

# Cape Hill Medical Centre

## 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	Outstanding	
Are services safe?	Good	
Are services effective?	Good	
Are services caring?	Outstanding	
Are services responsive to people's needs?	Good	
Are services well-led?	Outstanding	

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Cape Hill Medical Centre on 9 January 2017. Overall the practice is rated as outstanding.

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

- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. There was visible clinical and managerial leadership and effective governance arrangements.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice was proactive in the management of safeguarding children and vulnerable adults.

- The practice used innovative and proactive methods to improve patient outcomes. Clinical audits had been triggered by new guidance and from learning from significant events.
- Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. For example: 97% of respondents had confidence and trust in the last GP they saw or spoke to.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example, a new telephone system with the initial greeting in five languages and the ability to book an appointment with the GP of choice.

We saw several areas of outstanding practice including:

- The practice was one of only 17 practices nationally to receive the Gold Standards Framework award for end of life care. The End of Life Care programme

# Summary of findings

considered all care parameters using NICE guidance as the basis and demonstrated improvements in every aspect care. This included documentation of advanced planning, patient preferences, bereavement support, holistic assessment of care, plus seven other elements. One key factor was having a single clinical lead who examined all clinical notes, they co-ordinated the practice to meet the targets it had set in the aspiration for End of Life Care. Learning points showed a clear appreciation of the advantage of having a single person take the lead, with whole team buy in and continuous review and ongoing education and reflection in the regular clinical meetings.

- The practice had developed detailed holistic care plans that included reviews of physical and social care, plus patient education. They provide a holistic approach to reduce co-morbidities and reduce unplanned admissions. For example, the inclusion of social aspects of care, falls prevention and self-management education for the patients. We saw detailed evidence that demonstrated multiagency working to support isolated and patients who were housebound. The nurses attend weekly meetings with the community nursing team to enable concerns about patients to be acted upon immediately to improve unplanned admissions

- The clinical leads at Cape Hill Medical Centre believed that the 'standard' model of a short consultation with a single health professional was not well-adapted to serve the needs of their patient population. To meet the population needs and following a review of the patient experience the practice developed a wellbeing hub, this involved a work coach, link worker, chaplain and a mental health team practitioner working side by side. The aim of these roles was to provide high quality care, support and guidance to patients.

However there were areas of practice where the provider should make improvements:

- The practice should consider how to further promote national screening for bowel cancer in order to address the lower than average uptake.
- The practice should continue to monitor the measures taken to improve patient satisfaction rates in relation to access and appointments.

## **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?

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Learning was based on a thorough analysis and investigation.
- Information about safety was highly valued and was used to promote learning and improvement.
- Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. For example, the infection control lead nurse completed additional monthly audits, for sharps management, hand washing, equipment and environment cleaning and legionella testing. Feedback was provided to all staff concerned with a clear audit trail.
- The practice had a proactive approach to safeguarding vulnerable adult and children. A practice initiative had identified and specified a 'trio' of risk factors for children at risk, these were mental health issues, substance abuse including alcohol and domestic violence in the family home. The audits had assisted the practice in identifying patients who may be at risk

Good



### Are services effective?

- Systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- Each GP with an interest in a specific area managed all referrals for their speciality to ensure appropriate referrals were made.
- We saw ten clinical audits which had been undertaken. Clinical audits were triggered by new clinical guidance, significant events, personal interest, changes in prescribing practice and monitoring of effectiveness.
- The most recent published QOF results from 2015/16 showed the practice had achieved 98% of the total number of points available compared with the clinical commissioning group (CCG) average of 95% and national average of 95%.
- The practice had developed detailed holistic care plans that included reviews of physical and social care, plus patient

Good



# Summary of findings

education. They holistic approach assisted the reduction of co-morbidities and unplanned admissions. We saw evidence that demonstrated multiagency working to support isolated patients who were housebound.

- The practice had taken account of the practice population which had influenced additional training for GPs and nurses, for example in supporting patients who were asylum seekers and refugees. The nurses had received extended training in the management of long term conditions.
- The practice had reduced paediatric accident and emergency attendances by 16% following the introduction of a minor ailments clinic which ran each day after school. To improve outpatient attendance the practice provided a three monthly consultant led paediatric clinic
- The practice had reviewed the service available to patients with COPD. The practice had a low prevalence of patients with a COPD diagnosis and a high admission rate for asthma. They appointed a Respiratory Advanced Nurse Practitioner and had introduced a monthly one stop clinic with the ANP, GP and healthcare assistant. The practice had seen a reduction in admissions for asthma, COPD and paediatric respiratory admissions

## Are services caring?

- The practice had completed the Gold Standard Framework. The Gold Standard Framework (GSF) is a training programme for clinicians that provide care for all patients approaching the end of life. The practice was only one of 17 practices nationally to receive the GSF award. All the key outcome ratios for end of Life Care had improved, for example, patients are offered care planning discussions increased from 21 to 110.
- The practice had a team of staff that provided physical, mental, spiritual and social support for patients. The chaplain, employed by the practice, provided spiritual support to patients and staff of all faiths. Patients going through a life crisis in need of listening and guidance and patients in the last year of life in the nursing homes were referred by staff.
- The practice had identified 105 patients as carers (1% of the practice list). A nurse practitioner was the carers' lead to help ensure that the various services supporting carers were coordinated and effective with a carer's clinic held monthly. Carers were invited to attend carer's day which was supported by the Sandwell carers' team.

