Kings Norton Surgery

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Kings Norton Surgery on 16 December 2015. Overall the practice is rated as good.

Our key findings 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. The practice had good network meetings with the Clinical Commissioning Group (CCG) to improve outcomes for patients.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. The GPs each took responsibility in different areas and had regular clinical leads meetings to discuss concerns and share learning. They met daily to deal with immediate issues.
- There was a clear leadership structure and staff felt supported by management.
- Risks to patients were assessed and well managed although this was not always documented.
- Patients described staff as professional, efficient and helpful.

However there was an area of practice where the provider should make improvements.

Action the provider should take to improve:

- Ensure that systems are in place so that risk assessments and equipment checks are documented.

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. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep patients safe.

We found that some risk assessments had not been documented. We saw that fire risk assessments were carried out annually and that all staff had received fire training although fire drills had not been carried out. The practice manager was the lead for Health and Safety.

Are services effective?

Good

The practice is rated good for providing effective services. National patient data showed that the practice was at or above the average for the locality on the whole. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Staff had received training appropriate to their roles and the practice believed in developing and training their staff. Staff routinely worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated good for providing caring services. Patients felt involved in their care and treatment and described staff as helpful, efficient and caring. Patient information was easy to understand and accessible to patients. We saw staff treated patients with dignity and respect.

Are services responsive to people's needs?

Good

The practice is rated good for providing responsive services. The practice responded to the needs of its local population and engaged well with Birmingham South and Central 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. The practice was well equipped to meet the needs of their patients. Information about how to complain was available and easy to understand. Learning from complaints was shared and discussed at practice meetings.

A walk in clinic was in place. Patients could sit and wait if they had an acute problem and they were given advice and guidance.

Summary of findings

The practice had 60 patients who misused drugs or alcohol on its register. Two drug and alcohol workers visited the practice twice a week and went to the branch surgery once per fortnight.

The practice was one of 23 practices in Birmingham to take up participation in the Identification and Referral to Improve Safety (IRIS) scheme (a domestic violence and abuse training support and referral programme). In-house training for clinical and administration staff was scheduled for December 2015. It was anticipated that the training would help vulnerable patients.

The practice provided healthcare to 69 patients at a local homeless hostel which was run by the local authority.

Are services well-led?

Good

The practice is rated good for being well-led. It had a clear vision and strategy. The practice was looking at ways to continuously improve and they had a programme of continuous clinical and internal audit. Staff told us there was an open culture and they were happy to raise issues at practice meetings. The partners were visible in the practice and staff told us they would take the time to listen to them. Staff we spoke with said there was a no blame culture which made it easier for them to raise issues. We saw that there was good morale at the practice.

The practice proactively sought feedback from staff and patients, which it acted on and had an active 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.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice monitored and promoted healthcare for this population group and offered at least an annual review and more intense monitoring if required.

The practice considered the full context of patient's lives and most staff had known patients for a number of years and knew their patients well. The practice offered same day access for older patients and visited patients at home when required. The GPs discussed problems regularly with each other. The practice had recently signed up to an NHS constitution local enhanced service which promoted better cancer care and early intervention.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice aimed to diagnose patients early and believed in educating patients with regards to their conditions. They monitored attention to individual lifestyles. They achieved these things by extensive use of

NHS Health Checks, the use of Directed Enhanced Services (DES). These are schemes that commissioners are required to establish or to offer contractors the opportunity to provide, linked to national priorities and agreements and the provision of information. The practice had in house leaflets for pre-diabetes and chronic kidney disease. They systemised follow up of patients between the healthcare assistant, nurse and GPs, and the use of a health trainer.

The practice monitored their repeat prescription system with the use of set review dates.

The practice is a vanguard for diabetes prevention (the CCG is one of the seven CCG sites selected nationally to adopt the programme). Pre-diabetic patients were identified from results of blood sugar levels and given a leaflet and lifestyle advice was provided.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice offered extended access with appointments from 7am four days a week**.** Same day appointments were available using a nearby walk in clinic. Patients could pre book appointments one month in advance. The practice also offered telephone surgeries.

Summary of findings

There was a health visitor and midwife attached to the practice. The practice offered full sexual health services and one of the partners was a family planning trainer.

