

Dr P Pal and Jemahl

Quality Report

33 Newton Road
Great Barr
Birmingham
West Midlands
B43 6AA

Tel: 0121 357 1690

Website: www.drspalandjemahl.nhs.uk

Date of inspection visit: 19 April 2016

Date of publication: 10/06/2016

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?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	9
Areas for improvement	9

Detailed findings from this inspection

Our inspection team	10
Background to Dr P Pal and Jemahl	10
Why we carried out this inspection	10
How we carried out this inspection	10
Detailed findings	12
Action we have told the provider to take	23

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr P Pal and Jemahl on 19 April 2016. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- 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.

- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. Information about services and how to complain was available and easy to understand.

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

The areas where the provider must make improvement are:

- Appropriate risk assessments must be in place to assess and mitigate risks in the absence of DBS checks to ensure safety and welfare of service users.

The areas where the provider should make improvement are:

- Review incident reporting process to ensure it is consistent and facilitates effective analysis.

Summary of findings

- Actions taken following medical alerts should be documented and audited
- Review the practice whistleblowing policy to include third party details and ensure all staff are aware of process.
- Ensure that risk is assessed and managed in relation to safety of the premises.
- Ensure appropriate treatment protocols are available for 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?

The practice is rated as requires improvement for providing safe services. There was a system in place for reporting and recording significant events but this needed to be straightened to allow for effective analysis. The staff we spoke with were aware of their responsibilities to raise and report concerns, incidents and near misses. The practice had defined and embedded systems in place to keep people safeguarded from abuse. Staff demonstrated they understood their responsibilities and how to respond to a safeguarding concern. Some risks to patients were assessed and well managed but we saw that a health and safety risk assessment had not been undertaken and recruitment processes were not robust.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Staff members we spoke with told us that they assessed needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for staff. We saw evidence that multi-disciplinary team meetings took place and a range of chronic disease and vulnerable patient registers were continually reviewed and discussed as part of these meetings.

Good



Are services caring?

The practice is rated as good for providing caring services. Results from the national GP patient survey showed patients rated the practice comparable to other practices locally and nationally for several aspects of care. We observed a friendly atmosphere throughout the practice during our inspection. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. The practice also provided information and supported patients by referring them to counselling services and further support organisations. There was a practice register of all people who were carers. Information for patients about the services available was easy to understand and accessible. We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Good



Summary of findings

Are services responsive to people's needs?

The practice is rated as good for providing responsive services. Practice staff 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. For example, a specialist diabetes nurse and a consultant in diabetes from the local hospital held clinics at the practice for complex patients. This was a CCG initiative. The practice was taking part in the Primary Care Commissioning Framework (PCCF), a CCG initiative to help deliver improvements in clinical outcomes for patients. Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. Data we looked at from the national GP patient survey confirmed this. The practice planned to merge with three other local practice and relocate to a purpose built building to better meet the needs of patients. Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised.

Good



Are services well-led?

The practice is rated as good for being well-led. The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the overall vision about the practice. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify most risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings. The practice had a vision to become a teaching practice and was due to take medical students for 2017.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, shingles catch up vaccination, dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice nurse undertook home visits to housebound patients for medicine reviews. The practice had effective systems in place to identify and assess patients who were at high risk of admission to hospital. These patients were reviewed and care plans developed to reduce the need for them to go into hospital.

Good



People with long term conditions

The practice is rated as requires improvement for the care of people with long-term conditions. The practice offered a range of clinical services which included care for long term conditions such as diabetes, a range of health promotion and chronic disease support. Patients at risk of hospital admission were identified as a priority through the use of risk assessment tools. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. However, data we looked at showed that the practice achievement for diabetes was significantly lower compared to local and national averages for the previous two years. The practice was aware of this and had responded by providing specialist training for the practice nurse.

Requires improvement



Families, children and young people

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. Immunisation rates all standard childhood immunisations were similar to or above local averages. Appointments were available outside of school hours and children were given appointments as a priority.

Good



Summary of findings

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 offered online services and telephone consultations as well as a full range of health promotion and screening that reflected the needs of this age group. The practice offered Saturday opening as well as early morning appointments. This was beneficial for patients unable to visit the practice during the main part of the day such as those patients who worked during these hours.

People whose circumstances may make them vulnerable

Good



The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. We saw that there were 11 patients on the learning disability register and the practice had carried out annual health checks for nine people on the register. It offered longer appointments for people with a learning disability. The practice regularly worked with other health care professionals in the case management of vulnerable patients. The practice informed vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children.