**Outstanding**



# Summary of findings

- Carers were contacted by a nurse and offered a 30 minute appointment to gather a full account of support and guidance required. Referrals to other healthcare professions were actioned as required. The Carers lead had plans in place to visit schools in order to raise awareness of the needs of young carers.

## Are services responsive to people's needs?

Good



- The practice recognised that some patients who had been long term unemployed did not benefit from the experience of the mental and physical benefit of working or being employed. The practice had developed a wellbeing hub and employed a link worker and chaplain. The Hub also provided a work coach and mental health workers working side by side. The team enabled the practice to consider physical, mental, spiritual and social needs.
- The link worker, employed by the practice, offered social support and sign posting to other agencies. Over a 12 month period 733 patient appointments had been offered and 142 individual patients had received support. We saw evidence that showed positive outcomes for this patient group.
- The practice had seen an increase in the number of patients residing in nursing homes. As a result they had applied and were successful in achieving the Gold Standards Framework quality hallmark award and had initiated an End of Life Care programme. The practice demonstrated improvements in advanced planning, patient preferences, bereavement support, holistic assessment of care.
- We saw evidence that the practice had developed a training plan for the care home staff, this included training on sepsis, urinary tract infections, guidelines on admission avoidance and care planning, management of COPD and asthma and Mental Capacity training.
- The practice adapted it's services to meet the needs of the local population. For example developing guidelines, polices and service for those who may be vulnerable. Consideration had been given to ensuring this patient group were aware of how to access healthcare.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a

# Summary of findings

consequence of feedback from patients and from the patient participation group. The introduction of a new telephone system with the initial greeting in five languages and the facility to book the GP of choice.

- Practice data showed that a high percentage of non-attendance for paediatric outpatient appointment, with high follow up rates, as a result a paediatric consultant led clinic had been instigated. The practice had also introduced a nurse practitioner led paediatric minor ailments clinic each day to help reduce A&E attendance. The clinic ran outside of school hours and was supported and supervised by a GP. The practice demonstrated that this had reduced A&E attendance by 16%.

## Are services well-led?

- The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Throughout our inspection we noticed a strong theme of positive feedback from staff. Staff spoke highly of the culture of the practice and were proud to be part of the practice team.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.
- The practice was able to articulate its current challenges with regards to their population groups and opportunities within its local context and emerging national programmes. They had a clear understanding at a high level of their overall clinical and managerial performance.
- The leadership at the practice had focused on providing holistic care to their patients. For example, the delivery of comprehensive care to patients with multiple co-morbidities that were housebound and the introduction of the wellbeing hub which included the link worker and chaplain
- There was a strong focus on continuous learning and improvement at all levels.

**Outstanding**



# 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 had seen an increase in the number of patients in nursing homes. The practice had implemented regular visits to the homes and had seen the number rise from 45 to approximately 80 registered patients. The practice attributed this to the routine visits made by a nominated GP to proactively manage patients care. This included the review of care plans, liaising with relatives where appropriate and needs assessments for end of life care.
- The practice had initiated an End of Life Care programme. They developed a policy with consideration of all care parameters using NICE guidance as the basis. The practice demonstrated improvements in advanced care planning, patient preferences, bereavement support and holistic assessment of care. The practice demonstrated continuous reviews and ongoing education and reflection during regular clinical meetings.
- The practice was responsive to the needs of older people. The Advanced Nurse Practitioner (ANP) and nurse practitioners regularly provided home visits. The practice had developed detailed holistic care plans that included reviews of physical and social care, plus patient education. Their holistic approach assisted the reduction of co-morbidities and unplanned admissions. We saw evidence that demonstrated multiagency working to support isolated patients who were housebound.
- The practice provided care and treatment to patients living in two local care homes where some of the practice's patients lived. Each care home had a nominated GP who visited patients when necessary and attended each care home weekly. We received positive feedback from staff at both homes. We saw that the practice had developed a training plan for the care home staff, this included training on, sepsis, urinary tract infections, guidelines on admission avoidance and care planning, management of COPD and asthma and Mental Capacity training.
- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.

Outstanding



# Summary of findings

## People with long term conditions

- The practice ensured that patients with complex needs, including those with life-limiting progressive conditions were supported to receive coordinated care in innovative and efficient ways. The practice provided a holistic approach to reduce co-morbidities and reduce unplanned admissions. For example, they focus on social aspects of care, falls prevention and self-management education for the patients.
- The advanced nurse practitioners had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority. For example, diabetes, COPD and hypertension and they all provided home visits where necessary. The healthcare assistant provided phlebotomy, ECG, foot assessments, spirometry, blood pressure and weight checks for patients who were housebound.
- All these patients had a named GP and there was a system to recall patients for 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 care professionals to deliver a multidisciplinary package of care.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- The practice had a low prevalence of patients with a COPD diagnosis and a high admission rate for asthma. They appointed a Respiratory Advanced Nurse Practitioner and had introduced a monthly one stop clinic with the ANP, GP and healthcare assistant. The practice could demonstrate a reduction in admissions for asthma, COPD and paediatric respiratory conditions.

Outstanding



## 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. They were proactive in their approach to safeguarding children. A practice initiative had identified and specified a 'trio' of risk factors for children at risk, these were mental health issues, substance abuse including alcohol and domestic violence in the family home. The audits had assisted the practice in identifying patients who may be at risk.

