Charles Road Surgery

Quality Report

192 Charles Road
Small Heath
Birmingham
B10 9AB
Tel: 0121 772 0398
Website: www.charlesroadsurgery.co.uk

Date of inspection visit: 2 July 2015
Date of publication: This is auto-populated when the report is published

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 Charles Road Surgery on 2 July 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report and record incidents and near misses. Staff used significant events and national and local safety alerts to improve the service.
- The practice assessed risks to patients and managed these well.
  - The GPs and practice nurses assessed patients' needs and planned and delivered care following best practice guidance.
  - Staff received training appropriate to their roles and the practice identified and planned future training and development needs.
- Patients told us they were involved in their care and decisions about their treatment. They were positive about the practice which they described as helpful, competent, polite, respectful and re-assuring. There were differences between the very positive information we obtained and the less positive results of the national GP patient survey.
- Information about services and how to complain was available and easy to understand but responses to complaints were not always fully documented to support shared learning.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice worked closely with its patient participation group and acted on feedback from them and other sources.
- The practice was developing more comprehensive governance systems to support the clinicians and ensure the practice was managed effectively.

We saw some areas of outstanding practice including:

Summary of findings

- The practice worked with the chair of the PPG to facilitate the funeral and burial needs of Muslim patients, including when this was out of hours and the practice was closed. Community leaders and patients and their families had the contact details for the chair of the PPG. When a patient died the PPG chair contacted the practice so that death certificates could be arranged without delay and burials could take place.
- The practice was alert to the potential risks of female genital mutilation (FGM) and forced marriage. They provided patients with information and access to specialist support. They were sensitive to the importance of taking great care to protect patients who asked for help or who they believed might be at risk.

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

Importantly the provider should:

- Review whether the practice is due for its five yearly electrical installation checks to be carried out.
- Take the results of patient feedback, including the national GP patient survey into account when planning improvements at the service.

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 and record incidents and near misses. The practice used significant events and national and local safety alerts as learning opportunities and to support improvement. The practice assessed individual risks to patients and general health and safety matters and managed these well. Information and support was available for patients whose circumstances might place them at risk and staff understood their roles and responsibilities in respect of safeguarding children and adults from abuse or neglect.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely to guide their practice. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and the practice was working to improve these arrangements for non-clinical staff.

Staff worked in close partnership with multidisciplinary teams to improve outcomes for patients' health and social circumstances. The practice worked hard to improve outcomes for patients with diabetes or at risk of developing diabetes and data showed that they were successful in this. Other areas where the practice was achieving improved outcomes included the provision of healthcare reviews and care plans. Data showed patient outcomes were above local and national averages for a range to care and treatments. This included uptake of flu vaccinations, childhood vaccinations, cervical screening and smoking cessation. The practice was very knowledgeable about the diverse needs of its practice population and demonstrated an accepting, sensitive and non-discriminatory approach to the care and treatment of patients from all communities.

Are services caring?

Good

The practice is rated as good for providing caring services. The overall picture provided was of a thoughtful, caring and responsive service where patients felt well cared for. Patients told us the practice team was friendly and that they felt their GP listened to

Summary of findings

them. They used words such as helpful, competent, polite, respectful, re-assuring and safe. Several patients described how well the GPs provided care for their young children. Two of the patients we spoke with were members of the patient participation group (PPG). They commented that the senior partner was viewed by patients as going the extra mile. The practice team maintained patients' confidentiality and spoke about their patient population in a caring and respectful way.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It was knowledgeable about the diverse needs of its local population and engaged positively with NHS England and the CCG. They took part in a range of local initiatives aimed at improving outcomes for patients in areas such as heart and respiratory disease, admission prevention and cervical and breast screening programmes. The building was accessible to patients with mobility difficulties and had a hearing loop for patents who used hearing aids. Whilst most staff were multi-lingual and able to converse with most patients in their preferred language they also had access to interpreter services when needed. Information about how to complain was available and easy to understand. Learning from complaints was shared with staff.

