Dr Peter Gini

Quality Report

Broadway Health Centre
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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?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Peter Gini, Broadway Health Centre on 23 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, caring, responsive and well-led services. The practice was requires improvement for proving effective services. It was also good for providing services for the care of older people, people with long term conditions, families children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

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

- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Risks to patients were assessed and well managed and information about safety was recorded, monitored, appropriately reviewed and addressed.
- The practice frequently met with other organisations including district nurses, health visitors, social services, school nurses and midwives to discuss patients with complex needs and to ensure that they meet people's needs.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.
- There was a clear leadership structure and staff felt supported by management.

We saw an area of outstanding practice:

- The practice had started to address their low vaccination rates by developing a vaccine preventable illness plan which included offering flu jabs at a local homeless shelter and providing additional walk in clinics for patients to attend after working hours.

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

Importantly the provider should:

- Ensure staff performance and training needs are identified and documented through a regular programme of annual appraisals and ensure these are completed for nursing staff.

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. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. We saw a positive culture in the practice for reporting and learning from incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. The practice held regular multidisciplinary meetings to discuss patients with complex needs. There were enough staff to keep patients safe and we saw evidence of Disclosure and Barring Service (DBS) checks in staff files. The practice was able to demonstrate that checks had been completed for the GPs and nurses and they were also in the process of collecting paper evidence to add to their individual files.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice achieved 76% of the total QOF target in 2014, which was below the national average of 94%. National data showed that the practice was slightly lower than the national average figures for providing flu vaccinations to patients aged 65 or over (63% compared with 73%) and for those in high risk groups (42% compared to 52%). Seventy six percent of the practices patients with diabetes had flu jabs which was lower than the national average of 93%. The practice was also below local and national averages for some other aspects of care including blood pressure checks for patients with hypertension and the performance for the cervical screening programme was below average. The practice had started to address their low vaccination rates by working in conjunction with the Clinical Commissioning Group in developing a vaccine preventable illness plan. As part of this plan, the practice had completed a project the practice offered additional flu vaccinations to all homeless patients who attended a local drop in centre. The practice had also opened additional walk in clinics in January and February 2015 for patients to attend after working hours.

Summary of findings

We looked at five staff files during our inspection and we found that appraisals were overdue for the two nurses and the reception team. The practice manager had recognised this prior to our inspection and had scheduled appraisals in for the reception team. The last nurse appraisals took place in February 2012.

The practice regularly engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population. For example, the practice was exploring ways of working across a number of sites under a new umbrella sexual health screening pilot. The practice had signed up to female genital mutilation (FGM) educational events and was due to attend upcoming educational sessions this year.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than the national average for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

We were shown information available for carers to ensure they understood the various avenues of support available to them. Further information could also be accessed by a carer's corner which was situated in the reception area. The carer's corner held additional information on carer's workshops, local carer's hubs and information on flu jabs for carers. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and there was 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. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The practice had also purchased a zimmer frame and a wheelchair for use in the practice, to help patients where required.

Summary of findings

In the national GP patient survey 2015 he practice performed higher than the CCG and national averages for convenience of appointments. Ninety eight percent of the survey respondents said the last appointment they got was convenient. This was higher than the CCG average of 90% and the national average of 92%. Patients told us it was easy to get an appointment with a named GP or a GP of choice, there was continuity of care and urgent appointments were available on the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice had a clear vision to deliver high quality, proactive and holistic care through a patient centred approach. The practice was in the process of updating their business plan and we could see that the vision and values were part of the practices strategy.

A temporary practice manager had been appointed to cover the long term leave of the permanent practice manager and worked at the practice one day a week. There was also a deputy in place (senior receptionist) who worked collaboratively with the lead GP to ensure the practice ran smoothly in the absence of the practice manager.

The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active.

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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. Care plans were in place and all patients with dementia had an annual review. It was responsive to the needs of older people and offered them longer appointments as well as home visits. The practice also worked with the local pharmacy to implement a medication delivery service.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice made use of telehealth systems so that patients with long term conditions could remotely monitor their care at home.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services and extended hours as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 100% of these patients had received a follow-up. The practice offered longer appointments for people with a learning disability and there was a system in place for flagging vulnerability in individual patient records. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate. These care plans were reviewed annually and had a section stating the patient's preferences for treatment and decisions.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It provided information to vulnerable patients about how to access various support groups and voluntary organisations. The practice worked in conjunction with their Clinical Commissioning Group in developing a vaccine preventable illness plan. As part of this plan, the practice had completed a project with a specialised winter immunisation facilitation team . The project involved the practice offering flu vaccinations to all homeless patients who attended a local drop in centre, a total of 81 vaccinations were offered to these patients and the practices flu vaccination uptake increased by a further 56%.