Outstanding



# Summary of findings

- The clinical coder reviewed the records of all new children registered at the practice, if any concerns were identified a named GP was allocated to oversee their care in conjunction with the safeguarding team.
- Childhood immunisations were comparable to CCG and national averages. For example, rates for the vaccines given to under two year olds were 94% and five year olds were 91%.
- The practice's uptake for the cervical screening programme was 78%, which was comparable with the CCG average of 79% and the national average of 81%.
- The practice introduced a paediatric minor injuries clinics three times a week, to help reduce A&E attendance. The practice demonstrated that this had reduced by 16%. Practice data also showed poor outpatient attendance rates for paediatrics with high follow up rates, as a result a paediatric consultant led clinic had been instigated.

## **Working age people (including those recently retired and students)**

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours and Saturday appointments.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. Appointments could be booked over the phone, face to face and online.
- The practice had identified within their practice population patients who required additional support, they had developed a wellbeing hub, this involved a work coach to support patients.

**Outstanding**



## **People whose circumstances may make them vulnerable**

- The practice had taken account of the practice population which had influenced additional training for GPs and nurses, for example in supporting patients who were asylum seekers and refugees.
- The practice had developed guidelines, polies and services to ensure equitable services were afforded to marginalised groups. They gave examples of trafficked women and high infant mortality rates. Guidelines for care of pregnant migrant patients had been developed and utilised.
- With many patients from war torn countries the practice had developed in-house expertise in the management of patients

**Outstanding**



# Summary of findings

who may have suffered violence, torture or bereavement. Best practice guidelines for staff had been produced. Staff had received training from the Medical Foundation for Victims of Torture.

- The practice had developed an extended health check and had trained staff to identify new migrant patients who may be vulnerable. The health check provided screening for mental and physical health as well as highlighting social needs. The practice told us that this allowed for effective support and education in a timely way.
- Staff we spoke with knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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.
- The practice had identified within their practice population patients who required additional support, they had developed a wellbeing hub, this involved a work coach, link worker, chaplain and a mental health team practitioner working side by side. The link worker, employed by the practice, offered social support and sign posting to other agencies. Over a 12 month period 733 patient appointments had been offered and 142 individual patients had received support. We saw evidence that showed positive outcomes for this patient group.
- The practice's computer system alerted GPs if a patient was also a carer. A nurse practitioner was the carers' lead to help ensure that the various services to support carers were coordinated and effective, a carer's clinic was held monthly. Once an individual has been registered as a carer, they were contacted by a nurse and offered a 30 minute appointment to gather a full account of support and guidance required.

## People experiencing poor mental health (including people with dementia)

- Performance for mental health related indicators was 94% compared to the CCG average of 92% and a national average of 91%. For example, 95% of patients with severe mental health had a recent comprehensive care plan in place compared with the CCG average of 88% and national average of 89%.

Outstanding



# Summary of findings

- Performance for dementia related indicators was 100% compared to the CCG average of 96% and a national average of 71%, with an exception rate of 9% compared to the CCG and national average of 12%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. The link worker, chaplain and a mental health team practitioner worked side by side to provide support to patients.
- The practice had told patients experiencing poor mental health how they could access support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended A&E where they may have been experiencing poor mental health.
- Staff spoken with had a good understanding of how to support patients with mental health needs and dementia. One of the GPs had a diploma in primary mental health with special interest in neuropsychiatry

# Summary of findings

## What people who use the service say

The national GP patient survey results were published on July 2016. The results showed areas where the practice was performing below local and national averages. 334 survey forms were distributed and 120 were returned. This represented 36% response rate. This represents 1% of the practice population.

- 69% of patients described the overall experience of this GP practice as good compared with the CCG average of 83% and the national average of 85%.
- 48% of patients described their experience of making an appointment as good compared with the CCG average of 86% and the national average of 73%.
- 59% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 74% and the national average of 78%.

In March 2016 the practice completed an in house patient survey which was facilitated by the Patient Participation Group. The survey was completed by 258 randomly selected patients. Results were mixed and an action plan for improvement had been put in place

Results from the friends and family test, in the six months leading to the inspection, indicated that 81% of patients would recommend the practice.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received one comment card which was positive about the standard of care received. We also spoke with eight patients and two patient participation group (PPG) members during the inspection. These patients said they were satisfied with the care they received and found the staff to be professional, approachable, committed and caring.

In response to the national patient survey the practice had taken action and had completed an in-house survey in March 2016 and the data demonstrate improved patient satisfaction.

## Areas for improvement

### Action the service SHOULD take to improve

- The practice should consider how to further promote national screening for bowel cancer in order to address the lower than average uptake.
- The practice should continue to take action to identify carers registered at the practice.
- The practice should continue to monitor the measures taken to improve patient satisfaction rates in relation to access and appointments.

## Outstanding practice

- The practice was one of only 17 practices nationally to receive the Gold Standard Framework award. The End of Life Care programme considered all care parameters using NICE guidance as the basis and demonstrated improvements in every aspect care. This included documentation of advanced planning, patient preferences, bereavement support, holistic assessment of care, plus seven other elements. One key factor was having a single clinical lead who examined all clinical notes, they co-ordinated the practice to meet the targets it had set in the aspiration for End of Life Care. Learning points showed a clear appreciation of the advantage of having a single person take the lead, with whole team buy in and continuous review and ongoing education and reflection in the regular clinical meetings.