The practice worked in partnership with other professionals, the patient participation group and community leaders to meet the diverse health needs of their patients. They had a thorough understanding of the differing cultural and generational expectations of their patients regarding consultations and treatment. The practice was alert to the vulnerability of young women and female children in respect of female genital mutilation (FGM) and forced marriage and the need to safeguard patients approaching them for advice or help.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice aimed to provide personalised, patient focussed and ethnically sensitive care from the heart of the community where their patients lived. They recognised and valued the role of education for not only members of the practice team but also for patients. The practice worked closely with the patient participation group. The practice was improving their governance framework to help them manage and develop the service they provided. The practice engaged with the clinical commissioning group and the senior partner was a member of the local clinical commissioning board. The practice was involved in an initiative to develop extended hours GP services in Birmingham.

Summary of findings

The partners recognised and valued the role of education for not only members of the practice team but also for patients. It was a training practice providing up to two GP training places and was also involved in the education of medical students.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good or above average for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and prioritised appointments for those at highest risk.

The practice worked closely with a social work case manager with the aim of identifying and meeting the social needs of the elderly population and could provide examples of patients whose circumstances had improved as a result. For example one had been re-housed in safer and more suitable housing. They also worked with local district nurses who described the responsiveness of the practice in in preventing unplanned hospital admissions and supporting the community team when patients were discharged from hospital. All patients over the age of 75 who were at risk were seen by a GP for a face to face review of their care as soon as they were discharged from hospital. Flu vaccination rates for patients over the age of 65 were more than 10% higher than the national average. Other local professionals involved in the care of older patients praised the practice for their engagement, positive working relationships and excellent communication.

The practice worked with the chair of the PPG and community leaders to facilitate the funeral and burial needs of Muslim patients, including when this was out of hours and the practice was closed.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met.

Staff worked in close partnership with multidisciplinary teams to improve outcomes for patients' health and social circumstances. National data showed that the practice's performance for a range of conditions including heart disease was better than the national average. The practice worked hard to improve outcomes for patients with diabetes or at risk of developing diabetes and data showed that

Summary of findings

they were successful in this. This was also the case for flu vaccination rates for at risk patients and for the provision of healthcare reviews and care plans. The practice was very knowledgeable about the diverse needs of its practice population and demonstrated an accepting, sensitive and non-discriminatory approach to the care and treatment of patients from all communities.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. They had systems to identify and follow up children living in circumstances that might make them vulnerable and who were at risk. The practice followed up all children's A&E attendances. Immunisation rates were high for all standard childhood immunisations and exceeded the CCG average. For example, the MMR vaccination rate was 5% higher than the CCG average for children under two and 13% higher for five year olds. Appointments were available outside of school hours and the premises were suitable for children and babies. Appointments on Saturday mornings were used for book on the day appointments and to review patients, including children, with long term conditions. The practice worked closely with health visitors and other health and social care professionals.

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 was aware of the needs of the working age population, those recently retired and students. However a significant proportion of the practice's patients were not in employment. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. Saturday morning book on the day appointments were available as well as planned healthcare reviews. The practice did not provide early morning or evening appointments at the practice but participated in the provision of extended hours at a local extended hours 'hub'.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in circumstances which might make them vulnerable. This included patients with learning disabilities, the long term unemployed, asylum seekers and those at risk due to domestic violence. It carried out annual health checks for people with learning disabilities and offered them longer appointments.

Summary of findings

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice was alert to the potential risks of female genital mutilation (FGM) and forced marriage. They provided patients with information and were sensitive to the importance of dealing with the subjects sensitively and with great care to protect patients who asked for help or who they believed might be at risk

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). All of the practice's patients experiencing poor mental health had received an annual physical health check and had a care plan as had all patients with a diagnosis of dementia. The practice performed highly in supporting patients to stop smoking and monitoring their alcohol consumption. The practice worked closely with local mental health professionals and proactively supported patients experiencing poor mental health to access other services including culturally appropriate counselling services.

Summary of findings

What people who use the service say

There were 452 forms distributed for the national GP patient survey with results published on 8 January 2015. There were 65 responses which was a response rate of 14.4%. The results from this source were mixed and differed from positive responses given by patients we spoke with during the inspections and in CQC comment cards completed by patients in the two weeks before the inspection.

These are a sample of the national GP patient survey results:

- 54.3% with a preferred GP usually got to see or speak to that GP compared with a CCG average of 53.2% and a national average of 53.5%.
- 83.1% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 81.4% and a national average of 85.4%.
- 94% said the last appointment they got was convenient compared with a CCG average of 90% and a national average of 91.8%.
- 57.1% described their experience of making an appointment as good compared with a CCG average of 70.5% and a national average of 73.8%.
- 49.8% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 57.1% and a national average of 65.2%.
- 60.3% found it easy to get through to this surgery by phone compared with a CCG average of 70.6% and a national average of 71.8%.