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 normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice carried out advance care planning for patients with dementia and regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health. The dementia diagnosis rate was above the national average of 95% and 100% of the practice's patients diagnosed with dementia had regular face to face reviews. Staff had completed awareness training

in Mental Capacity Act (2005) and dementia awareness. Patients experiencing poor mental health were offered an annual health review which the practice booked as an extended appointment at a time convenient for the patient and with the GP they preferred to see. The practice had provided information to patients experiencing poor mental health on how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We spoke with four patients on the day of our inspection and we gathered further views of patients from the practice by looking at eight completed Care Quality Commission (CQC) comment cards. Patients told us that all staff within the practice treated them with dignity and respect. Patients told us that they did not feel rushed during their appointments. We received positive responses with regards to the GP and nurse care in the practice, particularly around the continuity of care. Patients described the environment as clean and safe. Patients wrote that their needs were responded and listened to and the staff were caring, helpful, friendly and approachable.

The patients we spoke to on the day of our inspection all had positive things to say about the clinical care, specifically with regards to diabetes care. One patient told us how the GP took extra steps by providing them with a range of information to take away with them regarding their condition. Patients said the staff were experienced, friendly and helpful, this also reflected comments seen on the CQC comment cards.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in January 2015. The data from the national patient survey 2015 showed that 88% of the respondents described their overall experience of the practice as good; this was higher than the national average of 85%.

Areas for improvement

Action the service SHOULD take to improve

Ensure staff performance and training needs are identified and documented through a regular programme of annual appraisals and ensure these are completed for nursing staff.

Outstanding practice

The practice had started to address their low vaccination rates by developing a vaccine preventable illness plan which included offering flu jabs at a local homeless shelter and providing additional walk in clinics for patients to attend after working hours.

Dr Peter Gini

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 second CQC inspector and a GP specialist advisor.

Background to Dr Peter Gini

Dr Peter Gini's practice is part of the Broadway Health Centre and is situated near the centre of Birmingham. The practice provides services under a primary medical services (PMS) contract and has expanded its contracted obligations to provide enhanced services to patients. An enhanced service is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients. The increased range of services provided includes in house diabetes care and phlebotomy (taking of blood samples).

There are approximately 3,450 patients of all ages registered and cared for at the practice. The practice building is purpose built with all treatment and practice office areas on one floor. The building has car parking, with allocated spaces and access for those with a disability.

The practice team consists of two male GPs and a female GP, and three practice nurses. The practice manager works collaboratively with the lead GP and senior receptionist to take care of the day to day running of the practice and is supported by a team of three reception staff who cover reception, secretarial and administrative duties. During our inspection, we spoke with a temporary practice manager who had been appointed to cover the long term leave of the permanent practice manager.

The practice has recently become a training practice for trainee GPs and medical students to gain experience and higher qualifications in General Practice and family medicine. The practice is currently waiting for a medical student to be allocated to them.

The practice opening times are 8.30am to 6.30pm on weekdays except for Mondays when the practice offers extended opening hours until 8.00pm. Patients can book appointment over the phone, online and in the practice. The practice does not provide an out-of-hours service to their own patients but they have alternative arrangements for patients to be seen when the practice is closed. The service providing out of hours cover for the practice also has a clinic based in Broadway Health Centre.

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 the 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
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

We carried out an announced inspection on 23 June 2015 at the practice. During our inspection we spoke with two GP's, one nurse, two reception staff, the temporary practice manager and four patients. We spoke with the chair of the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We observed how patients were cared for. We reviewed eight comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used information from a variety of sources to help them to identify and manage risk, learn from reported incidents and improve patient safety. These included national patient safety alerts, complaints and significant events.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We reviewed safety records, incident reports and minutes of meetings dating back to January 2014 where these were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. Significant events was a standing item on the practice meeting agenda and a practice meeting was held each week to review actions from past significant events, incidents and complaints. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff used an incident template on the practice shared drive and the completed templates were shared with the lead GP and the practice manager. The practice would complete the incident logging process by transferring any adverse events and near misses on to a secure online incident reporting system. The practice showed us the system used to manage and monitor incidents. We tracked six incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example, we saw how the practice had acted appropriately during a medical emergency. The incident was effectively managed at the time and also logged as a significant event, as a result the practice had called in an engineer to test their panic alarms and the practice also ordered specific medicines for their emergency medicines box as part of their actions.