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- The practice had developed detailed holistic care plans that included reviews of physical and social care, plus patient education. attend weekly meetings with the community nursing team to enable concerns about patients to be acted upon immediately to improve unplanned admissions
- The clinical leads at Cape Hill Medical Centre believed that the 'standard' model of a short consultation with a single health professional was

not well-adapted to serve the needs of their patient population. To meet the population needs and following a review of the patient experience the practice developed a wellbeing hub, this involved a work coach, link worker, chaplain and a mental health team practitioner working side by side. The aim of these roles was to provide high quality care, support and guidance to patients.

# Cape Hill Medical Centre

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and the team included a GP specialist adviser and a second CQC inspector.

## Background to Cape Hill Medical Centre

Cape Hill Medical Centre provides primary medical services to approximately 12,000 patients and is located in Smethwick, West Midlands. The surgery has a multicultural patient population and has a high number of younger persons aged between 0 and 9 years registered at the practice. Information published by Public Health England rates the level of deprivation within the practice population group as one; on a scale of one to ten, with level one representing the highest level of deprivation.

Services to patients are provided under a Personal Medical Services (PMS) contract. A PMS contract offers local flexibility by offering variation in the range of services which may be provided by the practice. For example, they offer minor surgery, near patient testing, a number of clinics, for example, long term condition management including asthma, diabetes and high blood pressure.

The practice is located in a purpose built building; there is step free access to the building with wheel chair access and car parking.

The clinical team includes five GP partners and five salaried GPs, five are male and five are female. There are two advanced nurse practitioners, three nurse practitioners, three healthcare assistants and one phlebotomist. The GP

partners and the practice manager form the management team and they are supported by an IT manager, finance manager and reception and administration staff. The practice is a teaching practice and had four GP registrars (a qualified doctor training to be a GP) plus five other trainees.

The practice is open 8am to 6.30pm Monday to Friday and 8.30am to 11.30am one Saturday each month. The service for patients requiring medical attention out of hours is provided by the NHS 111 service.

## Why we carried out this inspection

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

## How we carried out this inspection

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

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

# Detailed findings

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).

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 9 January 2017. During our inspection we spoke with a range of staff, which included the practice management, nursing staff, reception and administrative staff and GPs. We spoke with eight patients who use the service including two members of the patient participation group.

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

# Are services safe?

## Our findings

### Safe track record and learning

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under 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).
- We saw evidence that when things went wrong with care and treatment patients were informed of the incident, received reasonable support, a written apology and were told about any actions taken to improve processes and prevent the same thing happening again.
- The practice maintained a significant events summary spreadsheet and we found that they had reported 33 events in the last year. The practice reviewed each incident and conducted a timely analysis. Following the completion of the investigation, they implemented changes in practice policy or protocols, if necessary. For example, following a missed blood result, the practice had allocated one GP to review all results.
- Patient safety alerts were managed by an advanced nurse practitioner and disseminated to relevant clinicians for action. We saw evidence that alerts were actioned and shared appropriately. A spread sheet had been developed with links to the relevant alert and supporting evidence.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. Staff demonstrated their awareness of the most recent alerts.

### Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse:

- The practice had policies in place for safeguarding both children and vulnerable adults. These policies were available to all staff. All staff had received role appropriate training to nationally recognised standards, for GPs and nurses this was level three in safeguarding

children. The lead GP was identified as the safeguarding lead within the practice. The staff we spoke with knew their individual responsibility to raise any concerns they had and were aware of the appropriate process to do this. Staff were made aware of both children and vulnerable adults with safeguarding concerns by computerised alerts on patient records. The practice liaised with professionals involved in safeguarding.

- A recent practice initiative had identified and specified a 'trio' of risk factors for children at risk; these were mental health issues, substance abuse including alcohol and domestic violence in the family home. The first phase of the audit was completed and identified a number of children some of which were already known to the practice. Another review identified where two of the three factors were present. The practice were working with the safeguarding team to consider what other factors might be identified.
- A clinical coder reviewed the records of all new children registered at the practice, if any concerns are identified a named GP was allocated to oversee their care in conjunction with the safeguarding team.
- Chaperones were available when needed. All staff who acted as chaperones had received appropriate training, had a disclosure and barring services (DBS) check and knew their responsibilities when performing chaperone duties. The availability of chaperones was displayed in the practice waiting room and repeated in consulting and treatment rooms.
- The practice was visibly clean and tidy and clinical areas had appropriate facilities to promote the implementation of current Infection Prevention and Control (IPC) guidance. IPC audits of the whole service had been undertaken annually.
- An advanced nurse practitioner was the IPC lead. They had a robust schedule of additional monthly and annual audits, for example, equipment cleaning checks with an audit trail of feedback to staff with results. The IPC lead met weekly with the cleaners to discuss the schedule and feedback following monthly spot checks. Staff had their handwashing technique assessed regularly and feedback was given when appropriate.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). The vaccination fridges were well ventilated and secure,

## Are services safe?

records demonstrated that fridge temperatures were monitored and managed in line with guidance by Public Health England. Annual cold chain audits were completed.

- Processes were in place for handling repeat prescriptions, which included the review of high-risk medicines; this included regular searches, using alerts on the computer system and audits. For example we reviewed a selection of records for patients receiving Disease Modifying Anti Rheumatic Drugs (DMARD), the records we looked at demonstrated that reviews and investigations had been undertaken.
- The practice carried out regular medicines audits, with the support of the local Clinical Commissioning Group (CCG) pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGDs) had also been adopted by the practice to allow nurses to administer medicines in line with legislation. (A PGD is a set of instructions detailing conditions under which prescription medicine can be provided to patients without a prescription). Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription (PSD) or direction from a prescriber. (A PSD is written instruction, for medicines to be administered to a named patient after the prescriber has assessed the patient on an individual basis). The use of PGDs were reviewed during annual appraisals and supervised by the senior advanced nurse practitioner.
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

### Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire

marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.

- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- There was a health and safety policy available together with a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

### Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book was also available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice had a structured approach in assessing needs and delivering 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 demonstrated that it used the weekly clinical meetings to disseminate and discuss any new guidelines from NICE and used this information to deliver care and treatment that met patients' needs.

- The practice had developed an end of life care policy with consideration of all care parameters using NICE guidance as the basis. The practice demonstrated improvements in advanced care planning, patient preferences, bereavement support and holistic assessment of care. The practice demonstrated continuous reviews and ongoing education and reflection during regular clinical meetings.

### Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 98% of the total number of points available compared with the clinical commissioning group (CCG) average of 95% and national average of 95%. There was 13% exception reporting compared to the CCG and national average of 10%. (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).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/16 showed:

- Performance for diabetes related indicators was 96% compared to the CCG average of 91% and a national average of 90%.
- Performance for mental health related indicators was 94% compared to the CCG average of 92% and a national average of 91%. For example, 95% of patients

with severe poor mental health had a recent comprehensive care plan in place compared with the CCG average of 88% and national average of 89%. Exception reporting was in line with the national and local averages with the exception of one indicator which was 11% above the CCG average.

- Performance for dementia related indicators was 100% compared to the CCG average of 96% and a national average of 71%, with an exception rate of 9% compared to the CCG and national average of 12%.
- The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months was 84% which was similar to the CCG and national average.
- Performance for COPD related indicators was 99% compared to the CCG average of 97% and a national average of 96%.
- The percentage of patients with COPD that had had an influenza immunisation was 95% compared to the CCG average of 96% and a national average of 97%. Exception reporting was 19% which was in line with the CCG and national averages.

Clinical audits were carried out to identify quality improvement opportunities and all relevant staff were involved to improve care and treatment and people's outcomes. We saw that these were triggered by new clinical guidance, significant events, personal interest and changes in prescribing practice. We saw examples of 10 audits, six of which were two cycle audits. For example, the practice reviewed patient receiving Warfarin and examined data for evidence of blood results being in the correct therapeutic range. GP leads ensured that audit results were appropriately cascaded to staff and that learning from these was embedded in their systems.

The practice had initiated an End of Life Care programme. The evidence demonstrated improvements in every aspect of the data available. These included, for example, documentation of advanced planning, patient preferences, bereavement support, holistic assessment of care, plus seven other elements. One key factor was having a single clinical lead who examined all clinical notes. They were not responsible for the care delivery but co-ordinated the practice to meet the targets it had set in the aspiration for End of Life Care. Learning points showed a clear

# Are services effective?

## (for example, treatment is effective)

appreciation of the advantage of having a single person take the lead, with whole team buy in and continuous review and ongoing education and reflection in the regular clinical meetings.

The practice had recognised that it had a lower prevalence of COPD and had a high admission rate for asthma. They appointed a Respiratory Advanced Nurse Practitioner (ANP) and were training a respiratory lead GP. An analysis of the educational and process needs of the practice had been completed and several changes were made. For example, the introduction of a monthly one stop clinic with the ANP, GP and healthcare assistant, particularly targeting high salbutamol users and patients with high risk factors for COPD. High salbutamol users identified in September 2015 numbered 135; this was reduced by 14%. Patients with asthma self-management plans had increased to 51% of the register from 1%. Asthma admissions had reduced by 33% and COPD admissions by 36%. Paediatric respiratory admissions had reduced by 50% and respiratory medicine outpatient appointments had reduced by 50%.

There is a practice pharmacist in post for one session per week. The practice told us that the focus of their work in the management of post discharge reconciliation. They attribute the reduction in readmission numbers to this role.

### Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. There was also an up to date locum induction pack.
- There was continuing development of staff skills. One nurse practitioner was supported in their studies towards becoming an advanced nurse practitioner; two general nurses had recently been employed and were undertaking practice nurse training.
- The practice held monthly clinical education sessions and allowed dedicated time to teach the GP trainees. The trainees had two tutorials a week, referral reviews through the practice referral management programme and one GP had ring-fenced time to supervise the GPs.

- The practice had three student nurses on eight to nine week placements; there were four mentors for the students. The students had provided positive feedback indicating that they had a wide range of learning opportunities.
- The practice had developed their nursing team with the clinical lead provided clinical supervision and carried out competency assessments. The advanced nurse practitioners specialised in specific long term conditions, for example, diabetes, COPD and hypertension. One of the advanced nurse practitioners was a nurse specialist in diabetes and hypertension and provided training for the staff. Staff administering vaccines and taking samples for the cervical screening.
- The GPs had training in their specialist interest areas; for example, diploma in primary mental health with special interest in neuropsychiatry, working with asylum seekers and refugees, one GP provided services to the local prison.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.

### Coordinating patient care and information sharing

The practice had effective and well established systems to plan and deliver care and treatment. This was available to relevant staff in a timely and accessible way through the practices patient record system and the intranet system. This included care and risk assessments, care plans, medical records and test results.

