received.

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 promote good outcomes for patients. Staff spoken with were committed to providing high quality care and were caring and showed empathy towards patients. From discussions it was evident that staff had a good relationship with patients and strived to ensure that patients received the best care that they could provide.

We discussed how the practice planned to deliver care with the future challenges that face them such as access to the service and resources. They had started to explore the staffing skill mix and explore new ways of working. The practice were proactive and encouraged staff to undertake training, we were told that the nurse and health care assistant were being encouraged to undertake further training to develop their careers and to further meet the needs of the practice population and provide additional support to the GP.

We discussed succession plans and other changes that may take place at the practice. We were told that there was nothing formally documented.

We saw that the practice leaflet recorded the rights and responsibilities of the patient and also recorded that violent and abusive behaviour would not be tolerated and result in removal from the practice list. Reception staff told us that they attended an away day training event each year and the practice's mission statement was also discussed and changes made if necessary. The practice values were recorded on the new patient assessment form and new patients received a copy of this form when registering at the practice.

Governance Arrangements

Aspiring to Clinical Excellence (ACE) is a programme offered to all Birmingham Cross City Clinical commissioning group (CCG) practices. The ACE programme is based on the strategic objectives of the CCG and the NHS Outcomes Framework indicators. 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. The six components identified as priorities for the ACE Foundation level programme for the year 2014-2015 were Engagement & Involvement, Medicines Management, Quality & Safety, Carers, Safeguarding and Prevention. The two component of the ACE Excellence Pilot were holistic care and diagnosis of patients with long term conditions and integration of community teams into general practice and delivery of holistic care. Achievement of ACE are verified by a practice appraisal process.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards.

The practice manager was the clinical governance lead. We were shown evidence to demonstrate that information had been sent to staff regarding information governance. Staff had signed to confirm that they had received and read a copy of the practice's information governance policy and of the data protection act. 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.

Leadership, openness and transparency

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

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment, induction and disciplinary policy which were in place to support staff.

We saw from minutes that team meetings were held regularly, at least monthly. These meetings helped to ensure that information was shared and discussed amongst staff. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Staff told us that they felt supported and also supported each other as necessary. We were told that staff worked well as a team and also that they felt appreciated for the work that they did.

Are services well-led?

Good

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

Practice seeks and acts on feedback from users, public and staff

We discussed methods in which feedback of patients was sought at the practice. We were told that all staff had a good relationship with patients and patients we spoke with on the day confirmed this. The practice manager said that patients were involved at the practice and recently had been instrumental in choosing the colour of the paint in the waiting room.

The practice had gathered feedback from staff through monthly staff meetings and annual staff away days and generally through appraisals and day to day discussions. Staff told us they had a close working relationship with each other and worked well as a team. Staff said that they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The practice had an active patient participation group (PPG) which had seven members. The PPG did not contain representatives from various population groups such as working age but we were told that it had been difficult to maintain representation from younger age population groups due to work and family commitments. We met with all of the members of the PPG during our inspection. We were told that they received excellent support from the practice including attendance at all meetings by the GP, practice manager and a receptionist. The GP had arranged learning afternoons for PPG and other relevant parties but these had been poorly attended. A talk had been organised regarding Parkinson's disease and another discussion afternoon regarding diabetes.

The PPG had carried out a face to face survey of patients in February 2014. The practice manager showed us the analysis of the last patient survey. We saw that this was discussed at the following PPG meeting. The results of the survey and minutes of PPG meetings were available on the practice website. An action plan had been generated to address issues raised.

We were told that the practice manager and GP had an 'open door' policy which meant that staff could speak with them at any time. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff said that they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning & improvement

We looked at a random sample of staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and clinical staff said that they were supported to maintain their clinical professional development through training. The practice manager said that they encouraged clinical staff to further their careers, for example the practice nurse was being encouraged to complete a nurse prescribing course and the health care assistant to complete training to become a registered nurse. Staff told us that the practice was very supportive of training and we were told about future training for staff.

The practice had responded to feedback on service delivery from the PPG as well as other patients through surveys and complaints. We saw that changes had been made to improve service as a result of feedback, for example a change was made to the practice's telephone number at the request of patients.

The practice had completed two clinical audits, for audits on the use of specific medicines following MHRA or NICE guidelines. The benefits to the practice and patients following clinical audit were discussed.

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

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.