# Bosworth Medical Centre

## Quality Report

Crabtree Drive
Chelmsley Wood
Birmingham
B37 5BU
Tel: 0121 770 4484
Website: www.bosworthmedicalcentre.co.uk

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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**

We carried out a comprehensive inspection at Bosworth Medical Centre on 10 April 2015.

Overall we have rated the practice as good for safe, effective, caring, responsive and well led services for the population it served.

Our key findings were as follows:

- Systems were in place to ensure that all staff had access to relevant national patient safety alerts. Staff worked together as a team to ensure they provided safe, co-ordinated patient care.
- We found that patients were treated with respect and their privacy was maintained. Patients informed us they were satisfied with the standards of care they received.
- Patients we spoke with told us they were satisfied with the care they received and their medicines were regularly reviewed.
- The practice was visibly clean and tidy. Annual audits were carried out and resultant actions taken to protect patients from unnecessary infections when they visited the practice.
- 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.

**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 safe services. Safety within the practice was monitored and ways to improve were identified. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised to support improvement. Information about safety was valued and also used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. Recruitment practices were robust and there were enough staff to keep patients safe.

**Are services effective?**

Good

The practice is rated as good for providing effective services. Clinicians were up-to-date with both the National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. Practice staff were using innovative and proactive methods to improve patient outcomes and they linked with other professionals to ensure patients received effective care that was tailored to their needs. Practice staff carried out clinical audits and as a result made changes where necessary to promote effective care for patients. Systems were in place for regular reviews of patients who had long term conditions and those who were not able to visit the practice.

**Are services caring?**

Good

The practice is rated as good for providing caring services. 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 clinical staff treated patients with kindness and respect. Reception staff approached patients appropriately, in a helpful way and ensured confidentiality was maintained. There were arrangements in place to provide patients with end of life care that respected patients' needs and wishes.

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services. Patients were given opportunities to comment on the way care and treatment was delivered by GPs. Practice staff demonstrated how they listened to and responded to their patient group. Practice staff had initiated positive service improvements for their patients.

# Summary of findings

Patients with mobility difficulties were able to access the practice. There was a system in place which supported patients to raise concerns and complaints. Complaints received were recorded, investigated and responded to appropriately.

**Are services well-led?**

Good

The practice is rated as good for being well led. All staff worked closely together to innovate and promote continuous improvements. There was strong leadership with a clear vision and purpose. All staff were encouraged and involved with suggesting and implementing on-going improvements that benefitted patients. Governance structures were robust and there were systems in place to effectively manage risks. Staff had identified the need for change and made improvements that benefitted patient care and treatment. High standards were promoted and owned by all practice staff with evidence of team working across all roles. The practice sought feedback from patients and the Patient Participation Group. There was an effective way for patients and practice staff to work together to improve services and promote quality care.

# 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. The practice had a register of all patients over the age of 75 and these patients had a named GP. Patients at risk of an unplanned hospital admission had a care plan in place, which was regularly reviewed and updated. Housebound patients were routinely visited so they could be given information and advice to prevent hospital admissions. The wishes of patients requiring end of life care were met; this included care being provided in the patient's home by the GP and multi-disciplinary team. Telephone consultations were available so patients could call and speak with a GP if they did not wish to or were unable to attend the practice.

**People with long term conditions**

Good

The practice is rated as good for the population group of people with long term conditions. Practice staff supported patients to receive co-ordinated, multidisciplinary care whilst retaining an oversight of their care. Patients with long term conditions were regularly reviewed and any changes in their care needs were cascaded to other involved professionals to ensure co-ordinated care was provided. Staff kept a register of patients with long term conditions and those who had carers so that they could be offered support. When needed, longer appointments and home visits were available.

**Families, children and young people**

Good

The practice is rated as good for the population group of families, children and young people. The practice population included a higher than average younger patients and pregnancy. Practice staff worked with health visitors and community midwives who ran ante-natal clinics at the practice. There was a safeguarding policy in place for children and adults that included principles and definitions of the different types of safeguarding concerns. The GP who was the lead for safeguarding and all other staff had received appropriate training. Clinical sessions included out of school hours for children to attend the practice. The childhood vaccination programme was encouraged and undertaken by practice staff.