The practice was taking part in a domestic violence and abuse (DVA) pilot scheme, Identification and Referral to Improve Safety (IRIS) and held domestic violence multidisciplinary meetings. Minutes of meetings we looked at showed a number of patients had been discussed and reviewed. The GP partners told of specific cases where they had supported patients suffering abuse. 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). We saw that there were 48 patients on the mental health register and the practice had carried out annual physical health checks for all of those on the register. The practice regularly worked with multidisciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice had told

Summary of findings

patients experiencing poor mental health about how to access various support groups and voluntary organisations. Information was made available at the practice to sign post patients to various support groups and services. This was also available on the practice website. 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

The national GP patient survey results were published on 7 January 2016. The results showed the practice was performing in line with local and national averages. Out of 248 survey forms that were distributed, 119 were returned. This represented a completion rate of 48%.

- 82% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 80% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 85%.
- 88% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 85% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 78%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 44 comment cards which were all positive about the standard of care received. However, three of the comment cards also stated that they occasionally found it difficult to get an appointment when required. Overall, patients commented that they were happy with the service and felt that staff were supportive and friendly.

We spoke with five patients during the inspection. Three of the patients were members of the Patient Participation Group (PPG) including the vice chair. All five patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. A PPG is a group of patients registered

Areas for improvement

Action the service **MUST** take to improve

- Appropriate risk assessments must be in place to assess and mitigate risks in the absence of DBS checks to ensure safety and welfare of service users.

Action the service **SHOULD** take to improve

- Review incident reporting process to ensure it is consistent and facilitates effective analysis.
- Actions taken following medical alerts should be documented and audited

- Review the practice whistleblowing policy to include third party details and ensure all staff are aware of process.
- Ensure that risk is assessed and managed in relation to safety of the premises.
- Ensure appropriate treatment protocols are available for staff.

Dr P Pal and Jemahl

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team also included a GP specialist adviser.

Background to Dr P Pal and Jemahl

Dr P Pal and Jemahl provide primary medical services to approximately 5885 patients in the local community of various ages. There are two GP partners (both male) and two part time salaried GPs (one male and one female). The practice is based in the Great Barr area of the West Midlands.

The GPs are supported by a practice nurse and two health care assistants. The non-clinical team consists of a team of six administrative and reception staff and a practice manager. Supporting the practice manager was an assistant practice manager.

Services to patients are provided under a General Medical Services (GMS) contract with NHS England. The practice 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 practice is open between 8.15am and 6pm Mondays to Fridays except Thursdays when it closed at 1pm. Extended hours appointment is offered from 6.30am to 8pm on Tuesdays and Thursdays. The practice is also open every Saturday from 8am to 11am.

The practice has opted out of providing out-of-hours services to their own patients. This service is provided by 'Primecare' the external out of hours service provider.

We reviewed the most recent data available to us from Public Health England which showed that the practice is located in an area with a low deprivation score compared to other practices nationally. Data showed that the practice has a higher than average practice population aged 60 years and over in comparison to other practices nationally. The practice also has a lower than the national average number of patients below the age of 60.

The practice achieved 89% points for the Quality and Outcomes Framework (QOF) for the financial year 2014-2015. This was slightly below the national average of 94%. The QOF is a voluntary annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The 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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We carried out an announced visit on 19 April 2016. During our visit we:

Spoke with a range of staff including the GP partners, the practice nurse, reception staff as well as the practice manager. We also spoke with patients who used the service including members of the Patient Participation Group (PPG). We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

- Is it safe?
- Is it effective?

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework (QOF) data, this relates to the most recent information available to the CQC at that time.

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. There was a significant event monitoring and analysis template used to report significant events. Staff members we spoke with were aware of the process for reporting and escalating incidents. Staff told us they would inform the practice manager or the assistant practice manager of any incidents and they would also share this with the Clinical Commissioning Group (CCG) through the electronic reporting system. 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.

We saw that the practice had carried out an annual analysis of significant events. However, the recording process for incidents were not consistent as some incidents were recorded using a template while other incidents were being reported using an electronic system. As a consequence, copies of those incidents reported using an electronic system were not being kept and were not included as part of the practice analysis used to identify trends and themes.