The practice held quarterly multi-disciplinary child safeguarding meetings at both sites. Parents felt confident that if their child was poorly they would be seen the same day and their health care needs assessed.

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 practice offered extended hours on Mondays, Wednesdays, Thursdays and Fridays with appointments available from 7am so patients could be seen on their way to work. The practice offered on line services for booking appointments and repeat prescriptions which meant that patients could have their repeat prescriptions on the same day.

Patients over the age of 40 were offered NHS health checks.

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 had systems in place to ensure that children were kept safe.

The practice was one of 23 practices in Birmingham to take up participation in the Identification and Referral to Improve Safety (IRIS) scheme (domestic violence and abuse training support and referral programme). In-house training for clinical and administration staff was scheduled for 17 December 2015. The practice anticipated that the training will allow them to help more vulnerable patients.

The practice had 60 patients who misused drugs or alcohol on their register. Two drug and alcohol workers visited the practice twice a week and one day per fortnight at the branch surgery.

The practice looked after patients of a local homeless hostel which was run by the local authority.

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 adopted the palliative care Gold Standards Framework (GSF). GSF is a systematic, evidence based approach to optimising care for all patients approaching the end of life. Multi-disciplinary team meetings were held every two months and the practice had an excellent relationship with the local hospice.

Summary of findings

The dementia diagnosis rate was in line with national averages. When a new patient joined the practice the GPs went through the notes and any vulnerability was directed to the partners. Receptionists at the practice informed the GPs of concerns they had with a patient's memory. The practice worked closely with their case manager and actively referred into a local church-run older peoples group. The practice contacted their local psycho-geriatrician if there were any issues that needed to be discussed.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was performing above local and national averages:

- 90% of patients found the receptionists at this surgery helpful which was above the CCG average of 85.1% and a national average of 86.8%.
- 91% of patients said they were able to get an appointment to see or speak to someone the last time they tried which was above the CCG average of 80.2% and a national average of 85.2%.
- 85.2% of patients found it easy to get through to this surgery by phone which was above the CCG average of 72.3% and a national average of 73.3%.
- 98.6% of patients said the last appointment they got was convenient which was above the CCG average of 90.2% and a national average of 91.8%.
- 91.2% of patients described their experience of making an appointment as good which was abovethe CCG average of 70.6% and a national average of 73.3%.
- 73.1% of patients said they usually waited 15 minutes or less after their appointment time to be seen which was above the CCG average of 57.2% and a national average of 64.8%.
- 65.2% of patients felt they did not normally have to wait too long to be seen which was above the CCG average of 52.7% and a national average of 57.7%.
- 66.6% of patients said they usually got to see or speak with their preferred GP which was above the CCG average of 56.6% and a national average of 60.0%

There were 109 responses and a response rate of 34%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 40 completed cards and all were positive about the service they experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that systems are in place so that risk assessments and equipment checks are documented.

Outstanding practice

We saw two areas of outstanding practice:

The practice was very caring to older patients. We received extremely positive feedback from the care homes the practice looked after.

The practice was very responsive to vulnerable patients. The practice screened drug users for blood borne disease. The practice was one of the early prescribers of a drug which was preventing deaths from overdose in Birmingham and worked closely with other practices.

Kings Norton Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A Care Quality Commission (CQC) inspector. The team included a GP specialist advisor, a practice manager specialist advisor, a second CQC inspector and an expert by experience. Experts by experience are members of the inspection team who have received care and experienced treatment from a similar service.

Background to Kings Norton Surgery

Kings Norton Surgery is based in South Birmingham and also has a branch surgery. We had no specific information about the branch surgery to lead us to visit there and this inspection therefore focussed on the main site.

The practice has five GP partners and two salaried GPs. There are three female and four male GPs which provided a choice for patients. The practice has two practice nurses and two healthcare assistants. The clinical team are supported by a practice manager, a deputy practice manager and a team of reception staff. The practice has a General Medical Services (GMS) contract with NHS England.

The practice is open between 7am and 6.30pm Monday, Wednesday and Friday, 7am to 1pm on Thursdays and 8.30 am to 6.30pm on Tuesdays. Appointments are available at these times.

The practice offers minor surgery such as joint injections, mole removal and freezing of warts.