**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). GPs provided telephone consultations, which may reduce the need

# Summary of findings

for a visit to the practice. There were extended evening hours each Wednesday until 7.30pm. GPs also provided a Saturday session from 9am until 11am for face to face consultations. The practice was proactive in offering on-line services for making appointments and ordering repeat prescriptions. Patients were offered a choice when they were referred to hospital outpatient services. This system gave them greater flexibility about when and where they were referred to.

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients and had sign posted vulnerable patients to various support groups. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours. Patients had access to an interpreting service if English was not their first language so that they could have an extended consultation with the GP in a language they understood.

**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). There was a high prevalence of patients with mental health issues. Care was tailored to patients' individual needs and circumstances, including their physical health needs. Annual health checks were offered to patients with serious mental health illnesses. GPs had the necessary skills and information to assess and treat or refer patients with poor mental health. A Community Psychiatric Nurse visited the practice twice a week to see patients with mental health problems. Practice staff had recognised the need and provided health checks and support for patients who had dementia.

# Summary of findings

## What people who use the service say

We spoke with 11 patients during our inspection who varied in age. Some had been registered with the practice for many years. They informed us that staff were polite, helpful and knowledgeable about their needs. Patients told us they were given enough explanations so they understood about their health status and felt they were encouraged to make decisions about their care and treatment. They all gave us positive feedback about the standards of care they received.

Patients told us it was easy to obtain repeat prescriptions. We received mixed comments about the appointments system. When patients rang to ask for an appointment a GP would ring them and enquire about their symptoms. If the GP felt that an appointment was necessary a same day appointment could be offered. Patients who were retired felt that the system was good but some of those who worked did not like waiting for the call back from a GP. During our feedback at the end of the inspection we informed senior staff about this. Patient's feedback informed us that they had difficulty in getting through to the practice by telephone. We were informed by a number of staff that there were plans in place to install a new phone system.

We collected two patient comment cards on the day of the inspection. Positive comments were made about the care patients received, and the helpfulness of staff.

We looked at results of the GP patient survey dated 2015. Findings of the survey were based on 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. The latest results were:

- 65.8% of respondents would recommend the practice, the local CCG average was 76%,
- 56.4% were satisfied with the opening times, the local CCG average was 72.8%,
- 31.4% felt it was easy to get through by telephone, the local CCG average was 68.5%,
- 46.0% had good or very good experience for making an appointment, the local CCG average was 69%.

The practice had a Patient Participation Group (PPG). PPGs can be an effective way for patients and practice staff to work together to improve services and promote quality care. We spoke with two members of the PPG including the lead person. They told us they were influential in encouraging the practice to review and improve patient's ability to make appointments. As a result the appointments system was changed. This had resulted in a large reduction in the 'did not attend' (DNA) numbers, which permitted more availability of appointments.

# Bosworth Medical Centre

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a specialist advisor who had experience in practice management and an expert by experience who had personal experience of using primary medical services.

## Background to Bosworth Medical Centre

The practice provides primary medical services to approximately 9400 patients in the local community. Practice staff told us there is a higher than average rate of pregnancy in the younger population and a high prevalence of patients with mental health issues. Patients are mainly white British and some Eastern European patients whose first language is Polish.

There are three female and one male GP partners in this practice. This helped to ensure that patients could book an appointment with a female or male GP if they preferred. There is also a salaried GP working at the practice. Advanced nurse practitioners, practice nurses and a health care assistant are employed and have lead roles. For example infection control and diabetes and minor ailments. The practice manager is supported by a lead receptionist, receptionists and administration staff who worked varying hours.

Each GP and the nursing team had specialist lead roles. For example, in mental health, sexual health and diabetes.

The practice has a General Medical Service (GMS) contract with NHS England. A GMS contract means that patients are registered with the practice and not an individual GP (with the exception of those aged 75 years or more) but the practice will focus on delivery of quality clinical care and well managed services.

The practice offers a range of clinics and services including, asthma, child health and development, contraception, chronic obstructive pulmonary diseases (COPD) and minor surgery.

The practice opening times are Monday, Tuesday and Friday from 8.30am until 6.30pm, Wednesdays 8.30am until 7.30pm and closes at 1.30pm each Thursday. Extended hours also include Saturdays 9am until 11am.