The practice manager logged copies of patient safety alerts in a folder and circulated to staff members electronically. We saw evidence where the practice manager had sent alerts to clinicians highlighting specific and relevant alerts via email. Staff members we spoke with also confirmed this. For example, we saw an alert from Public Health England that needed to be actioned by 31 March 2016. However, actions taken following an alert were not being documented. Staff members we spoke with confirmed that alerts were actioned.

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse. This included arrangements to safeguard children and vulnerable adults which reflected relevant legislation and local requirements. One of the GP partners was the safeguarding lead for the practice and the lead for safeguarding children for the CCG. Evidence we looked at showed that they were aware of the safeguarding process as issues raised were escalated appropriately. Staff

members we spoke with were aware of the lead, the process for raising any issues and had access to the policy which contained appropriate names and contact details of relevant agencies.

One of the GP partners was appointed as the lead for safeguarding vulnerable adults and children. All the GPs and practice staff had been trained to an appropriate level and demonstrated they had gained the necessary knowledge from this training to enable them to fulfil this role. The practice was taking part in a domestic violence and abuse (DVA) pilot scheme, Identification and Referral to Improve Safety (IRIS). One of the GP partners told us about a specific patient they had recently dealt with was referred to IRIS. The practice shared learning and received positive feedback from the IRIS team regarding the handling of the incident. The practice held domestic violence multidisciplinary meetings. Minutes of meetings we looked at showed a number of patients had been discussed and reviewed.

A chaperone policy was in place and information about the service was visible on the waiting room noticeboard and in consultation rooms. 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. We saw certificates to confirm that staff had been trained to act as chaperones and staff members we spoke with were able to tell us how they would fulfil the role of a chaperone appropriately.

We reviewed three personnel files and found recruitment checks undertaken prior to employment were not robust. Some staff members including administration staff who acted as chaperones had not had a Disclosure and Barring Service (DBS) check. Furthermore, risk assessments to assess and mitigate risk in the absence of DBS checks were not robust. 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 had a whistle blowing policy and staff members we spoke with were aware of the policy. However, they were unable to tell us the actions they would take to raise concerns outside of the practice where appropriate. We looked at the policy which did not provide guidance on this.

Are services safe?

The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse and the healthcare assistant were joint leads for infection control. There was an infection control protocol in place and staff had received up to date training via the CCG. We saw that an infection control audit had been carried out. The audit did not contain a date to confirm when it had been carried out. However, the practice manager told us that it had been undertaken in February 2016. We saw that there were no actions identified following the audit.

The practice employed an external contractor for cleaning the premises and we saw there were cleaning schedules in place. The external contractor carried out quarterly spot checks to ensure effective cleaning. We saw that the latest spot check was assessed with a score of 97%.

We checked medicines stored in refrigerators and found they were stored securely and were only accessible to authorised staff. Processes were in place to check medicines were within their expiry date. Records showed and fridge temperature checks were carried out and all the medicines we checked were within their expiry dates.

The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Data we saw showed that although the practice had over prescribed for some medicines including antibiotics, overall their annual prescribing was predicted to be below their allocated budget. Patients received regular reviews of their medicines and the nurse visited patients who were unable to visit the practice to help manage their medicines. This was particularly for patients who had been on multiple medicines to reduce the risk of polypharmacy.

Monitoring risks to patients

Some risks to patients were assessed and well managed. There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office but no risk assessments were carried out. The practice manager had carried out an up to date fire risk assessment. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.

The practice had some other risk assessments in place to monitor safety of the premise. For example, the cleaners had access to risk assessments such as control of substances hazardous to health (COSHH) for cleaning products they used. There was also and a legionella risk assessment in place. Legionella is a term for a particular bacterium which can contaminate water systems in buildings

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. Staff told us that they normally covered each other during holidays and unplanned absences. The practice could also access clinical staff through locum agencies.

Arrangements to deal with emergencies and major incidents

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

All staff received annual basic life support training and there were emergency medicines available and in date. They were easily accessible to staff in a secure area of the practice and all staff knew of their location.

The practice did not have a defibrillator available on the premises. The practice decided to purchase a defibrillator and confirmed this immediately after our inspection visit and had sent in proof of purchase to us. There was emergency medical oxygen available with adult and children's masks.