We reviewed records of six significant events that had occurred during the last 12 months and saw this system was followed appropriately. Significant events was a standing item on the practice meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the practice manager and the GPs to practice staff. The GPs all received alerts directly and had signed up to a central alerts cascade from the Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. Staff we spoke with were able to give examples of recent alerts that were shared with the practice and how they were acted on within the practice. For example, following a national alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) the practice carried out a review and made adjustments to the dosage in cholesterol lowering medicines. They also told us alerts were discussed at the weekly practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. We saw evidence that these discussions were taking place in the minutes of the practice meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Staff understood their roles and responsibilities regarding safeguarding including their duty to report abuse and neglect and knew where to find information about safeguarding on the practice's computer system. The practice also kept a backup folder containing policies and safeguarding protocols. Staff knew how to recognise signs of abuse in vulnerable adults and children. They were also aware of their responsibilities and knew how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. We looked at training records which showed that all staff had received relevant role specific training on safeguarding.

There was a system to highlight vulnerable patients on the practice's electronic records. This included patients

receiving end of life care as well as children who had a child protection plan in place. The practice shared a report with us to demonstrate that those with child protection plans in place were regularly reviewed.

The practice had a lead GP for safeguarding and staff we spoke with knew who they were. The lead safeguarding GP was aware of vulnerable children and adults and records. Staff were proactive in monitoring missed appointments and attendance at accident and emergency for children and vulnerable adults. These were highlighted on a report and brought to the GPs attention and the lead GP for safeguarding would complete a daily check of any children or vulnerable who adults attended accident and emergency. The report was also shared with the nurses who were responsible for monitoring and following up on missed appointments. A secondary check for patients who attended accident and emergency was also completed by the practice staff on a weekly basis and a list of attendances was discussed at the weekly practice meetings to discuss any key themes and further actions.

The GPs and nurses took part in regular multi-disciplinary meetings with district nurses and the health visitors based on site to discuss children and young people known to be living in vulnerable circumstances, including those with child protection plans or in the care of the local authority. We also saw that the GPs and nurses would discuss individual cases including missed appointments and attendances at accident and emergency with the relevant safeguarding organisations.

Staff told us that their multi-disciplinary meetings were held every three months and we saw minutes to support this. The practice also had regular contact with other agencies including social services, school nurses, midwives and the local authority to actively engage in local safeguarding procedures and ensure key information on safeguarding was shared. The practice attended a monthly steering group which was facilitated by their CCG, the practice told us that this also a way for them to have regular contact with their safeguarding board each month.

There was a chaperone policy, which was visible on the waiting room noticeboard and on consulting room doors. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing and reception staff had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice told us how they were looking to increase awareness of female genital mutilation (FGM) and to be able to provide support and advice to those who were affected by this. The practice had signed up to FGM events and was due to attend upcoming educational sessions this year.

We noticed that the practice worked closely together and communicated effectively as a whole team. We spoke with a nurse who was able to tell us how the GP had shared safeguarding concerns regarding a patient and how action was taking including referral and follow up with social services.

We saw that there were posters about domestic violence and leaflets available in the practice so that patients who needed support could make a note of helpful contact information or take information away with them if they wished to.

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 policy for ensuring that medicines were kept at the required temperatures and described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. 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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were kept securely at all times. The practice had recognised the need to implement a robust tracking

system for the prescriptions to ensure that they could be tracked through the practice at all times. The practice had developed a process and templates to track the prescription details to ensure a full audit process was in place to reflect the storage and movement of prescriptions. The practice had plans to roll the new system out to staff during the staff meeting the day following our inspection so that staff could be properly coached through the process and any questions could be answered promptly.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of prescribing were discussed in line with an audit of antibiotic prescribing within the practice. The actions were documented in the meeting minutes, these included a reminder for clinicians to use CCG guidance and to ensure regular reviews were carried out for patients on a particular types of antibiotics.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They carried out regular audits of the prescribing of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area. The practice also worked with a Medicines Management Team which attended the practice quarterly to review prescribing trends and give advice on medication management within the practice. Staff we spoke with told us how a representative from the Medicines Management Team was gave advice on prescribing a controlled drug. The process was changed so that only the GPs could issue them as a one off prescription rather than on a repeat prescription.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD.

The practice had established a service for patients to pick up their dispensed prescriptions at the pharmacy which was located next to the practice. Patients could request repeat prescriptions over the phone, face to face and online. We spoke with a member of the Patient Participation Group (PPG) during our inspection and they told us how that the online repeat prescription service worked exceptionally well. A Patient Participation Group (PPG) is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

The practice also had a process in place for patients who wished to have medication delivered to their home. The patients were able to order their repeat prescriptions through the practice and provide consent in order for the pharmacy staff to collect the medication and deliver it to the patient's home. The practice had systems in place to monitor how these medicines were collected and they also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required.

The practice had a system in place to alert them whenever a patient required an annual medication review; the practice managed this by attaching an alert to the patient's electronic record. Prescriptions would not be issued for any out of date reviews and only when the patient completed their medication review would a prescription be re-issued.