The practice has opted in of providing out-of-hours services to their own patients. This service was provided by Birmingham and District General Practitioner Emergency Rooms (Badger) an external out of hour's service on behalf of the practice.

## Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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.

# Detailed findings

## How we carried out this inspection

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

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

Before our inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 10 April 2015. During our inspection we spoke with a range of staff including three GPs, two advanced nurse practitioners, the senior practice nurse, practice manager, the lead receptionist and one receptionist. We also spoke with 11 patients who used the service and observed, how patients were being cared for and staff interactions with them. We looked at care and treatment records of patients. Relevant documentation was also checked. Patients had completed two comment cards giving their opinion about the service they received. We spoke with two 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.

Good

# Are services safe?

## Our findings

Safe Track Record

We spoke with 11 patents about their experience at the practice. None of the patients we spoke with reported any safety concerns to us.

Practice staff used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. The management team, clinical and non-clinical staff told us that they discussed significant events at a range of monthly staff meetings so that all relevant staff learnt from incidents and reduced the likelihood of recurrences.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last three years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

There was a system in place for reporting, recording and monitoring significant events. A recent significant event had been recorded where there had been a delay in prescribing a medicine. A system was put in place that provided written guidance and a template was developed for each GP to use for prescribing a specific type of medicine to ensure that medicines were prescribed when needed.

Clinical staff spoken with confirmed that significant events, incidents and complaints were discussed at their regular monthly practice meetings and they were able to give some examples. This was confirmed from the minutes of the meetings that we saw. The lead receptionist attended these meetings and fed back information to the reception and administration team. The practice had a written protocol, which confirmed that GPs were responsible for completing investigations and taking any resultant actions of significant events.

National patient safety alerts were disseminated by the practice manager to relevant staff to read and sign off.

Safety alerts were discussed at practice meetings to ensure all were aware of any that were relevant to the practice and where action needed to be taken. All staff spoken with knew where patient safety alerts were kept.

Reliable safety systems and processes including safeguarding

The practice had a lead GP for safeguarding vulnerable adults and children. All clinical staff had had been trained to the appropriate level in safeguarding to enable them to fulfil their roles. Practice training records made available to us showed that all non-clinical staff had received relevant role specific training on safeguarding. Staff we spoke with were aware who the lead was and who to speak with if they had concern about patient safety. We saw that there were policies regarding the protection of vulnerable children and work had commenced on developing a policy regarding vulnerable adults.

Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and were aware that they should contact the relevant agencies in or out of hours. Contact details of agencies were easily accessible to staff in clinical rooms and the reception area.

Community staff including health visitors were invited to attend regular meetings so that patients who were considered to be at risk could be discussed. There was close co-operation with health visitors which helped to identify children at risk and keep them safe. An alert was included on the patient's file of those who were at risk so that they could be easily identified.

Practice staff ran a search every three months of children who were at risk and those on the register. Where further concerns were found these were acted on to protect patients from unnecessary harm.

We saw that a chaperone policy was in place. Chaperone duties were usually undertaken by nursing staff or the health care assistant. A chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure. Although all non-clinical staff had received training in chaperoning duties only the lead receptionist carried out this role. They demonstrated an appropriate understanding of the role. We saw a chaperone

notice was displayed in the waiting area and at regular intervals on the electronic patient display screen in the waiting area. Some patients we spoke with were aware that they could have chaperone if needed.

Medicines Management

Patients were able to order repeat prescriptions on line, by fax, by email, in person or via their local pharmacy. Patients we spoke with said they were happy with the system. There was a protocol for repeat prescribing which was in line with national guidance and was followed by practice staff. Patients who had repeat prescriptions received regular reviews to check they were still appropriate and necessary.

We found that vaccines were stored within the recommended safe temperature range in a lockable fridge. Temperature checks were taken and recorded each day. Medicines were kept safely within locked cupboards.

Emergency medicines were stored in a locked cupboard. We saw recordings that confirmed they had been checked regularly to ensure they were still in date and safe for administration. We saw that they were stored appropriately and were in date. We were told that GP's did not routinely carry medicines in their bags but collected a supply from the practice before they visited patients in their home. Otherwise GPs relied on the services of paramedics for provision of urgent treatment.