We received 46 completed CQC comment cards and spoke with 10 patients during the inspection including two who were members of the patient participation group. Patients were very positive about the practice. The overall picture provided was of a thoughtful, caring and responsive service where patients felt well cared for. Patients told us the practice team was friendly and that they felt their GP listened to them. They described the team as competent, respectful and re-assuring. Patients commented on the practice having good standards of hygiene and cleanliness and access in respect of mobility. Six patients made negative comments about getting through on the telephone or the availability of appointments but were very happy with the practice in other respects. Other patients did not raise this or specifically remarked that appointments were readily available. Recent NHS Friends and Family results were positive and showed that most patients who had completed a form would recommend the practice.

Areas for improvement

Action the service SHOULD take to improve

- Review whether the practice is due for its five yearly electrical installation checks to be carried out.
- Take the results of patient feedback, including the national GP patient survey into account when planning improvements at the service.

Outstanding practice

- The practice worked with the chair of the PPG to facilitate the funeral and burial needs of Muslim patients, including when this was out of hours and the practice was closed. Community leaders and patients and their families had the contact details for the chair of the PPG. When a patient died the PPG chair contacted the practice so that death certificates could be arranged without delay and burials could take place.
- The practice was alert to the potential risks of female genital mutilation (FGM) and forced marriage. They provided patients with information and access to

specialist support. They were sensitive to the importance of taking great care to protect patients who asked for help or who they believed might be at risk.

Charles Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a second CQC inspector and a practice manager specialist advisor. The team was supported by an interpreter.

Background to Charles Road Surgery

Charles Road Surgery is the Small Heath area of Birmingham which has high levels of social and economic deprivation (approximately two times higher than the national average). The practice is in two converted houses in a residential street in the heart of its practice catchment area. It has around 5,032 patients who live within a one mile radius of the practice. There has been a GP practice at the property since 1945 and the practice has been run by GPs from the same family since 1981.

The practice catchment area is ethnically diverse as well as being very densely populated with a much higher number of patients under 35 and children than the national average. The numbers of patients over 40 was much lower than the national average. The practice explained that 80% of their patients were Pakistani, 10% originated from India and Bangladesh and 5% from Africa, including Somalia. The other 5% were white British and eastern European. The senior partner told us that whilst many patients were from second and third generation immigrant families there were also many first generation immigrants who they needed to educate about the British healthcare system. The practice highlighted to us that they faced challenges relating to differing cultural and generational expectations regarding consultations and treatment.

The practice is open between Monday to Friday from 9am to 6.30pm and on Saturday mornings. The telephone is answered from 9.15am and the GPs operate a triage system between 9.15am and 10.30am when they will speak with patients to assess the need for a face to face appointment.

The practice is involved with other practices in providing increased access outside core practice hours. Appointments are available at a local 'hub' practice between 8am and 9am, and 6pm to 8pm on weekdays and 8am to 8pm at weekends. This service is available to all patients registered at Charles Road Surgery.

Appointment times to see a GP vary each day as follows:

Monday, Tuesday, Wednesday and Friday – 9.30am -1pm and 4pm to 6.30pm.

Thursday – 9.30am to 1pm (the local out of hours service provided a message service between 4pm and 6.30 and passed information to the practice's on call GP)

Saturday – 9.30am to 11am

Appointments times to see a nurse varied slightly from this. Information about this was detailed on the practice website which also provides a chart showing patients which days and times each of the GPs and the practice nurse or health care assistants is on duty. Whilst the practice does not provide appointments between 1pm and 4pm any urgent patient requests during that time are allocated to one of the GPs to review and the practice told us those patients were then often offered appointments during the 4pm to 6pm surgery. Appointments with GPs on Saturdays are book on the day with priority for working patients and children. Appointments with the nurse on Saturdays are

mainly for immunisations and long term condition reviews. The practice provides online appointment booking. Home visits were provided for patients unable to visit the practice due to illness or mobility problems.

The practice has three GP partners and two salaried GPs, a practice nurse and four health care assistants. There is one female GP who works each day so patients have a choice about the gender of the GP they see. At the time of the inspection the clinical team was supported by a temporary practice manager. The practice had an established team of four administrative and receptionist staff.