There was an alert on the computer system that could be operated in all the consultation, treatment rooms and reception which alerted staff to any emergency. There was also an alert system in reception that was directly linked to the police in event of they were required.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. We were told that the Practice manager, the assistant practice manager and the GP kept a copy of the business continuity plan in their homes. As part of the plan three laptops were available with remote access to the server so that in the event of a disaster appropriate arrangements could be made.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice held monthly clinical meetings to keep all clinical staff up to date sharing any new guidelines. The practice nurse we spoke with confirmed that they were emailed any new NICE guidelines and were happy with how information was shared with them.

The practice also followed guidance from the CCG. For example, we saw that the practice used guidance for the management of neuropathic management of pain from Sandwell and west Birmingham CCG. However, in other areas such as diabetes, the practice did not have a particular protocol despite the practice nurse undertaking extended training. The practice used the Quality and Outcomes Framework (QOF) guidance instead. QOF is a system intended to improve the quality of general practice and reward good practice. The practice had a high prevalence of patients with hypertension. However the healthcare assistant did not have a protocol for new diagnosis of hypertension.

Management, monitoring and improving outcomes for people

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The most recent published results were 89% of the total number of points available. Exception reporting for the practice was 4%. This was 4% (half) below the CCG average and 5% below the national average. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.

Data from 2014/15 showed:

- Performance for diabetes related indicators was worse compared to the national average. The practice achievement for diabetes was 62% which was 23% and 27% below local CCG and national averages respectively. However, the practice exception reporting was below local and national averages.

- Performance for mental health related indicators was better compared to the local and national averages. The practice achievement for mental health was 100%. This was 11% better than local CCG average and 7% better than the national averages. The exception reporting at 5% was 6% below local CCG and 7% below national averages.

We spoke with one of the GP partners who told us that they were aware that their achievement for diabetes had dropped over the past two years. They told us that they had a higher clinical prevalence of diabetes. Furthermore, the practice nurse who was a specialist in diabetes was on long term leave and had returned in September 2015. A salaried GP had then left on long term leave in December 2015 and the practice felt that the absence of two key staff members had contributed to the lower achievement.

Unpublished data for 2015/16 showed that the practice achievement for diabetes was 76%. This was an improvement on the previous year and we were told that the return of the practice nurse midway through the year had contributed to the improvement. To further improve, the practice nurse had completed the PITstop diabetes course and was undergoing final accreditation before they were able to review patients. One of the GP partners was also undergoing this training. Specialist diabetes clinics were currently being held at the practice by a specialist nurse and a consultant from the local hospital. This was a CCG initiative.

There was evidence of quality improvement including clinical audit. One of the GP partners had undertaken an audit to look at advice given to patients during consultation for emergency contraception between December 2014 and December 2015. The outcome of the audit had led to the GPs intention to develop a protocol to highlight the need to advise patients of the possibility of insertion of intrauterine device (IUD) at the local family planning clinic.

We saw that the practice had undertaken other audits including two cycles of a medicine audit, safeguarding audit and pregnancy audit. Findings were used by the practice to improve services.

Regular multidisciplinary meetings were held to discuss vulnerable patients with health visitors attending. However, social services did not attend the meetings and as a result the practice intended to invite the school nurse.

Are services effective?

(for example, treatment is effective)

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. The practice had an induction programme for newly appointed clinical and non-clinical members of staff that covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. We spoke with the practice nurse who had started three years previously and they confirmed that they had been through the induction process and were mentored by the previous nurse.

The practice could demonstrate how they ensured role-specific training and updating for relevant staff. Documents we looked at showed lead areas for relevant staff members. We also saw a training plan for each staff member and saw they were appropriate to their lead roles. For example, the practice nurse was the lead for Asthma and Chronic obstructive pulmonary disease (COPD). We saw that the nurse had attended training for Asthma and had received update on spirometry. COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections.

Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example they were part of a nurse forum and had received training.

The learning needs of staff were identified through a system of appraisals. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support and mentoring. For example, the practice nurse was undergoing specialist training in diabetes to respond to needs of the practice.

Staff received training that included: safeguarding, domestic violence, basic life support and information governance.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and

accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and investigation and test results.

The practice shared relevant information with other services in a timely way, for example when referring people to other services. We spoke with one member of staff who was responsible for following up referrals to ensure it was timely and any reasons for delays were communicated to patients. The practice secretary was responsible for emailing relevant information to out of hours service providers for patients on end of life care.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. We saw evidence that multi-disciplinary team meetings took place on a quarterly basis and that care plans were routinely reviewed and updated.