The practice's prescribing rates were similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required the GPs to regularly review patients receiving repeat prescriptions. Routine health checks were completed for long-term conditions such as diabetes and to ensure the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, they outlined the reason why they decided this was necessary.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Cleanliness and 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?

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a GP lead and a deputy nurse for infection control, both had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received training about infection control specific to their role and received annual updates. We saw evidence that the leads had carried out infection control audits. The most recent audit was completed at the beginning of June 2015 with support from the CCG. The practice had an action plan in place with dates for completion between July and August 2015, minutes of the practice meetings showed that the audit findings and action plans were discussed. We saw actions from previous audits had been implemented. This included hand hygiene facilities in every clinical room and adequate stock of hand gel on display in reception areas, toilets and clinical rooms for patients and staff to use. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap and hand towel dispensers (as well as hand gels) were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We saw records that the practice had undertaken a risk assessment for legionella and had decided that the risk was sufficiently low to not require formal testing.

Equipment

Staff we spoke with confirmed that they had the equipment they needed for the care and treatment they provided. 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 which was June 2014. We saw evidence that the equipment used by staff was calibrated in September 2014, this included blood pressure measuring devices and oximeter equipment for measuring oxygen levels in the blood.

Staffing and recruitment

The practice had an experienced and skilled staff team with clear responsibilities and lines of accountability. Most of the team had been at the practice for a long time, with the newest permanent staff member joining just over a year ago. The staff demonstrated a good understanding of the practices protocols and were knowledgeable with regards to the running of the practice, patient safety needs and their responsibilities within the practice.

A temporary practice manager had been appointed to cover the long term leave of the permanent practice manager. The practice manager worked at the practice one day a week and the practice had a deputy in place (senior receptionist) and a lead GP who would work collaboratively to ensure the practice ran smoothly in the absence of a practice manager.

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 keep patients safe. Staff told us about the arrangements for planning and monitoring the number of staff and skill mix of staff needed to meet patients' needs. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

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 some appropriate recruitment checks had been undertaken prior to employment. For example, qualifications and registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These 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). Although the staff had NHS smartcards, some of the staff files did not contain a copy of this as photo ID or full employment history including references. The practice manager had identified the need to update the practice's staff files and had developed a checklist which was attached to the front of each staff file and contained a list of documents required for each file. The practice had started the process of gaining copies of these documents from staff

and planned to have the files fully populated by the end of July 2015. We saw evidence of Disclosure and Barring Service (DBS) checks in the non-clinical staff files. The practice was able to demonstrate that checks had been completed for the GPs and nurses and they were in the process of collecting paper evidence to add to their individual files.

The practice would occasionally use a locum GP to cover for annual leave, sickness and training commitments. A locum GP is a fully qualified doctor who provides temporary cover to fill a vacancy or cover sick leave, staff holidays or training commitments. We saw that on the rare occasions where locums were employed, they were accessed through a locum agency and appropriate recruitment checks were in place prior to providing locum cover at the practice.

Monitoring safety and responding to risk

Health and safety information was displayed for staff to see and there was an identified health and safety representative. The practice also had a health and safety policy and systems in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, health and safety risk assessments and fire risk assessments. We saw that the practice had a programme of risk assessments which were completed every six months. The latest health and safety check was completed in April 2015 and a fire risk assessment was completed in June 2015. Records showed that staff were up to date with fire training and that they practised fire regular fire drills with tests being carried out every three months. The practice also kept a maintenance log to record any maintenance requirements throughout the practice, some minor actions had been identified and the practice had plans to address these actions by the end of August 2015, for example one action was for a broken window blind that needed fixing.

The practice had systems for identifying patients who may be at risk. There were practice registers in place for patients in high risk groups such as those with long term conditions, mental health needs, dementia or learning disabilities. The practice computer system was used to inform staff of individual patients who might be particularly vulnerable.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. The practice computer system had the facility of a panic alert button for staff to use if they needed to summon urgent help from other members of the team. Records showed that all staff had received training in basic life support.

Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked weekly. We checked that the pads for the automated external defibrillator were within their expiry date. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that the practice had learned from this appropriately.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis, hypoglycaemia and epileptic fits. Processes were also in place to check whether 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. Emergencies identified included risk of power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff we spoke with all demonstrated knowledge of National Institute for Health and Care Excellence (NICE) guidance and local guidelines. The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They accessed guidelines from the NICE website and disseminated them to staff. We saw minutes of meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. The nurses also attended regular educational updates to ensure they were up to date with best practice guidelines; an example was a recent refresher course on diabetic care.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required. The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

The GPs told us they lead in specialist clinical areas including chronic disease management, dementia and mental health. The practice nurses supported this work to allow the practice to focus on specific conditions.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders such as Chronic Obstructive Pulmonary Disease (COPD). COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. The practice showed us COPD rescue packs initiated by the clinical team at the practice in line with national guidelines. The rescue packs were available for patients with COPD who had been assessed for a pack. The rescue packs contained treatment in line with NICE guidance, advice on when and how to use the rescue pack and signpost information to other services.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information was used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. The practice showed us examples of six completed clinical audits that had been undertaken in the last two years. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, a clinical audit was carried out following a national patient safety alert regarding nutritional supplements. The aim of the audit was to review and establish the appropriateness of the prescribing of oral nutritional supplements. The audit highlighted patients who no longer needed to take these medicines and patients who were due to have a medication review. Further actions were taken from the audit which involved the practice adjusting their approach, encouraging food first and documenting dietary advice. These actions were shared within the practice during a meeting shortly after the audit was conducted.

The GPs had also conducted a two cycle audit of antibiotic prescribing within the practice. The action points following on from the first audit included a reminder for clinicians to use CCG guidance and to use recommended diagnoses methods prior to treating specific conditions in line with guidance from the National Institute for Health and Care Excellence (NICE). Action and learning points were identified following on from the second cycle of the audit. Actions included the need for GPs to review patients on a particular type of long term antibiotics at regular six

monthly intervals. As a learning point, the practice identified that a particular antibacterial agent should be used as a second line of treatment for certain conditions in line with guidance by the practices CCG (Clinical Commissioning Group). These actions were shared within the practice during a meeting shortly after the audit was conducted.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). 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. For example, we saw an audit regarding the prescribing of anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice achieved 76% of the total QOF target in 2014, which was below the national average of 94%. The practice was aware of all the areas where performance was not in line with national or CCG figures and we saw and discussed the practice's plans setting out how these were being addressed.

Specific examples to demonstrate this included:

- Performance for diabetes related indicators was similar to the national average except for the percentage of patients with diabetes who have had flu jabs. Seventy six percent of the practices patients with diabetes had flu jabs which was lower than the national average of 93%. The practice were working in conjunction with their CCG in developing a vaccine preventable illness plan. The practice's aim was to increase the uptake of influenza and pneumococcal vaccinations especially among the high risk groups and hard to reach communities during the 2014-15 flu season and beyond.
- The percentage of patients with hypertension having regular blood pressure tests below the national average of 83%. The practice scored 67% for this QOF indicator.
- The dementia diagnosis rate was above the national average of 95%, with 100% of the practice's patients diagnosed with dementia having regular face to face reviews.

Performance for mental health related QOF indicators was similar to the national average except for care plans for patients experiencing poor mental health and for the recording of smoking status for patients experiencing poor mental health. The latest QOF data shows that 56% of the practices patients experiencing poor mental health had care plans in place; this was below the national average of 86%. The latest data also shows that 88% of the practices patients experiencing poor mental health had their smoking status recorded; this was below the national average of 95%.

Patients experiencing poor mental health were offered an annual health review which the practice booked as an extended appointment at a time convenient for the patient and with the GP they preferred to see. The practice explained that in certain circumstances they worked closely with other professionals such as Birmingham Healthy Minds who were also based on site to make sure they had the support they might need to attend their appointment and gain the most benefit from this. Care plans were in place for 42% of the practices patients experiencing poor mental health, staff we spoke with told us how the practice was working on an on-going project to develop more care plans for their patients.

Every patient over the age of 75 had a named GP who had been agreed with each of them based on their preference. The practice had made use of the gold standards framework for end of life care. The practice had a register of their patients who were receiving care and treatment at the end of life so that the team were aware of these patients and could respond promptly when needed. They provided information about those patients to the local out of hours and ambulance service. Patients at the end of life had written care plans and where appropriately agreed had 'do not attempt resuscitation information' available so that patients would not be resuscitated against their wishes.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as homeless patients and patients with a learning disability. Structured annual

Requires improvement

Are services effective?

(for example, treatment is effective)

reviews were also undertaken for patients with a learning disability. We were shown data that all 22 patients on the practices learning disability register had been given an annual review in the last year.

The practice was involved in a telehealth pilot project which began in June 2015. The practice explained how during the first stages of the project, the GPs had identified patients who would benefit from remote healthcare monitoring at home. The remote monitoring system involved patients being provided with a kit to monitor blood pressure. Patients would send results through the telehealth system by text message which was received by the GPs who would review and follow up accordingly. The practice informed us that because the project was fairly new they were in the process of collating information to monitor success rates. Four out of 20 patients who were offered the service took up the of the remote monitoring service.