- Staff worked together and with other health and social care professionals 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, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record.
- The practice demonstrated close and effective working with other health and social care professionals. We saw

# Are services effective?

## (for example, treatment is effective)

evidence of comprehensive multidisciplinary meeting notes with action plans and follow up. We noted that clinical entries were updated appropriately and in a timely manner.

- The practice worked closely with other health professionals with regard the management of unplanned admissions.
- The practice had an effective referral management programme. Each GP with an interest in a specific area managed the referrals in that speciality to ensure appropriate referrals and that unnecessary pressure was not put on services.
- The practice reviewed all expected deaths in a structured manner in order to share learning and ensure that care provided met 'best practice' guidance.

### 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, staff carried out assessments of capacity to consent in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment. The process for seeking consent was monitored through patient records audits.

### Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. These included patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. A nurse practitioner was available to provide advice on weight management in accordance with NICE guidelines and a health trainer supported the Practice for general cardiovascular risk reviews

The practice's uptake for the cervical screening programme was 78%, which was comparable with the CCG average of 79% and the national average of 81%. The exception reporting for this indicator was 6% which was below the CCG average of 8% and a national average of 6%.

The practice demonstrated how they encouraged uptake of the screening programme and sent text messages to patients that did not attend. There were systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. National cancer intelligence data 2014/15 indicated that the breast cancer screening rates for 50 to 70 year olds was 75% compared to the CCG average of 67% and a national average of 72%. Bowel cancer screening rates for 60 to 69 year olds was 39% compared to the CCG average of 50% and a national average of 58%. In response to this the practice had developed a strategy to improve the uptake and had met with Cancer UK team. The practice team had completed training on the importance of bowel cancer screening and how to collect a specimen. Patient information was available in the waiting area. The practice were also participating the national cancer audit.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG/national averages. For example, rates for the vaccines given to under two year olds were 94% and five year olds were 91%.

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

During our inspection we observed that members of staff were courteous and very helpful to patients, and treated them with dignity and respect, both at the reception desk and on the telephone

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

We spoke with eight patients including two members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required. The practice had a high number of minority groups registered at the practice. Patients from some of these groups spoken with praised the service they received which included, leaflets, multi lingual information on the telephone and a number of multilingual staff.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. For example:

- 84% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 84% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 97% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%
- 84% 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 the national average of 85%.

- 90% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 91%.
- 91% of patients said the nurse gave them enough time compared with the CCG average of 91% and the national average of 92%.
- 97% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 97% and the national average of 97%.
- 88% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 89% and the national average of 91%.
- 79% of patients said they found the receptionists at the practice helpful compared with the CCG average of 84% and the national average of 87%.

The views of external stakeholders were positive and in line with our findings. For example, the practice supported two care homes where some of the practice's patients lived. All praised the care provided by the practice. Each care home had a nominated GP who visited patients each week or as required. We saw evidence that the practice had developed a training plan for the care home staff, this included training on, sepsis, urinary tract infections, guidelines on admission avoidance and care planning, management of COPD and asthma and Mental Capacity training.

### 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.

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 in line with local and national averages. For example:

- 82% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 86% and the national average of 86%.
- 78% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and the national average of 82%.



## Are services caring?

- 92% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 89% and the national average of 90%.
- 84% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 83% and 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.
- Information leaflets were available in a number of languages, large print and in easy read format.
- The practice had developed a Migrant Health Leaflet providing information on an introduction to the NHS and services offered.

### **Patient and carer support to cope emotionally with care and treatment**

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 had developed detailed holistic care plans for patients where appropriate, this included for example patients who were housebound or isolated. They included reviews of social care needs, education as well as physical health. We saw evidence that demonstrated comprehensive support, guidance and persistence by the clinical team to assist patients to overcome anxieties and succeed in improving their quality of life. This encompassed comprehensive communication with other agencies and achieved reductions in unplanned admissions.

Referrals to the chaplain service were utilised, they provided spiritual support to patients and staff of all faiths. This was a listening and guidance service and designed to give patients time to talk through their concerns. Patients going through a life crisis, patients in the last year of life and those in nursing homes could be referred by staff.

The practice was one of only 17 practices nationally to receive the Gold Standard Framework award, a training programme for the whole team in relation to providing care to patients approaching the end of life. We saw evidence that the framework was in place at the practice and that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. The chaplain visited patients at the request of the patient or the family.

A nurse practitioner was the carers lead. Their role was to ensure care was coordinated with support and guidance offered in relation to external support services. The practice had identified 105 patients as being a carer (1% of the practice list). The practice's computer system alerted staff if a patient was also a carer. Once a patient had been registered as a carer, they were offered a 30 minute appointment with a nurse to gather a full account of support and guidance required. Referrals to other healthcare professions was actioned as required.

Staff invited carers to attend the practice carer's clinic which ran monthly. There was an annual carer's event which was attended by Sandwell Carers team.

Staff told us that if patients suffered bereavement their usual GP contacted them by telephone or sent a condolence letter. This contained personalised words of sympathy as well as signposting to bereavement services, and in-house services such as the chaplaincy service.

# 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. The practice had a detailed understanding of their population groups.

We saw that the practice were proactive in developing guidance, policies and services to meet the local needs. For example the practice informed us that they had on of the highest infant mortality rates in the country. They had considered the needs of migrant women who may have difficulty accessing the service. They also report an increase in the number of trafficked women. As a result they had developed and used guidelines which ensured an equitable and holistic service for this group of patients.