The health visitor holds a weekly baby clinic (no appointment required) and the midwife holds a clinic once a week by appointment.

The practice offers a full range of contraceptive advice. The GPs fit coils, implants both to their own patients and patients of other practices.

Kings Norton Surgery is a training practice providing up to two GP training places. A GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice. Only approved training practices can employ GP trainees and the practice must have at least one approved GP trainer. The practice is also a teaching practice and provides placements for medical students who have not yet qualified as doctors from Birmingham University.

The practice does not provide out of hours services to their own patients but provided information about the telephone numbers to use for out of hours GP arrangements (NHS 111). The practice website and leaflet also provides information about an NHS Walk-in centre which patients can use if Kings Norton Surgery is closed or if patients are unable to get a suitable appointment.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme 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 references to the Quality and Outcomes Framework data in this report relate to the most recent information available to CQC at the time of the inspection.

Detailed findings

How we carried out this inspection

Before the inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. These organisations included NHS England and Birmingham South and Central (CCG). A CCG is a group 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 carried out an announced inspection on 16 December 2015. We sent CQC comment cards to the practice before the inspection and received 40 comment cards giving us information about these patients' views of the practice. During our inspection we spoke with a range of staff and with patients who used the service. We observed how people were being cared for during the 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)

Good

Are services safe?

Our findings

Safe track record and learning

The practice prioritised safety and reported and recorded significant events. During the inspection we saw that within 12 months 31 significant events had been reported. Staff used incident forms on the practice's computer system and completed the forms for the attention of the practice manager. In the absence of the practice manager the assistant practice manager dealt with the significant events. The incidents were discussed at the practice meetings. 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 and incident reports where these were discussed and saw evidence of changing practice in response to these. The practice provided evidence that significant events were appropriately recorded and discussed, and that actions taken and any learning identified was disseminated to relevant staff. We saw examples where improvements had been made as a result of significant events. For example, staff were reminded to be vigilant when a family member of a patient pretended to be the patient. We saw another example where changes had been made to an administration service to make it more efficient.

National patient safety alerts were sent to the practice manager and one of the partners who ensured that the GPs were aware of this and any necessary action was taken.

Overview of safety systems and processes

The practice had processes and practices in place to keep people safe, which included:

- The practice had systems to manage and review risks to vulnerable children, young people and adults. One of the partners was the safeguarding lead for the practice. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. The GPs were trained to level 3 in children's safeguarding. Safeguarding was on the agenda at each of the practice meetings. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were displayed in every clinical room. There was a system to highlight vulnerable patients on the practice's electronic records. Staff described examples of situations where they had identified and escalated concerns about the safety of patients. This included working closely with the local care homes.
- The practice worked closely with the local domestic violence service. Following the inspection we spoke with the manager of the service who explained that the practice worked closely with them to gain an understanding of their work and has been pro-active in meeting with women who have experienced domestic violence.
- There was a chaperone policy and information to tell patients the service was available was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. 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 staff had received on line chaperone training. All non-clinical staff undertaking chaperone duties had not 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 manager had carried out a risk assessment identifying that all members of staff carrying out chaperone duties should be DBS checked. The process for DBS checks had been started at the time of the inspection. The certificates were not available at the time of the inspection due to some extra documentation required. During this time non-clinical staff were not carrying out chaperone duties and only allowed to re-chaperone once their DBS checks were complete. The practice has now provided evidence of DBS certificates for all non-clinical staff carrying out chaperone duties.We observed the premises to be visibly clean and tidy. One of the practice nurses was the infection control lead. There was an infection control protocol in place and staff had received up to date training. An infection control audit was carried out annually.
- All staff received a full induction on their first day of employment. Records we looked at contained evidence

that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identity, references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