Cleanliness & Infection Control

We were told that an external cleaning company completed daily cleaning at the practice. We saw that cleaning records were kept. Details of the required frequency for cleaning areas of the practice and the responsibilities of cleaning staff was also recorded in cleaning schedules. We observed the premises to be visibly clean, tidy and well organised. Patients we spoke with confirmed that the practice was clean and had no concerns about standards of hygiene or infection control.

We discussed infection prevention and control with the senior practice nurse who was the lead for infection control. They told us they had spent time with the infection control lead at the local hospital who also assisted with the annual audits of the practice. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures.

Infection prevention and control measures in place included the use of personal protective equipment (PPE), wipe clean chairs and examination couches. There was a schedule for washing curtain screening and soiled curtains were replaced promptly. There was hand washing technique signage above each wash hand basin throughout the practice. We saw that hand soap; hand gel and hand towel dispensers were available in treatment rooms.

Spill kits were available in clinical areas. Staff were aware where spill kits were stored and when they should be used. This helped to ensure that any potentially infectious substances were attended to by staff in a timely and effective manner.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy.

A legionella risk assessment had been completed to ensure that any risks to patients had been acted on. The document was dated May 2014 and stated that it was due for review May 2015. Legionella is a term used for a particular bacteria which can contaminate water systems in buildings. All hot and cold tap water temperature was checked and recorded monthly. A schedule was in place for running water from taps that were used infrequently.

Equipment

We saw all equipment had been tested and that the provider had contracts in place for annual portable appliance testing (PAT).There were arrangements in place for routine servicing and calibration, where needed, of equipment such as blood pressure cuffs, weighing scales, and blood pressure monitoring equipment.

Staffing & Recruitment

There was an up to date recruitment policy that covered all aspects of staff recruitment. We looked at a sample of personnel files for a range of staff. Some staff had been employed at the practice for several years. We saw that a complete work history was obtained, evidence of identity, references and a Disclosure and Barring Service (DBS) criminal record checks had been carried out for all staff including non-clinical staff.

Good

# Are services safe?

The professional registration status of all clinical staff had been checked with the General Medical Council (GMC) for GPs and the Nursing and Midwifery Council (NMC) for nurses to ensure they were fit to practice.

There were systems in place to monitor and review staffing levels to ensure any shortages were addressed and did not impact on the delivery of the service. GPs provided some cover for each other by working extra sessions and they used locum GPs when necessary. Nursing staff arranged patients' appointment around their annual leave dates. Non-clinical staff worked extra shifts and they rearranged their administration work to release staff to cover reception. Senior staff were in the process of recruiting another receptionist to release the lead receptionist from covering the reception desk. This would provide an extra member of staff during unplanned staff absences.

Monitoring Safety & Responding to Risk

Staff had received regular fire safety training and participated in regular fire drills to maintain their knowledge of how to respond in an emergency. A fire safety risk assessment was in place and had been reviewed annually to ensure it was still relevant.

We saw that fire escape routes were kept clear to ensure safe exit for patients in the event of an emergency.

There was a health and safety policy in place and staff knew where to access it.

Arrangements to deal with emergencies and major incidents

Staff at the practice had received training in medical emergencies such as basic life support. The practice had a defibrillator and oxygen on standby for dealing with medical emergencies. These were checked regularly to ensure they were fit for purpose.

Emergency medicines and equipment were kept in clinical rooms and staff knew where they were stored. We saw information that confirmed they were regularly checked and that the medicines remained in date and fit for administration.

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 were identified and actions recorded to reduce and manage the risk. Risks identified included power failure, computer failure, and access to the building. Areas of responsibility for staff were identified along with risks and actions recorded to reduce the risk. The document also contained relevant contact details for staff to refer to.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

Effective needs assessment

GPs and nurses demonstrated how they accessed guidelines from the National Institute for Care and Health Excellence (NICE) and from local commissioners. We saw minutes of clinical and practice meetings where new guidelines were disseminated and the implications for the practice's performance and patients were discussed. The GPs interviewed were aware of their professional responsibilities to maintain their knowledge.

Patients with long term conditions were reviewed by the GPs and the practice nurses to assess and monitor their health condition so that any changes could be made. Each GP took a lead role for some conditions. For example, mental health, asthma and sexual health. Advanced nurse practitioners assessed and treated patient who had common complaints such s flu. Other practice nurses also specialised in conditions such as diabetes, asthma, chronic obstructive pulmonary disease and immunisations.