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 essential courses such as annual basic life support. The GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers' list with NHS England).

We looked at five staff files during our inspection and we found that appraisals were overdue for the two nurses and the reception team. The practice manager had recognised this prior to our inspection and had scheduled appraisals in for the reception team and the practice told us that the GP would carry out the nurses' appraisals which had not taken place since February 2012.

Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example nurse training in cervical cytology and their extended roles in seeing patients with long-term conditions such as asthma, coronary heart disease and Chronic Obstructive Pulmonary Disease (COPD). COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema.

All the staff we spoke with felt supported by the practice and were encouraged to develop their knowledge and skills. The practice provided in-house education sessions for staff as part of the weekly practice meetings and ensured staff have protected learning time to attend external training events and complete e-learning.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Out-of hour's reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were slightly higher at 16% compared to the national average of 13%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a two weekly check of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed. The practice completed an audit of patients who had declined hospital admission in the last year and the lead GP followed up by contacting any patients who had declined admission.

The practice held multidisciplinary team meetings every three months to discuss patients with complex needs. For example, those with end of life care needs and children on

Requires improvement

Are services effective?

(for example, treatment is effective)

the at risk register. These meetings were regularly attended by district nurses and health visitors and occasionally included other agencies including social services, school nurses, midwives and the local authority. The practice ensured that regular information sharing would continue in the event that other agencies could not attend the practice and regular phone calls, emails and sharing of key information would continue in-between meetings when required. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

The practice also liaised with Birmingham Healthy Minds, the out of hour's service and the health visitors on a more frequent basis as they all ran clinics from the health centre premises. The practice also attended a monthly steering group which was facilitated by their CCG, the practice told us that this also a way for them to have regular contact with their safeguarding board each month.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. The clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. Staff kept up to date with legislation by attending regular updates facilitated by the CCG. Staff told us about a recent event they attended in February 2015 with the Multi-Agency Safeguarding Hub which included awareness on the Mental Capacity Act. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation decisions. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated an understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent. We were shown an audit that confirmed the consent process for minor surgery had being followed.

The practice had not needed to use restraint, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs and nurses to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. Patients were offered support to stop smoking by the practice nurses.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice nurses provided appointments for a variety of health checks and conditions. These included blood tests, health checks, baby immunisations and health reviews for patients with long term conditions such as diabetes or respiratory problems The practice also provided phlebotomy (taking blood samples), electrocardiograms (ECGs) and spirometry (a spirometer measures the volume and speed of air that can be exhaled and inhaled and is a method of assessing lung function). The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 78%, which was slightly below the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was below average for the majority of immunisations where comparative data was available. For example:

- National data showed that the practice was slightly lower than the national average figures for providing flu vaccinations to patients aged 65 or over (63% compared with 73%) and for those in high risk groups (42% compared to 52%).
- Childhood immunisation rates for the vaccinations given to under twos ranged from 73% to 90% and five year olds from 82% to 90%. Most of the rates for vaccinations given to under twos were below the CCG averages which ranged from 86% to 100%.

The practice had started to address the low vaccination rates by working in conjunction with their Clinical Commissioning Group in developing a vaccine preventable illness plan. The practices aim was to increase the uptake of influenza and pneumococcal vaccinations especially among the high risk groups and hard to reach communities during the 2014-15 flu season and beyond. As part of this plan, the practice had completed a project with a specialised winter immunisation facilitation team (SWIFT). The SWIFT project involved the practice offering flu vaccinations to all homeless patients who attended a local drop in centre, a total of 81 vaccinations were offered to these patients and the practices flu vaccination uptake increased by a further 56%.

The practice also held four walk in clinics in January and February 2015 for patients to attend after working hours.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 60% of patients in this age group took up the offer of the health check. We were shown the process for following up patients within one week if they had risk factors for disease identified at the health check and how further investigations were scheduled.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in January 2015. The data from the national patient survey 2015 showed that 88% of the respondents described their overall experience of the practice as good; this was higher than the national average of 85%. Further results showed a mixture of high and low percentages compared with CCG and national averages. For example:

- 73% said the GP was good at listening to them. This was lower than the CCG average of 84% and national average of 89% however, 90% said the last nurse they saw was good at listening to them and this was higher than the CCG average of 89% and slightly lower than the national average of 91%.
- 79% said the GP gave them enough time compared to the CCG average of 82% and national average of 87%. Ninety one percent said the nurses gave them enough time; this was higher than the CCG average of 88% and slightly lower than the national average of 98%.
- 90% said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and national average of 95%. Ninety two percent said they had confidence and trust in the last nurse they saw or spoke to, this was lower than the CCG average of 95% and the national average of 97%.