The practice carried out assessment of mental capacity and the GP partner discussed a recent case where they worked with other agencies to help a patient transfer to a care home.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. The practice had a process to ask for, record and review consent decisions that were needed from patients. The practice had a minor surgery consent form which was used before a procedure was carried out. The forms were then scanned on to the system for documentation.

We saw that the practice had developed shared care plans for many of the patients with long term and complex conditions. The practice involved patients to take part in developing their care plan so that they were involved in the decision making.

The practice offered interpreters to patients that did not speak English so that they could be made aware of their care and treatment. Some of the staff including the GPs were multilingual and could speak some of the languages spoken by patients.

There were 11 patients on the learning disability register and 39 patients on the mental health register. Nine patients on the learning disability register had been reviewed and 38 patients on the mental health register had been

Are services effective?

(for example, treatment is effective)

reviewed. We reviewed a sample of care plans for patients with a learning disability and those with mental health needs and saw that they were supported to make decisions through the use of care plans, which they were involved in agreeing.

Supporting patients to live healthier lives

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition through chronic disease management clinics and those requiring advice on their diet, smoking and alcohol cessation well person clinics.

The practice's uptake for the cervical screening programme was 82%, which was comparable to the CCG average of 80% and the national average of 82%. There was a lead

administration staff member to offer telephone reminders for patients who did not attend for their cervical screening test. The staff member also ensured they followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 90% to 98% and five year olds from 78% to 96%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard. Reception staff we spoke with told us when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 44 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered a brilliant service and staff were helpful, caring and treated them with dignity and respect.

We spoke with five patients; three of the patients were also members of the patient participation group (PPG). All the patients we spoke with told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 86% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 83% and the national average of 89%.
- 87% of patients said the GP gave them enough time compared to the CCG average of 81% and the national average of 87%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 87% and the national average of 95%
- 88% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%).

- 92% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%).
- 95% of patients said they found the receptionists at the practice helpful compared to the CCG average of 81% and the national average of 87%)

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We looked at some care plans and saw that they were well documented and personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were similar local and national averages. For example:

- 85% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and the national average of 86%.
- 81% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 88% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%).

The practice provided facilities to help patients be involved in decisions about their care. 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 patients this service was available. Some of the staff members including the GPs were able to speak some of the languages spoken by the patients. The practice website could be translated in to various languages. Patients could log in to register for their appointments on an electronic system in other languages.

Patient and carer support to cope emotionally with care and treatment

Are services caring?

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. For example, the practice website had a link to online health information such as mental health, men's and women's health. The practice utilised the route2wellbeing website promoted by the CCG to further signpost patients.

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 102 patients as carers (1.7% of the practice list). There was a carers corner in the reception area which encouraged patients to register as a carer. Written information was available to direct carers to the various avenues of support available to them. The practice website also directed people to other helplines.

We also saw information on bereavement advertised in the reception area. If a patient informed the practice that they had suffered bereavement we were told that staff offered them a consultation with the GP and directed them to other agencies for further help and advice. The practice also informed all staff members and other organisation through the electronic system where appropriate.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice 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. For example, the practice was taking part in the primary care commissioning framework (PCCF) and as part of this was expected to offer various services such as end of life care, improve patient safety through better safeguarding processes and to improve on management of long term conditions.

The practice had arrangements for managing patients with chronic conditions such as asthma, diabetes and heart disease. Patients were invited for regular reviews of their health condition which were carried out by the GPs and a trained nurse. The practice nurse visited house bound patients to carry out medication reviews. The practice achievement for diabetes QOF indicators were below local and national averages due to the practice nurse being away on long term leave along with a salaried GP. However, this was being addressed as the practice nurse was completing specialist course on diabetes (PITstop).

The practice was open early from 6.30am on Tuesdays and Thursdays. The practice also opened on Saturday from 8am to 11am. Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. The practice nurse visited patients at home for chronic disease management such as administering flu vaccines especially if they were house bound.

There were longer appointments available for patients with a learning disability. Same day appointments were available for children and those patients with medical problems that require same day consultation. Patients were able to receive travel vaccinations available on the NHS as well as those only available privately/were referred to other clinics for vaccines available privately.

There were disabled facilities and patients using a wheelchair could access the practice, there was a designated disabled parking bay. For patients who did not speak English, a translations service was available and there was an option on the practice website to translate contents to

another language. Some of the staff were multilingual and could speak languages such as Bengali, Hindi, Punjabi, and Urdu. A staff member was also trained in British Sign Language (BSL).