GPs, nurses and health care assistants had the facility to offer longer appointments where they thought this would be helpful. It was normal practice for clinical staff to contact all patients and discuss the symptoms with the patient on the telephone prior to an appointment being arranged. Staff could therefore ensure longer appointments were provided where it was felt a more in-depth needs assessment was required.

Care plans had been put in place for patients who required higher levels of care or were considered to be at risk. The care plans were reviewed regularly and shared with community professionals to promote co-ordinated care.

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

Clinical staff actively participated in recognised clinical quality and effectiveness schemes such as the national Quality Outcomes Framework (QOF) and the local Clinical Commissioning Group (CCG) enhanced service schemes. QOF is a national performance measurement tool. We were shown the latest QOF achievements that told us practice staff were below average, meeting or above average for all of the national standards. For example, 96.4% for asthma reviews was above the target and 93.1% reviews of patients with dementia was also above target. However, those patients diagnosed with diabetes who had foot examinations were 77.7% compared with a 90% target.

There was a system in place for carrying out clinical audits. One audit concerned reviews of all patients who were prescribed a specific medicine. The results were that some patients had the dosage reduced and some were discontinued. The outcome was that improvements had been made resulting in improved patient treatment. Another audit concerned patient's knowledge and their satisfaction with the treatment they had received for a certain condition. The result was that not all patients had been made fully aware of the signs and symptoms of high or low blood test readings. Action was taken to ensure all of these patients were fully informed. There was a list of audits that had been carried out and which GP was responsible for them and for reviewing their effectiveness.

Standards of care were discussed during regular meetings and whether any changes could be made to improve outcomes for patients.

GPs were supported by Clinical Commissioning Group pharmacist who regularly attended the practice. The pharmacist provided advice about medicines that GPs prescribed for patients.

There were arrangements in place to ensure women received cervical screening by one of the GP partners and the practice nurse. Samples were sent to a local NHS hospital to be analysed and reported on in line with national guidance and recall systems

GPs in the practice undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept their skills up to date.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff had attended training courses that were relevant to their roles. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses.

Good

# Are services effective?

## (for example, treatment is effective)

GPs had completed their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

All staff had annual appraisals that identified any learning needs from which action plans were documented. We saw that the advanced nurse practitioners, practice nurses' and health care assistant's appraisals were carried out by clinical staff. This was so that that their clinical practices and competencies could be discussed and appropriately evaluated.

Working with colleagues and other services

Discussions with staff and records showed that the practice worked in partnership with other health and social care providers such as social services, end of life care teams and district nursing services to meet patients' needs.

All practice staff worked closely together to ensure provision of an effective service for patients. They worked in collaboration with community services. Monthly meetings minutes evidenced that district nurses and other community staff attended monthly meetings which were held at the practice. Patients with complex care needs were discussed. The minutes gave evidence of good information sharing and arrangements for integrated care for those patients.

The practice provided out-of-hours (OOH) services. This was provided by Birmingham and District General Practitioner Emergency Rooms (Badger). Patients had access to on-going care and treatment.

The practice received an electronic summary for patients who had accessed the OOH service. These patients were reviewed and followed up where necessary by the GPs at the practice. Correspondence received from other services was dealt with by GPs who were working on the day. There were systems in place to ensure that the results of tests and investigations from out of hours and hospitals were reviewed and actioned.

Patients were invited to contact the practice to receive their test results. However, if a test result was abnormal, patients would be contacted and informed by the GP either face to face or by telephone consultation. Where necessary referrals would be made to hospitals and other services such as physiotherapy.

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 hour's provider to enable patient data to be shared in a secure and timely manner. Regular meetings were held at the practice. These included all clinical and senior non-clinical staff. Information about risks and significant events were shared openly at meetings and all staff were able to contribute to discussions about how improvements could be made. The management team attended Clinical Commissioning Group (CCG) meetings and information from these meetings was fed back to staff.

There was a practice website with information for patients including signposting, services available and latest news. Patients registered so they could access the full range of information on the website. Information leaflets, and electronic screen and posters informed patients about local services were available in the waiting area.