The practice had produced guidelines in relation to female genital mutilation (FGM), this was shared with the CCG and police. It was aimed at helping staff to be aware of the risks relating to patients and FGM.

The practice participated in the IGRA TB testing programme which was used to develop the IGRA screening programme which is used in practice.

The practice was selected by the CCG to pioneer new initiatives in its Aspiring to Clinical Excellence (ACE) programme, planned to run for 12 months in 2014. At the end of the project the clinical leads at Cape Hill Medical Centre believed that the 'standard' model of a short consultation with a single health professional was not well-adapted to serve the needs of their patient population.

The practice recognised that patients may require advice and support beyond medical issues. They recognised that some patients required more time for consultations or a different sort of engagement in relation to support and advice. The practice had developed a wellbeing hub, this involved a work coach, link worker, chaplain and a mental health team practitioner working side by side once a week. The practice currently evaluating the service and preliminary results from the work coach were encouraging.

The link worker, employed by the practice, offered social support and sign posting. Over a 12 month period 733

appointments had been offered and 142 patients had received additional advice and support. We saw evidence that showed positive outcomes accomplished for the patients that sought support.

The chaplain, employed by the practice, provided spiritual support to patients and staff of all faiths. Patients going through a life crisis in need of listening and guidance and patients in the last year of life in the nursing homes were referred by staff.

The practice had initiated an End of Life Care programme, introduced as a result of the high increase in the numbers of patients in nursing homes. The evidence demonstrated improvements in every aspect of the data available. These included, for example, documentation of advanced planning, patient preferences, bereavement support, holistic assessment of care. The practice had an effective process that took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.

- The practice offered extended hours Mondays Tuesdays and Thursdays plus additional hours on one Saturday per month.
- An anticoagulant service was available at the practice, with a clinic being held weekly.
- There were longer appointments available for patients with a learning disability and long term conditions. There were 65 patients on the learning disability register and they were all offered an annual review.
- All patients that were housebound were visited at home by the GPs, nurse practitioners and healthcare assistant when required.
- The practice sent text messages to patients to remind them of their appointments
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- Many of the practice staff were multilingual, this included for example Punjabi, French, Arabic, Spanish, Somali, Dutch.

The practice focused its quality improvement programme to support the high number of children registered at the practice, through the introduction of the paediatric

# Are services responsive to people's needs?

(for example, to feedback?)

minor ailments clinic. The nurse practitioner clinic ran each day after school and was supported by a GP. This resulted in a reduction of Accident and Emergency attendances by 16%. Practice data showed poor outpatient attendance rates for paediatrics with high follow up rates. The practice initiated a consultant led paediatric clinic three monthly

## Access to the service

The practice is open 8am to 6.30pm Monday to Friday and 8.30am to 11.30am one Saturday each month. Patients requiring medical attention out of hours were signposted to the NHS 111 service.

Results from the national GP patient survey July 2016 showed areas for improvement, with how they could access care and treatment, for example.

- 72% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 74% and the national average of 76%.
- 67% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 81% and the national average of 85%.
- 88% of patients said their last appointment was convenient compared with the CCG average of 91% and the national average of 92%.
- 48% of patients described their experience of making an appointment as good compared with the CCG average of 66% and the national average of 73%.
- 30% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 53% and the national average of 58%.
- 40% of patients said they could get through easily to the practice by phone compared to the CCG average of 60% and the national average of 73%.

The practice had completed an in house survey facilitated by the PPG. The results from this survey indicated the 85% of patients were satisfied with the practice opening hours. Similarly the practice received a more positive response to questions relating to telephone access, where 58% of patients responded positively.

The practice had taken action to improve outcomes identified in the survey. They had invested in a new telephone system. The initial message provided an option to select a different language to enable patients to choose the correct option. The telephone system had an integrated

ability to book appointments; the practice had also increased the number of telephone lines available. There was an ongoing patient education programme pertaining to patients that do not attend (DNA) appointments. These patients received a call from the clinician; if unavailable the practice manager contacted the patient at a later time. The DNA rates for the practice had reduced from 800 to 560 in a year. The practice manager had sourced customer training for the receptionist staff. The practice had introduced a 'walk in' surgery every day following patient feedback pertaining to access.

The practice had an active PPG with 24 members. The PPG were actively involved in engaging with patients, for example, supporting them to use the self-check in screen to alleviate queues at the reception desk.

The practice had a system in place to assess whether a home visit was clinically necessary; and the urgency of the need for medical attention. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, the call was transferred to the duty doctor and alternative emergency care arrangements were made if required. Clinical and non-clinical staffs were aware of their responsibilities when managing requests for home visits.

## Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- A GP and the practice manager were the designated responsible persons who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system, for example, posters were displayed and leaflets were available.

We looked at 20 complaints received in the last 12 months. We found these were dealt with in a timely way. There was openness and transparency when dealing with complaints, which included the complainants' involvement. Lessons were learnt from individual concerns and complaints and action was taken as a result to improve the quality of care, and this was shared with all practice staff. Complaint records reviewed demonstrated that complaints were recorded and well documented.

# Are services well-led?

Outstanding



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

## Our findings

### Vision and strategy

The practice had a clear vision to deliver high quality safe care and promote good outcomes for patients. The practice had a robust strategy and supporting business plans which reflected the vision and values. These actions were regularly monitored.

The practice was able to articulate its current challenges with regards to their population groups and opportunities within its local context and emerging national programmes. They had a clear understanding at a high level of their overall clinical and managerial performance.