We discussed results from the national patient survey with the practice on the day of our inspection and we found that the practice had reviewed its' results from the survey to see if there were any areas that needed addressing. One of the actions the practice identified was to arrange for customer care training for the whole practice team, this was also picked up by the practice when they analysed their complaints.

We spoke with four patients during our inspection. Patients said staff treated them with dignity and respect and were positive about the service experienced. Patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. The positive feedback from patients was also reflected in the CQC comment cards patients completed to tell us what they thought about the practice. We received eight completed cards where patients had described staff as caring and respectful. Patients commented that they never felt rushed during consultations as the GPs and nurses always took the time to ensure patients understood any advice and treatment. The practice was in line with the CCG average of 84% with regards to patients who found the receptionist staff helpful. Comment cards also highlighted that staff were respectful and overall the practice was described as providing an excellent, friendly service.

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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. Staff told us that patients were given the option to speak with them in a private area away from the reception desk if they needed to talk in private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

There was a visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The national patient survey information (2015) we reviewed showed mixed responses to questions about GP and nurse involvement in planning and making decisions about their care and treatment. For example:

Good

Are services caring?

- 82% said the last GP they saw was good at explaining tests. This was in line with the CCG average of 82% and slightly lower than national average of 86%. Eighty eight percent said the last nurse they saw or spoke to was good at explaining tests and treatments. This was in line with the CCG average and slightly lower than the national average of 90%.
- 67% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 76% and national average of 82%. Seventy eight percent said the last nurse they saw or spoke to was good at involving them in decisions about their care. This was lower than the CCG average of 83% and national average of 85%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. One patient described how the GP had used diagrams to help explain their treatment and said that the GP printed out extra health care information for them to take away and read after their appointment, the patient said they found these resources very helpful. Patients 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. Patient feedback on the comment cards we received was also positive and aligned with these views. We noticed that several cards made reference to the time and care given by the GPs, patients commented that the GPs always took the time to clearly explain things during examinations and some patients commented on how the GPs never rushed when discussing symptoms and conditions. We also spoke with three members of the patient participation group (PPG) during our inspection. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The PPG members told us how in particular, there is good continuity of care at the practice and how the patients have built good long term relationships with the GPs and nurses.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required. The patient survey information we reviewed showed that the survey responses were less positive about the emotional support provided by the practice. For example:

- 65% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 80% and national average of 85%.
- 82% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 90%.

Patients we spoke with described the practice as a caring, helpful, friendly and professional service. This was also reflected in the CQC comment cards and through the feedback from the patient participation group (PPG). Staff also described their service as caring and the GPs shared many examples of where they had carried out extra home visits for patients who were too ill to attend the practice. One GP explained how some of their patients had been receiving care from them for many years and how over time they had developed trusting professional relationships with their patients. On the morning of the inspection we also saw how the GP made it a priority to attend to a patient who had turned up earlier than their appointment which was the first appointment of the day. The GP explained that they didn't want to leave the patient waiting and saw to them as a priority. When interacting with patients at the front desk and when speaking with the inspection team, the caring nature of the practice staff really shone through. Staff we spoke with revolved their feedback around patients, staff came across as passionate about their practice and overall we found the practice to have a genuinely caring approach.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer, the practice had a register of carers in place and the practice had recently adapted their registration form to identify any new carers joining the practice. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. Further information could also be accessed by a carer's corner which was situated in the reception area. The carer's corner held additional information on carer's workshops, local carer's hubs and information on flu jabs for carers.

Good

Are services caring?

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and by giving them advice on how to find a support service. The practice would also give the patients the option to be referred for counselling to provide further support to them. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

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 patient's needs and had systems in place to maintain the level of service provided. The practice served a diverse population of all ages and various ethnic backgrounds. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. These included extended hours for the working population, flexible access options for booking appointments and ordering prescriptions, as well as offering a home visit service. The practice was also culturally sensitive and offered an interpreting service for patients who didn't have English as a first language. One GP also offered advice on circumcision care, in line with national guidance.

The practice regularly engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population. For example, the practice was exploring ways of working across a number of sites under a new umbrella sexual health screening pilot.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients. Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence. The practice had also purchased a zimmer frame and a wheelchair service to help patients where required.

Staff told us that they did not currently have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor. Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Access to the service

The surgery was open for extended hours from 8:30am to 8:00pm on Mondays and from 8:30am to 6:30pm on Tuesdays to Friday. Appointments were available from 8:40am to 7:50pm pm Mondays and from 8:40am to 6:20pm on weekdays.

Comprehensive information was available to patients about appointments on the practice website and within the practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments online. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients on the practice website, in the practice leaflet and also on notices within the practice.