Consent to care and treatment

The patients we spoke with told us they had been involved with decisions about their care and treatments. They told us they had been provided with sufficient information to make choices and were able to ask questions when they were unsure.

Patients who had minor surgery had the procedure explained to them and the potential complications before they were asked to sign a consent form to confirm this.

Clinicians were aware of the requirements within the Mental Capacity Act 2005. This was used for adults who lacked ability to make informed decisions. Staff gave examples of how a patient's best interests were taken into account when a patient did not have capacity to make decisions about their treatment.

GPs knew how to assess the competency of children and young people about their capability to make decisions about their own treatments. They understood the key parts of legislation of the Children's and Families Act 2014 and were able to describe how they implemented it in their

Good

# Are services effective?

## (for example, treatment is effective)

practice. GPs demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has maturity to make their own decisions and to understand the implications of those decisions).

Health Promotion & Prevention

The practice manager told us all new patients were offered a health check. New patients were asked to attend the practice to undergo a health check and review any illnesses they had and medicines they received.

Patients who were due for health reviews were sent a reminder letter and if they failed to attend a further reminder letters would be sent to them. Patients were asked about their social factors, such as occupation and lifestyles. These ensured GPs were aware of the wider context of their health needs.

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. We saw some health and welfare information displayed in the waiting area. For example, breast screening, shingles vaccinations for patients aged 70 years and Macmillan nurses.

A health trainer visited the practice twice a week to provide advice on healthy living and weight control.

We spoke with a member of the Patient Participation Group (PPG). PPG's act with practice staff in an effective way to improve services and promote quality. They had suggested and practice staff had supplied them with leaflets that promoted the importance of childhood immunisation. Solihull Community Housing distributed the leaflets on behalf of the practice to raise awareness.

The senior member of the PPG developed regular newsletters, which were available in the practice for patients to take away with them. The newsletters often included advice about the need for regular reviews of long term conditions and advice on healthy living.

The practice offered a full range of immunisations for children, flu and shingles vaccinations in line with current national guidance. The uptake of flu vaccines was 96.4% and the QOF target was 97% for this.

The practice's performance for cervical smear uptake was 76% which was 4% lower than the QOF target. Practice staff had identified this and were making efforts to educate patients about the importance of screening.

The practice website signposted patients to places where they could obtain advice about long term conditions such as diabetes and heart disease. It also displayed details about minor illnesses and how patients could access smoking cessation clinics. Health promotion literature was readily available in the waiting area.

Good

# Are services caring?

## Our findings

Respect, Dignity, Compassion & Empathy

We spoke with 11 patients during our inspection. We received two completed cards where patients shared their views and experiences of the service. Patients we spoke with told us they felt that all of their health matters were assessed and they were cared for by staff who were considerate of their needs. Patients told us that staff displayed empathy and were respectful when they were in contact with practice staff.

The national GP patient survey dated 31 March 2015 showed us that the practice was rated as average for patients being treated with care and concern the practice GPs and nurses. The practice's own patient survey analysis dated 2014 gave positive results for the way that staff treated them.

We saw that staff treated patients with kindness and respect ensuring their confidentiality was maintained. Reception staff told us that a consultation room was always available if a patient requested private discussions.

Some patients we spoke with confirmed they knew their rights about requesting a chaperone. They told us this service was offered to them by clinical staff.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. 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.

Care planning and involvement in decisions about care and treatment

Patients were encouraged to take responsibility for their health conditions and to be involved in decisions about medicines and other forms of treatments. They were empowered through discussions to acknowledge risks and make decisions about their treatments. All patients with complex needs or palliative (end of life) had care plans in place and these were regularly reviewed in line with patient's wishes. Patients we spoke with told us that clinical staff were good at involving them in making decisions.

Patients told us they were given the time they needed and were encouraged to ask questions until they understood about their health status and the range of treatments available to them. Patients we spoke with told us they were able to make informed decisions about their care and felt in control.

The Quality Outcomes Framework end of year (31 March 2015) data informed us that in some areas the practice had exceeded the national target. For example, the practice had achieved 100% for contraceptive advice and emergency hormonal treatment; the national target was 90% for this service.