The practice had conducted a Disability Discrimination Act (DDA) audit in October 2015. As part of the audit it recognised that the building did not have automatic front doors leading to the reception area to ensure it was easily accessible for patients using a wheelchair. However, practice planned to merge with two other local practices and relocate to purpose built premises which would have better access for patients with a disability. The DDA has been replaced by the Equality Act 2010.

Access to the service

The practice was open between 8.15am and 6pm Mondays to Fridays except Thursdays when it closed at 1pm. Extended hours appointments were offered from 6.30am to 8pm on Tuesdays and Thursdays. The practice was also open every Saturday from 8am to 11am. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

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

- 75% of patients were satisfied with the practice's opening hours compared to the local average of 71% and the national average of 75%.
- 82% of patients said they could get through easily to the practice by phone compared to the local average of 62% and the national average of 73%.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns. We saw that complaints system was displayed in the practice waiting area to help patients understand the system better. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice. We saw that the practice had received 12 complaints during the previous year. We saw that they were discussed during the quarterly team meetings. The practice manager also told us that they

Are services responsive to people's needs? (for example, to feedback?)

would communicate any issues with staff through notifications on the commuter system and we saw

evidence if this. We also saw evidence of tasks assigned to staff members as a result of complaints. We saw evidence that the practice had responded appropriately to complaints.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality effective care in a safe respectful and welcoming environment through teamwork. Staff members were aware of the overall vision of the practice which was the merger with three other local practices which would allow them to deliver a quality service in a purpose built welcoming environment.

The partners and management staff also told us that the practice aspired to become a teaching practice. They told us that they would be taking medical students from 2017 as a local university was due to open a new medical school.

Governance arrangements

The practice had a governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that there was a clear staffing structure and that staff were aware of their own roles and responsibilities. Practice specific policies were implemented and were available to all staff. Staff members demonstrated to us how they accessed policies from the computer system.

Staff members had specific roles such as ensuring follow up of referrals made to hospitals and keeping patients aware of any changes to those. A staff member was responsible for following up patients that had missed their appointment for cervical cytology. The practice nurse and the healthcare assistant were leads for infection prevention and control. There were robust arrangements for identifying, recording and managing most risks and implementing mitigating actions.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. The partners told us that they were a high QOF achieving practice and one of the partners had been a QOF assessor and a GP appraiser. Another partner told us that they were currently a GP appraiser. Both GP partners had specialist areas in Gynaecology and in musculoskeletal disorders. Although the practice achievement for diabetes was below local and national averages. Previous data we looked at showed that the practice achievement for diabetes was

similar to or above local and national averages. The GP partners told us that the current achievement had been affected by long term absence of the practice nurse and a salaried GP and this was now being addressed.

Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support and training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty and this was part of the practice vision and value.

There was a clear leadership structure in place and staff felt supported by management. Staff told us the practice held quarterly team meetings. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. For example, we spoke with one staff member who told us that many patients were unhappy and contacting the practice because they had not received an update after referral to hospital by the GPs. They told us that one of the reasons was because GPs were telling patients they should expect to hear the outcome of their referral soon. The staff member told us that they felt confident to feed this back to the GPs so that they could provide a realistic timeframe and it was taken on board.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. We spoke with three patients who were members of the PPG on the day of the inspection one of whom was the vice chair. They told us that the PPG met three monthly and the practice listened to their views to improve practice. For example, members of the PPG told us that the practice previously had a newsletter and this was started again because of feedback from patients. We saw the latest newsletter in the practice which was published in April 2016. PPG members also told

Are services well-led?

Good 

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

us that some patients were unaware of the repeat prescription process and asked this to be communicated via the newsletter. We saw that this was done in the April newsletter.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. And a staff member we spoke with told us of a specific example in regards to issues involving referral times.

Continuous improvement

The practice had achieved the RCGP research ready status. This was an online quality assurance framework, designed for use by any general practice in the UK actively or potentially engaged in research, on any scale. We were told that the practice had undertaken in a University of Birmingham bowel screening study. As part of this one of the GP partners had undertaken training in good clinical practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>How the regulation was not being met:</p> <p>The registered person did not ensure safety and welfare of service users by having appropriate risk assessments in place to assess and mitigate risk in the absence of DBS checks.</p> <p>This was in breach of regulation 17(2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>