The national patient survey (2015) information we reviewed showed patients responded positively to questions about access to appointments and rated the practice well in these areas. For example:

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 75% were satisfied with the practice's opening hours compared to the CCG average of 74% and national average of 76%.
- 88% described their experience of making an appointment as good compared to the CCG average of 78% and national average of 85%.
- 47% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 54% and national average of 65%.
- 70% said they could get through easily to the surgery by phone compared to the CCG average of 67% and national average of 74%.

The practice was also exceptionally higher than the CCG and national averages for convenience of appointments. Ninety eight percent of the survey respondents said the last appointment they got was convenient. This was higher than the CCG average of 90% and the national average of 92%.

Patients we spoke with were also satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent and it was often a GP of their choice. They also said they could see another GP if there was a wait to see the GP of their choice. Routine appointments were available for booking two weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. One patient told us how they have never had a problem getting an appointment with the GPs and nurses and they described the access as amazing.

The practice offered longer appointments for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. The practice also offered emergency appointments for babies on the same day. Home visits were made by a named GP and to those patients who needed one.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at three complaints received in the last 12 months and found that they were satisfactorily handled and dealt with in a timely way. Lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. For example, the practice acknowledged the need for receptionists to inform patients if clinics were running late. The practice changed their approach in response to a complaint received about communication and concerns regarding appointment waiting time, receptionists were reminded to keep patients informed when clinics were running late and keep patients informed as much as possible. In addition to this, the practice were also looking in to customer care training for staff.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no complaint themes had been identified. However, the practice had recognised the need to ensure all complaints were dealt with in a timely way. The practice shared with us a detailed complaints report that they completed in March 2015. The report contained an analysis of their complaints which highlighted that some complaints had not been acknowledged in a timely way. The practice developed an action plan and have since demonstrated that all complaints have been acknowledged in line with their complaints policy and recognised guidance.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality, proactive and holistic care through a patient centred approach. The practice was in the process of updating their business plan and we could see that the vision and values were part of the strategy. The practice also worked towards their seven fundamental standards which included the delivery of high quality care, best access possible, good engagement and clinical excellence. The practice told us how the whole team had been involved in the practice plan which also included creating a brand for the practice, a practice logo and uniforms for staff. We spoke with five members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at six of these policies and saw that they had been reviewed annually and were up to date. The practice had a whistleblowing policy which included information about the rights and responsibilities of staff. Staff knew that this was available on the practice shared drive. Staff who told us they would not hesitate to report any concern because they knew they would be well supported by the practice.

The GP and senior nurse took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing below national standards. However, we saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, a clinical audit was carried out to review and establish the appropriateness of the prescribing of oral nutritional supplements. The audit highlighted patients who no longer needed to take these medicines and patients who were due to have a medication review. Further actions were taken from the audit which involved the practice adjusting their approach, encouraging food first and documenting dietary advice. These actions were shared within the practice during a meeting shortly after the audit was conducted. Additionally, the practice was working with the NHS commissioning support unit (CSU) in completing an audit on the quality of the practices data. The aim of the audit was to improve the data quality, improve prevalence monitoring in line with QOF and to enable the practice to explore data sharing programmes where records can be shared quicker in situations such as emergencies.

The practice held weekly staff meetings where governance issues were discussed. We looked at minutes

from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead and deputy role. For example, there was a lead and also a deputy for infection control, safeguarding and health and safety. We spoke with five members of staff and they were all clear about their own roles and responsibilities. Staff told us how the lead GP would often thank the team for their work. The team said they felt valued and supported by each other.

All staff knew who to go to in the practice with any concerns. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Seeking and acting on feedback from patients, public and staff

Are services well-led?

Good

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

The practice had an active patient participation group (PPG), the group represented the patient population of the practice and was made up of several members with a variety of ages, mixed genders and diverse ethnic backgrounds. The PPG had implemented suggestions for improvements including the suggestion of creating a carers corner in the practice which the practice had responded to and implemented The PPG met quarterly and we saw minutes to support that meetings were taking place.

The practice was actively encouraging patients to be involved in shaping the service delivered at the practice. There was a suggestions box in place for staff and the practice was developing a suggestions register for staff to log suggestions for discussion at the weekly meetings. Staff told us how a nurse had communicated patient suggestions during a staff meeting where patients had requested that appointments for blood tests could be available later during the day. The GPs agreed to this and the practice approached the local hospital that were able to adjust their collection times for testing at the laboratory. The practice now offers later appointments for blood tests in line with patient needs.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended; examples shared were dementia awareness and learning disability awareness training. The practice had recently become an accredited training practice and was working closely with a local university in the set-up of a new medical school. The practice was waiting for a trainee GP to be allocated to them.