Patient/carer support to cope emotionally with care and treatment

The respective GP contacted bereaved families and offered a range of services they felt to be appropriate for the family to access. There were also bereavement counselling services available and GPs could make referrals to them. Families were sent an information pack that included access to counselling services.

We saw information was on display in the waiting area for patients to pick up and take away with them. They informed patients of various support groups and how to contact them.

There was a poster in the waiting area and the electronic screen provided information about carers. The practice held a register of carers and at the time of our inspection there were 60 persons on the register. This enabled staff to offer carers additional support and referral to carers groups and support organisations.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

Responding to and meeting people's needs

At the start of our inspection a GP gave a presentation about the practice. This included information about the needs of the practice population which were clearly identified and understood. We were also told about the recent history of the practice and recent changes which had been made with the aim or improving services to patients. The practice delivered services to meet the needs of the patient population. For example, the practice had introduced a minor illness scheme. Patients could sign up at the local pharmacy to discuss their minor illnesses and received a prescription so they did not have to be seen by a GP or advanced nurse practitioner. There were nurse led services such as vaccinations and cervical screening 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 held a register of patients who had a mental health problem. This enabled staff to identify those who patients who required annual health checks and we saw that these had been done. There was a palliative care register and monthly multidisciplinary meetings were held to discuss patient and their families care and support needs.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' and buying health and care services. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example, clinical staff maintained regular liaison with a pharmacist to ensure patients received appropriately prescribed medicines.

The lead receptionist organised the diabetic reviews by writing to patients and giving them appointments for blood tests followed by their review with a clinician.

A Community Psychiatric Nurse visited the practice twice a week to see patients with mental health problems. An alcohol worker also visited the practice twice a week to provide guidance and education for patients.

The local hospital provided a phlebotomy (obtaining blood specimens) service at the practice each Thursday from 8:30am until 10:30am. The practice health care assistant also provided this service. If specimens were required urgently the nurses would provide a phlebotomy service.

The practice had an active patient participation group (PPG). The practice manager told us that they were continually recruiting for new members. A PPG noticeboard gave information about future meetings and about joining the PPG. The PPG is a useful tool to help the practice engage with a cross section of the practice population and obtain patient views. PPGs are a group of patients who meet on a regular basis and are involved in decisions that may lead to changes to the services the practice provides.

Tackling inequity and promoting equality

Practice staff had recognised the needs of different groups in the planning of its services. For example arrangements were in place for temporary residents to register at the practice to ensure they had access to a GP when necessary.

The practice had access to a translation service when a patient's first language was not English. Some of the GPs spoke other languages. The name of the GP and the language they spoke was on display at the entrance to the practice so that patients could request appointments with those GPs.

The practice was fully accessible for patients with poor mobility. There were additional toilet facilities for patients who had restricted mobility. All consulting rooms were located on the ground floor with wide access corridors and doorways to accommodate wheelchairs.

Various systems were in place to aid working patients to access the service. This included extended opening hours and telephone triage. Home visits were available for patients who were unable to attend the practice.

Access to the service

When a patient requested an appointment they received a call back from a GP who asked questions to ascertain if the appointment was needed. Those who needed to be seen were offered a same day appointment. We received mixed

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

patient comments about this service. Some patients said they preferred not to have to wait for a call back. The new system had resulted a reduction by 65% of the number of patients who did not attend (DNA) for their appointments. This resulted in more appointments being available for patients to book.

The practice opening hours were 8.30am until 6.30pm Monday, Tuesday and Friday, until 7.30pm Wednesday and 1.30pm Thursday. Longer appointments were offered to those patients who had complex needs so that full assessments were carried out. The practice had extended opening hours on Wednesday evenings until 7.30pm and 9am until 11am on Saturdays. Patients were able to book and order repeat prescriptions on line. This was useful for working age patients as well as those who had difficulty with their mobility.

A survey of the telephone system had recently been carried out and as a result senior staff were seeking to find and have installed an improved system. To alleviate pressure on the reception staff the broken sign in touch screen was being replaced.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. The out of hours service was provided by an external service contracted by the CCG and were held in the practice. Details of the out of hours provider was available on the practice phone and in the patient leaflet.

Listening and learning from concerns & complaints

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

There was a complaints procedure that informed patients of how to make a complaint and what they could expect. It included the contact details of NHS England and the local ombudsman if the complainant was not satisfied with the outcome of the investigation.