The practice provides a range of minor surgical procedures.

The practice has a patient participation group (PPG), a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

The practice has a General Medical Services (GMS) contract with NHS England.

Charles Road 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; Charles Road Surgery has three. The practice is also a teaching practice and provides placements for medical students who have not yet qualified as doctors.

The practice does not provide out of hours services. Information for out of hours GP services was provided for patients at the practice, on the website and on the out of hours answerphone message. This service is provided by a GP Out of Hours Service called BADGER. The service is accessed by a designated telephone number which is provided on the practice website. The practice website also provides information about two NHS urgent care centres and an NHS Walk-in centre which patients can use if Charles Road 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 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.

How we carried out this inspection

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

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

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

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

Before the inspection, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. We carried out an announced visit on 2 July 2015. During our inspection we spoke with a variety of staff including GPs, the practice nurse, the temporary practice manager and members of the reception and administration team.

During the inspection we spoke with 10 patients, two of whom were members of the patient participation group (PPG). A PPG is a group of patients registered with a practice who worked with the practice team to improve

Detailed findings

services and the quality of care. We reviewed 46 CQC comment cards completed by patients to provide information about their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record and learning

The practice used information from a variety of sources to help them identify risks and improve patient safety. These included national and local safety alerts. Staff we spoke with were aware of their responsibility to raise concerns, and how to report and record significant events. The practice demonstrated an established system for monitoring safety dating back to 2009.

Staff told us that significant events were discussed at a clinical meeting every Tuesday. This included the practice nurse, GPs, a representative of the reception team and the practice manager. They were also reviewed at meetings for the whole practice team every two months.

Staff gave us examples of significant events that had occurred at the practice and described ways in which improvements had been made. We saw the records of these which were detailed and showed that staff had properly considered events and how to minimise the potential for these happening again. Staff confirmed that patients were always informed about any significant event or safety alert that directly concerned them.

Overview of safety systems and processes

The practice had systems, processes and practices to support the provision of a safe service.

The practice had links to the Birmingham Multi Agency Safeguarding Hub (MASH) website and referral forms and advice were available on all the practice computers. Staff understood their roles and responsibilities regarding safeguarding including their duty to report abuse and neglect. The practice team took part in safeguarding meetings with other involved professionals every two months and completed training about safeguarding relevant to their role. The practice computer system provided clear information for staff so that they were aware of any patients whose circumstances might make place them at risk.

The GP safeguarding lead liaised closely with the health visiting team regarding children about whom there were known concerns. The practice made the health visitor team aware of any children under five newly registered with the practice, particularly where the family had changed practices more than once. When children were not brought for planned appointments the practice had a system for following this up and for making a referral to the health visitor team. All accident and emergency attendance by children was followed up by a GP.

The safeguarding lead had attended a Royal College of General Practitioners update regarding coding in respect of domestic violence and was checking that the practice's coding was correct for patients this might apply to. There were leaflets and posters about domestic violence where patients who needed support could take discretely. Staff shared examples of appropriate referrals they had made to other services.

The practice were alert to the potential risks of female genital mutilation (FGM) for female children and young women (including newly married women who had just arrived in the United Kingdom) and of forced marriage. The practice had information leaflets and posters at the practice to provide patients with information and were sensitive to the importance of dealing with these subjects sensitively and with great care to protect patients who asked for help or who they believed might be at risk.

The practice had a chaperone policy which staff were fully aware of. A chaperone is a person who acts as a witness to safeguard patients and health care professionals during medical examinations and procedures. The practice had signs to inform patients that chaperones were available. The practice obtained disclosure and barring service (DBS) checks for all staff carrying out this role. 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. Staff we spoke with confirmed they had been trained for this role and understood what was expected of them.

The practice had procedures for monitoring and managing risks to patient and staff safety including an up to date health and safety policy. This was last reviewed in May 2015 and all staff were involved with updating this. Staff we spoke with confirmed that premises maintenance checks were planned for July 2015. The practice had systems for identifying patients whose circumstances might place them at risk. This included alerts on the practice computer system and registers of patients in high risk groups such as those with long term conditions, mental health needs or learning disabilities.

Good

Are services safe?