- Staff confirmed they had the equipment they needed to meet patients' needs safely. Each clinical room was appropriately equipped. We saw evidence of calibration of equipment used by staff but no equipment check list was available and no evidence to suggest that portable electric appliances were routinely checked and tested.
- The practice had a policy and procedures for the safe management of medicines and monitoring the use of blank prescriptions which were stored securely. Patients' records were updated when their medicines changed and there was a system for repeat prescriptions which included reviews of patients' medicines. The practice had clear arrangements for the safe administration and storage of vaccines.
- There was a sharps injury policy and staff knew what action to take if they accidentally injured themselves with a needle or other sharp medical device. The practice had written confirmation that all staff were protected against Hepatitis B. All instruments used for treatment were single use. The practice had a contract for the collection of clinical waste and had suitable locked storage available.
- There were procedures in place for monitoring and managing risk to patients and staff safety. For example, an infection control audit was carried out annually and we saw that fire risk assessments were carried out annually. The fire alarms were tested weekly by the practice manager and the deputy practice manager in their absence. Staff had all done fire training and knew what to do in the event of a fire although fire drills had not been carried out. We found that some risk assessments had not been carried out. The practice manager was the lead on Health and Safety. The practice had not carried out a health and safety risk assessment.

Arrangements to deal with emergencies and major incidents

All staff received annual basic life support training. There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. There was an oxygen cylinder and emergency medicines located in the treatment room. The expiry dates and stock levels of the medicines were being checked and recorded monthly by the nursing team. No medicines were stored in the GPs' bags.

There was a business continuity plan which was last reviewed in February 2015. This contained a list of contact telephone numbers to use in an emergency and a copy of this was kept off site with the senior partner. The practice would use the branch surgery as a base if there was an emergency at the main site.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and practice nurse were able to give a clear rationale for their approaches to treatment. Monthly practice meetings took place and the latest clinical guidelines such as those from National Institute of Health and Care Excellence (NICE) were discussed. In addition to this the GPs met daily to discuss patient care, significant events and complaints leading to early resolution. The GPs held a daily phone call between the branch and main surgery at the end of each day to discuss any issues. Our discussions with the GPs and nurse demonstrated that they completed thorough assessments of patients' needs in line with NICE guidance and these were reviewed when considered appropriate.). A CCG is a group 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. The CCG held quarterly meetings to share good practice, discuss audit results, significant events and any other learning points. The practice participated in the network meetings. The network was particularly focussed on reducing non-elective admission to accident and emergency (A&E) for children.

The GPs were leads in different areas and had regular clinical leads meetings to discuss concerns and share learning.

The practice had a register of patients for unplanned admissions and had care plans in place for each of these patients. The practice held a monthly meeting to discuss unplanned admissions

The practice had a communal box system on the computer so that all clinicians had access at all times and any test results could be communicated back to patients as promptly as possible.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 99.5% of the total number of points available which was 5.2% above the national average, with 12.3% exception reporting. Exception reporting relates to patients on a specific clinical register who can be excluded from individual QOF indicators. For example, if a patient is unsuitable for treatment, is newly registered with the practice or is newly diagnosed with a condition.

Data from 2014/15 showed;

- Performance for diabetes related indicators was 98.8% which was above the CCG average by 8.4% and above the national average by 9.6%.
- The percentage of patients with hypertension having regular blood pressure tests was 82.2% which was 1.1% above the CCG average and above the national average by 1.4%.
- Performance for mental health related and hypertension indicators were 93.2% which was above the CCG average by 1.8% and above the national average by 3.7%.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and patients' outcomes. We reviewed two clinical audits completed in the last two years; both of these were completed audits where changes were made and implemented.

The first audit was an audit of rheumatology care to ensure that patients understood their condition, the medicines they were taking and the monitoring arrangements. The patients were coded correctly on the computer system. The re-audit showed that by using the practice administration team to set up clinics and call patients in that patients complied much better with their care and the GP partners understood the needs of rheumatology care better.

The second audit was an audit of hormone replacement therapy preparations used in women over 54 years old to consider what was most effective.

Effective staffing

We found that the GPs valued the importance of education and effective skill mix. Kings Norton Surgery was a training practice providing GP training places for two GP trainees. A GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice. Only approved training practices can employ GP trainees

Good

Are services effective?

(for example, treatment is effective)

and the practice must have at least one approved GP trainer. The practice also provided placements for fifth year medical students from Birmingham University who had not yet qualified as doctors.

The learning needs of staff were identified through a system of appraisals and meetings. All non -clinical staff had their appraisals with the practice manager and the clinical staff had their appraisals with the lead GP. We saw that all staff were up to date with their appraisals.