We saw that the practice had received 21 complaints during 2014-2015. They had dealt with them appropriately and written responses had been sent to complainants. Lessons learned had been documented to prevent recurrences. For example, mislaid prescriptions. All staff were reminded of the importance of and the system for dealing with repeat prescriptions.

# 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

In conjunction with the local Clinical Commissioning Group senior staff had compiled a development plan for 2014-2015. We saw that some objectives had been achieved. For example, Clinical meetings where a sample of reviews took place of patient's care and any changes were fed back to all GPs. Also the practice staff were developing protocols on alcohol advice to distribute to patients. Other milestones concerned treatment of long term conditions such as asthma and self-care promotion that was added to the practice newsletter.

The practice had an objective to provide quality care that met the population groups. Senior staff were working towards recruiting GP partners and use of the same locum GPs to provide continuity of care for patients.

We spoke with nine members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. They told us they felt an integral part of the team and were actively encouraged to make suggestions for making further improvements. The practice manager told us they would continue striving to improve the service.

Governance Arrangements

There was a clear governance structure at the practice that provided assurance to patients and the Clinical Commissioning Group (CCG) that the service was operating safely and effectively. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' and buying health and care services. There were clearly defined lead roles for areas such as safeguarding, a range of long term conditions and regularly checking that the clinical sessions met patient's needs. Responsibilities were equally shared between all respective staff.

We saw that monthly practice meetings were held that enabled decisions to be made about issues affecting the general business of the practice. All staff were encouraged to attend these meetings. Recordings were made of the meetings and any actions that arose from these meetings were clearly set out and reviewed to ensure required changes were made. Staff told us they could make suggestions for improvements and that they were treated as equals by senior staff. The meetings included strategy discussions and where improvements could be made for the benefit of patients.

The practice manager took an active role in overseeing the effectiveness and consistency of systems. GP partners were also proactive in that process. All policies and procedures that we saw had been regularly reviewed and kept up to date so that staff received appropriate guidance.

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.

We saw evidence of staff appraisals that were regularly undertaken. Staff members we spoke with told us that they aimed to provide a caring service.

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.

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

The practice had an active Patient Participation Group (PPG). PPG's act as a representative for patients and work with practice staff in an effective way to improve services and promote quality care. The PPG told us they had been involved with the questions for the annual patient surveys. PPG members were also given copies of the annual survey results and discussions were held about how improvements could be made. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with members of the PPG. The outcome was positive but patients were not satisfied with the telephone system. The report included areas where improvement could be made and these were being dealt with where possible.

We spoke with two members of the PPG. They told us practice staff worked as a team and the PPG had positive

# Are services well-led?

Good

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

working relationships with staff. They informed us that staff made on-going efforts to improve the quality of the service and constantly searched for ways to improve staff practices. For example, the electronic information screen was to be replaced with a much larger screen to make it easier for patients to read it. PPG members told us they had been involved in discussions with practice staff about the type of screen to be installed.

The practice was participating in the 'Friends and Family' survey where patients were asked to record if they would recommend the practice to others. The survey commenced 1 December 2014 and the outlet operations manager told us the responses received so far had been positive.

Management lead through learning & improvement

Staff told us that senior staff supported them to maintain their clinical professional development through training and mentoring. We looked at some staff files and saw that staff appraisals included a personal development plan. Staff told us that the practice was very supportive of training and that staff were given time to attend training courses.

GP's held regular meetings to discuss each patient who had been admitted to hospital to monitor their progress and to determine if there were any lessons to be learnt. Minutes of meetings seen confirmed this. For example, a delay in a diagnosis of a patient's condition. GPs attended assessment training and introduced weekly case review meeting to prevent a similar recurrence.

The practice had completed reviews of significant events and other incidents and shared them with staff through meetings to ensure the practice improved outcomes for patients. There had been 19 recorded during the previous 12 months. For example, a medicine had not been discontinued at the appropriate time. Staff had recorded significant events that were secondary care errors and the importance of questioning if medicines were licensed. A system was out in place where all medicines prescribed were checked by a GP and recorded. The significant events had been analysed and where possible trends identified. An action plan was put in place for each type of event.