Staff confirmed they had the equipment they needed to meet patients' needs safely. Each clinical room was appropriately equipped. We saw evidence that the equipment was maintained. This included checks of electrical equipment, equipment used for patient examinations and treatment and items such as weighing scales and refrigerators. The practice was unclear when the most recent safety check of the electrical installations had been completed.

The practice was visibly clean and tidy. Patients who filled in CQC comment cards or spoke with us during the inspection told us they were happy with the cleanliness of the practice. The practice nurse was the lead for infection prevention and control (IPC) and the temporary practice manager was the lead for legionella precautions. Legionella is a bacterium which can contaminate water systems in buildings. The practice manager had completed a legionella risk assessment. The practice had an up to date IPC policy and staff completed IPC training relevant to their role. The practice provided disposable gloves and aprons for staff to use. Notices about hand hygiene techniques were displayed and liquid soap, hand gel and disposable towels were available. The cleaning staff had a cleaning schedule and cleaning equipment and products were stored securely. Privacy curtains were cleaned frequently and we saw labels with dates for when these were changed.

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 minor surgery were single use. The practice had a contract for the collection of clinical waste and had suitable locked storage.

The practice had a policy and procedures for the safe management of medicines and monitoring the use of blank prescriptions which were stored securely. The practice carried out medicines management audits and we looked in detail at two of these. These showed that the practice took suitable action when the need arose. For example, following a national alert regarding potential heart related risks of a specific medicine the practice reviewed patients taking this and took suitable action in each case. 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. The practice nurse had completed appropriate training and was proactive in maintaining their professional knowledge and experience in respect of vaccine administration.

The practice had a recruitment policy which set out the standards they followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, conduct in previous health or care roles, qualifications, registration with the appropriate professional body and the appropriate DBS checks. The practice had a reminder system to monitor the GPs' and practice nurse's professional registrations to ensure they were up to date.

Staff told us there were enough staff to maintain the smooth running of the practice and to ensure patients were kept safe. Staff informed us an analysis of staffing levels was going to be undertaken in August 2015. Staff covered for each other's annual leave to help maintain continuity of care. The practice rarely used locums but had a comprehensive locum policy to ensure that the required checks were made when locums were employed. The practice only had one practice nurse who told us they managed their leave carefully and ensured that any patient reviews were booked before or after this. Many tasks such as taking blood and health checks were carried out by the healthcare assistants so patients care was not delayed. They said for unplanned absences from work the practice would arrange to use a locum practice nurse.

Arrangements to deal with emergencies and major incidents

The practice had an alert system for staff to use if they needed urgent help from other members of the team. All staff were up to date with cardiopulmonary resuscitation (CPR) training and the practice had a system for monitoring when refresher training was due.

The practice had oxygen and an automated electronic defibrillator (AED – a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). There were appropriate, securely stored medicines available for use in a medical emergency at the practice. We saw that staff checked these regularly to

Good

Are services safe?

make sure they were available and ready for use if needed. The GPs had appropriate and in date emergency medicines in their bags which were kept locked and were stored securely.

We saw that there was a fire risk assessment, which was completed in April 2015. The practice had a business continuity plan which was available for all staff on the practice computers.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Our discussions with the GPs and the practice nurse showed that they were aware of and worked to guidelines from local commissioners and the National Institute for Clinical Excellence (NICE) about best practice in care and treatment. The practice stored NICE guidelines on the computer systems and used these and other guidance to keep their practice up to date. They held weekly meetings to share information. These meetings were not minuted but the practice confirmed that they had begun doing so from the first meeting following the inspection.

The practice had templates to help them manage patients' care and treatment in an organised and structured way.

Management, monitoring and improving outcomes for people

The practice had a good awareness of the needs of its patient population and took part in a wide range of enhanced services and local improvement schemes to improve patient outcomes. They used registers to enable them to monitor patients with specific needs including those who might be vulnerable, patients approaching the end of life, people with learning disabilities and those with long term conditions or experiencing poor mental health. All these groups of patients were called for annual reviews of their care and treatment.

The practice participated in the Quality and Outcomes Framework (QOF), a voluntary system intended to improve the quality of general practice and reward good practice. During 2013/14 the practice achieved 98.2% of the total points available, with 6.7% exception reporting which was 1.1% lower than the CCG average and 1.2% lower than the national average. Exception reporting relates to patients on a specific clinical register who can be excluded from individual QOF indicators for specific reasons. These include situations where a treatment is unsuitable for patients, patients who are newly registered with a practice or those newly diagnosed with a condition.