Staff told us about their desire to provide patients with caring, responsive and professional care. Staff members told us that they put patients at the heart of everything they do.

### Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- The practice demonstrated that it understood its overall performance and also the clinical areas where they had plans in place to target improvements through specific projects. For example, to support the high number of children registered at the practice, they held a paediatric clinic five times a week, and in order to improve access a consultant led paediatric clinic was held at the practice three times per month.
- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and advanced nurse practitioners had lead specialties.
- Practice specific policies were implemented and were available to all staff.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were effective arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

- The practice took a proactive approach to safeguarding vulnerable adults and children and implemented additional governance processes to support staff to identify and report concerns.
- There were effective systems in place for the management of significant events within the practice. The practice were able to demonstrate they analysis and learning taken from incidents.

### 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. They told us they prioritised safe, high quality and compassionate care. The practice had detailed knowledge of the population groups, the clinical conditions that existed in their area and the challenges that they faced in terms of deprivation.

The practice recognised that some patients who had been long term unemployed did not benefit from the experience of the mental and physical benefit of working or being employed. The practice negotiated with the local Jobcentre and Remploy who agreed to work from the surgery to reduce barrier for patients. Alongside this, emotional and spiritual support were offered as a one stop service through support given by our chaplains, link worker and Esteem counselling team. This program was funded by the Practice.

The practice told us that they believed that they were the only practice in the UK adopting this model.

The practice had a team of advanced nurse practitioners with training and expertise in a number of the long term conditions. For example, diabetes, Chronic Obstructive Pulmonary Disorder (COPD), hypertension (high blood pressure) and heart failure. The practice were pro-active in the management of patients with Chronic Obstructive Pulmonary Disorder and their care and treatment of these patients had led to improved health care and a reduced number of hospital admissions. There was a strong supportive team culture in the practice.

The practice had completed the Gold Standard Framework. The Gold Standard Framework (GSF) is a training programme for clinicians that provide care for all patients approaching the end of life. The practice was only one of 17 practices nationally to receive the GSF award.

# Are services well-led?

Outstanding



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

The provider was aware of and complied with the requirements of the Duty of Candour. The partners and management team encouraged a culture of openness.

- The practice kept written records of verbal interactions as well as written correspondence. The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- Staff said they felt valued, respected and supported. Staff told us the partners were approachable and took the time to listen to all members of staff. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- The practice had invested in staff development. Providing practice nurse training for two general nurses, advanced nurse training for nurse practitioners and additional courses for long term condition management. The practice had structured practice learning and protected time they held monthly clinical education sessions and allowed dedicated time to teach the GP students. The trainees had two tutorials a week, referral reviews through the practice referral management programme and one GP had ring-fenced time to supervise the GPs.

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

The practice encouraged and valued feedback from patients. They gathered feedback from patients through a patient survey and formal and informal complaints received and from the patient participation group (PPG) which met quarterly. We spoke with members of the PPG who told us that they were able to provide feedback on survey results and other issues.

- The practice had an active PPG met every two months. The two members we spoke with said that meetings were well managed and were enthusiastically supported by the practice manager. The PPG had been involved with introduction of the new telephone system and reduction of DNA project.
- The practice had gathered feedback from patients via in house surveys. The latest survey facilitated by the PPG had been completed in March 2016. The survey had been completed by 258 randomly selected patients. The results were analysed and discussed with the PPG who

were instrumental in developing an action plan for improvement. The outcome of the survey and action plan was shared with patients on the practice website and in the waiting area.

- Action taken by the practice following patient feedback included for example, a multilingual telephone system and text messaging. In order to address satisfaction with waiting times PPG members came to practice to assist patients to use the self-check in system.

## Continuous improvement

The GPs demonstrated a strong commitment to continuous learning and improvement at all levels in the practice.

- The practice demonstrated a strong approach to end of life care and the management of long term conditions and providing the best care to their patients. The systems and processes which it had introduced demonstrated continuous improvement.
- The in house chaplain service had been developed by Cape Hill Medical Centre and a neighbouring practice. The practice told us that this model had been thoroughly assessed by Staffordshire University as part of the ACE Pioneer project and was nationally recognised by NHS England.
- The leadership at the practice had focused on providing holistic care to their patients. For example, the delivery of comprehensive care to patients with multiple co-morbidities that were housebound, the introduction of the wellbeing hub which included a link worker and wide-ranging services provided to patients in the last year of their lives.
- The systems and processes that the practice had implemented in regards to end of life care had been adapted for inclusion the the Birmingham CrossCity CCG ACE Excellence Framework for 2017/18. This model was set to be delivered by 98 practices covering a population of 750,000.
- A medical student at the practice had facilitated a listening event and gathered data concerning barriers to accessing healthcare for difficult to reach groups. A leaflet was produced in order to educate new migrants on how to access healthcare. At the time of the inspection this was awaiting translation for publication.

# Are services well-led?

Outstanding



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

- Staff competencies were assessed annually by the lead advanced nurse practitioner. The practice initiated this quality assurance process to support staff with their personal development, to provide the management team with validation and reassurance that work was completed correctly, providing evidence of the quality of service provided.
- The introduction of educational information in a number of languages explaining how to use the services.
- The practice was working with schools to raise awareness of the needs of young carers.
- Systems and processes to improve clinical care were highly developed with further ideas for on going progress together with a programme of clinical audit to support on going improvements.
- The practice was an accredited teaching and training practice. Four of the nurses provided mentorship to student nurses.