All staff had the essential training for their role such as safeguarding, fire safety and information governance. Further training needs were identified at appraisals on an individual basis. We saw evidence of individual training certificates which were kept in a systematic manner in individual files.

Staff at the practice had the skills, knowledge and experience to deliver effective care and treatment. One of the practice nurses had attended an anti-coagulation (medication used for blood thinning) course ran by Birmingham University which was supported by the practice. The nurse explained how helpful she had found the training to be.

Coordinating patient care and information sharing

The practice used electronic systems to communicate with other providers and to make referrals. Staff felt that the system was easy to use and patients welcomed the ability to choose their own appointment dates and times through the Choose and Book system. Choose and Book enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to co-ordinate, document and manage patients' care. Scanned paper letters were saved on the system for future reference. All investigations, blood tests and X- rays were requested and the results were received online. The GPs had a shared inbox and read the results, coded them and filed them. This enabled all the GPs to be aware of what was happening with individual patients.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred to, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated. The meetings involved Macmillan nurses, district nurses, midwives and health visitors.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Health promotion and prevention

Health promotion information was available in the waiting area of the practice. Patients who may be in need of extra support were identified by the practice. The practice had patient alerts through their computer systems. Patient alerts could be used for a number of different situations .such as when there were safeguarding concerns, if a patient had learning disabilities and to highlight when long-term condition reviews were due.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 79%, which was below with the national average of 82%.

- Flu vaccination rates for the over 65s were 73% which was the same as the national average.
- Flu vaccination rates for those patients in the at risk groups were 51% which was in line with the national average of 52%.

The practice also carried out NHS health checks for people aged 40-74 years, smoking cessation and offered weight management advice. The practice offered drug and alcohol related counselling to patients and had 60 patients who misused drugs or alcohol on its register at the time of our inspection.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The results from the national GP patient survey published in July 2015 showed that patients were happy with how they were treated and that this was with compassion, dignity and respect. 318 survey forms were distributed; 109 responses were returned, which represented a 34% response rate.

The practice was in above or in-line with averages for its satisfaction scores on consultations with GPs and nurses for example:

- 93% of patients said the GP was good at listening to them compared to the CCG average of 88% and national average of 89%.
- 90% of patients said the GP gave them enough time compared to the CCG average of 85% and national average of 87%.
- 95% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%.
- 100% of patients said they had confidence and trust in the last nurse they saw compared to the CCG average of 96% and national average of 97%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 40 completed cards and all were positive about the service experienced. Patients felt the practice offered an excellent service and described staff as efficient, helpful and caring. Patients felt that staff treated them with dignity and respect. We spoke with 17 patients on the day of our inspection. This included three members of the patient participation group (PPG). A patient participation group is a group of patients registered with a practice who work with the practice to improve services and the quality of care. All patients we spoke with were satisfied with the care provided by the practice and patients provided examples of when GPs went the extra mile for them and the support they had been given.

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 doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Notices about the chaperone service were clearly displayed in consulting rooms.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. There was a glass screen between the reception area and a small wall, which ensured privacy. Additionally, 90% of patients said they found the receptionists at the practice helpful compared to the CCG average of 85% and national average of 87%. Customer care training and equality and diversity training had been delivered to staff; both the practice manager and deputy practice manager emphasised during the inspection that establishing good patient relationships was paramount.

We noted that GPs always collected patients from reception for their appointment, which meant that they were able to offer assistance where necessary. We observed GPs helping patients with mobility problems and a receptionist suggesting the use of the lift. This personal approach was indicative of the caring and compassionate ethos of the practice.

Care planning and involvement in decisions about care and treatment

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 and generally rated the practice well in these areas. The practice scored above average in the following areas:

- 90% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and national average of 81%.
- 87% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and national average of 81%.
- 93% of patients said that the last nurse they saw was good at involving them in decisions about their care compared to 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

Good

Are services caring?

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 they wished to receive. Patient feedback on the comment cards we received was also positive.

Staff told us that translation services were available for patients who did not have English as a first language. There was a hearing loop in reception for patients with hearing impairments.

Patients were actively involved in decisions about their care. The practice nurse informed us that patients attending the warfarin (a medication used for blood thinning) clinic had their medication increased/decreased as required with a full explanation.

A patient had shared an example of the way the GPs had communicated with a child in simple language so they could understand.

The practice had close links with the local homeless centre and a care home which cared for patients with learning disabilities. The manager of the homeless centre taught the medical students at the practice about social care. We spoke with the managers of two of the care homes which the practice looked after. The care home managers explained that the practice had a long-standing relationship with the care home. They described the GPs as accommodating, proactive and helpful. One of the care home managers said how helpful she found the help the GPs provided.

We saw that there was pro-active engagement with the local community. For example, two GPs from the practice ran in the Birmingham half marathon to raise money for the nearby domestic violence refuge.

Patient/carer support to cope emotionally with care and treatment

Results from the national GP patient survey showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 90% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 85%.
- 99% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 88% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, comments highlighted that staff responded compassionately when they needed help and provided support when required.

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. 1% of the patient population was coded on the clinical computer system as being a carer. Support information had been collated by one of the GPs with useful telephone numbers. There was a Carers Direct link on the practice website, which had a video clip about carers' support groups as well as links to financial and legal advice.

GPs told us that if families had suffered bereavement, their usual GP contacted them as a matter of routine. One patient commented that the GP rang her whilst the GP was on annual leave. A practice nurse would also talk to the family of the bereaved person. Staff received in-house training on bereavement. 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

The practice worked closely with the Birmingham South and Central Clinical Commissioning Group (CCG) to plan services and improve outcomes for patients in the area. 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. The CCG informed us that the practice engaged well with them. The lead GP was the chair of the CCG.

Services were planned and delivered to take into account the needs of different patient groups and to help provide flexibility, choice and continuity of care. We saw evidence that the practice had both adopted recommended services and developed innovative new services to meet the local needs of the population for example:

- The practice had employed a management consultant company in 2011 to review working processes. The company made a suggestion to streamline working processes and the advice was followed. A walk in clinic was introduced as result of analysis of capacity and demand. This enabled patients to be seen on the same day. Patients could sit and wait if it was an acute problem and they were given advice and guidance.
- The practice offered telephone consultations to patients.
- The practice offered a number of enhanced services including minor surgery, anti-coagulation monitoring (for patients on blood thinning medication) and drug and alcohol services.
- The practice had 60 patients who misused drugs or alcohol on its register. Two drug and alcohol workers visited the practice twice a week and went to the branch surgery once per fortnight.
- The practice screened their drug users for blood borne diseases and they were one of the early prescribers of a drug which was preventing deaths from overdose in Birmingham. The practice worked closely with other practices.
- The practice was one of 23 practices in Birmingham to take up participation in the Identification and Referral to Improve Safety (IRIS) scheme (a domestic violence and abuse training support and referral programme). In-house training for clinical and administration staff was scheduled for December 2015. It was anticipated that the training would help vulnerable patients.
- The practice provided health care for 69 patients at a local homeless hostel which was run by the local authority.
- The practice had recently signed up to an NHS constitution local enhanced service which promoted better cancer care and early intervention.
- The practice was a vanguard for diabetes prevention (the CCG is one of the seven CCG sites selected nationally to adopt the programme). Vanguard sites move specialist care out of hospitals into the community. Pre-diabetic patients were identified from HbA1c results and given a leaflet and lifestyle advice was provided.
- The practice participated in the unplanned admissions enhanced service. These were colour coded by the deputy practice manager and patients were either telephoned or visited as required. The practice informed the CCG pharmacy when patients were discharged and the patient would then receive information and support which the practice reviewed.
- There was a health visitor and midwife attached to the practice. They offered sexual health services and one of the partners was a family planning trainer.
- The practice held quarterly multi-disciplinary child safeguarding meetings at both sites. Parents felt confident that if their child was poorly they would be seen the same day and their health care needs assessed.
- The practice adopted the palliative care Gold Standards Framework (GSF). GSF is a systematic, evidence based approach to optimising care for all patients approaching the end of life.

Multi-disciplinary team meetings were held every two months and the practice had excellent relationship with the local hospice.

- The dementia diagnosis rate was in line with national averages. When a new patient joined the practice the GPs went through the notes and any vulnerability was directed to the partners. Receptionists at the practice informed the GPs of concerns they had with a patient's memory. The practice worked closely with their case

Good

Are services responsive to people's needs?

(for example, to feedback?)

manager and actively referred into a local church run older people's group. The practice contacted their local psycho-geriatrician if there were any issues that needed to be discussed.

The practice also provided the following:

- There were longer appointments for people with a learning disability.
- Home visits were available on request for older patients and patients who would benefit from these.
- There were parking facilities for disabled patients.
- Ramps were available for wheelchairs and buggies.
- The practice had a hearing loop and translation services.

Access to the service

The practice was open from 7am to 6.30pm Monday, Wednesday and Friday. On Tuesdays the practice was open from 8.30am to 6.30pm and on Thursdays the practice was open from 7am to 1pm. The branch surgery was open 8.30am to 6.30pm Monday, Tuesday and Friday. On Wednesdays the branch surgery was open 8.30am to 5pm and on Thursdays from 8.30am to 12 midday. Appointments were available within these times.

The practice offered routine appointments from 8am to 8pm for doctors and nurses through their involvement with the Prime Ministers Challenge Fund Scheme.

Urgent appointments were available on the same day and patients could book their appointments up to four weeks in advance.

Results from the national GP patient survey published in July 2015 showed that patients' satisfaction with how they could access care and treatment was higher than local and national averages. All of the patients we spoke with on the day of the inspection said they were able to make appointments when they needed to.

• 85.4% of patients were satisfied with the practice's opening hours compared to the CCG average of 73.6% and national average of 74.9%.

• 85.2% of patients said they could get through easily to the surgery by phone compared to the CCG average of 72.3% and national average of 73.3%.

• 91.2% of patients described their experience of making an appointment as good compared to the CCG average of 70.6% and the national average of 73.3%.

• 73.1% of patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 57.2% and national average of 64.8%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager handled all complaints at the practice.

We saw that information was available to help patients understand the complaints system on the website and leaflets were available which set out how to complain, what would happen to the complaint and the options available to the patient.

We reviewed the four formal complaints the practice had received in the last year and found these had been dealt with according to their policy and procedure. We saw evidence that complaints were discussed at practice meetings and lessons were learned from these. All of the complaints were dealt with as significant events to ensure learning. For example, one of the complaints we reviewed was about techniques in wound management. As a result of this complaint the staff involved attended a wound management course to try to prevent this incident reoccurring.

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 values were aligned to that of Birmingham South and Central 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. The values were embedded in all staff across the organisation.

The practice had regular network meetings with the CCG and information was shared every quarter in this way. The practice offered all the Directed enhanced services (DES) available. These schemes are where commissioners are required to establish or to offer contractors the opportunity to provide, linked to national priorities and agreements and local enhanced services to meet the needs of the local community.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity.

- There was a clear leadership structure with the partners working closely with the practice manager. The practice valued their staff and invested in them. Previous trainee GPs at the practice had joined the partnership.
- There were robust arrangements for identifying, recording and managing risk. The GPs had daily meetings which facilitated communication regarding patient care. This system enabled prompt discussion about significant events and complaints, and led to early resolution.
- The practice had a programme of continuous clinical and internal audit which was used to monitor quality and make improvements.
- The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing above national standards. QOF was regularly discussed at practice meetings.

Leadership, openness and transparency

Meetings were held regularly. The GP leads had meetings daily and practice had regular team talks.

Staff told us there was an open culture and they were happy to raise issues at practice meetings. The partners were visible in the practice and staff told us they would take the time to listen to them. Staff we spoke with said there was a no blame culture which made it easier for them to raise issues. We saw that there was good morale at the practice. The practice had an all-inclusive approach.

We saw evidence that staff had annual appraisals and were encouraged to develop their skills. Both the practice manager and deputy practice manager emphasised how well supported they felt by the GPs.

All staff were encouraged to identify opportunities to improve the service delivered by the practice. Staff interacted with each other socially.

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

The importance of patient feedback was recognised and there was an active 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 met with three members of the PPG during the inspection. The PPG had 10 members and met whenever issues were raised.

The practice was working closely with the PPG who had made several recommendations which the practice had implemented. For example, following recommendations from the PPG earlier appointments were offered to patients four mornings a week.

Staff we spoke with said they would not hesitate to give feedback and all felt valued by the practice.