Examples from the QOF data from 2013/14 showed:

- The percentage of patients experiencing poor mental health who had a care plan was 100% compared with the national average of 86.09%.
- The percentage of patients experiencing poor mental health whose smoking status and alcohol consumption was recorded was 99.38% and 97.56% respectively compared with 95.29% and 88.65%.
- Performance for three QOF indicators for atrial fibrillation (a heart condition) was 100% in each case and between 2.7 and 17.2% better than both CCG and national averages. Their exception reporting was zero for two out of three indicators and for the third was 13% lower than the CCG average and 4.5% lower than the national average.
- The percentage of patients with a diagnosis of dementia who had received a face to face review of their care in the preceding 12 months was 100% compared with the national average of 83.83%
- The percentage of patients at risk of fragility fractures treated with an appropriate medicine was 100% compared with 81.29% with zero exception reporting.

The practice participated in the unplanned admissions avoidance enhanced service. Their accident and emergency (A&E) attendances, emergency inpatients and secondary care referrals during January 2014 to December 2014 were in line with the national average. The practice was keen to reduce unnecessary and inappropriate attendances at A&E. GPs reviewed all cases where patients went to A&E to check whether these were necessary and appropriate or were health concerns that could have been dealt with by the practice. If this was the case the practice wrote to patients with advice and the offer of a GP appointment.

The practice had a high prevalence of patients with diabetes. This was 8.78% of the patient population and was 2.67% and 3.78% above the CCG and national averages respectively. Information we reviewed for diabetes indicators measured under QOF showed that the practice achievement was better than both the CCG and national averages for all but one of these. The practice's exception reporting was lower than or in line with the average for 12 out of 15 indicators. Overall the practice achieved 99.9% of the total points available for diabetes care. The number of the practice's patients admitted to hospital due to diabetes was slightly lower than the national average. Education regarding the risks of uncontrolled diabetes and regular reviews were at the heart of the practice's approach to diabetes care. All newly diagnosed patients were referred

Good

Are services effective?

(for example, treatment is effective)

for to a structured education programme and to a dietician for assessment and advice. The practice provided insulin initiation for newly diagnosed patients. The practice actively screened patients at increased risk of developing diabetes and identified 240 new cases of pre-diabetes between June 2014 and June 2015. All patients diagnosed with pre-diabetes received a detailed letter from the practice. This confirmed and explained their diagnosis and provided guidance about diet and lifestyle. Patients were offered the opportunity to discuss their diagnosis with the GP or Practice Nurse.

The practice had a low prevalence for dementia diagnosis. The practice had noticed that patients rarely came to see their GP due to symptoms which might be due to dementia. They identified that this was because of the level of support provided by their extended family. They recognised that they needed to be more proactive in identifying patients living with dementia. As a result a GP attended a dementia training update in February 2015 and shared their learning from this at a subsequent practice meeting.

The practice carried out annual reviews for patients with learning disabilities and showed us that they had gathered a wide range of national guidance regarding best practice in learning disability care. They used an easy read care plan template to provide information to patients. They saw patients for an appointment during which they checked height, weight and blood pressure and took blood tests where appropriate. The patients then had an appointment with the GP a week later when all this information was available for the GP to refer to. The practice booked longer appointments for patients with learning disabilities.

The practice used the Gold Standard Framework to help them respond to the care and treatment needs of patients receiving palliative care and nearing the end of life. The practice had a register of patients needing care in these circumstances so all staff were aware of their situation.

The practice carried out and acted upon the results of clinical audits to improve patients' care and treatment. We discussed four recent clinical audits with the practice. Two of the four were completed audit cycles which re-visited previous audits to review findings and monitor changes. Three of the four related to medicines safety alerts or National Institute for Health and Care Excellence. These showed that the practice had reviewed patients' medicines and taken action to make changes where this was appropriate. The two completed audit cycles related to the prescribing of laxatives and to the care, treatment and review of nine patients with coeliac disease. Both audits resulted in improved outcomes for patients. For example, six patients were supported to stop taking laxatives and the health of five patents with coeliac disease improved due to additional advice and support regarding their diet.

Another audit related to consent being recorded in patients' records. The practice nurse planned to carry out an audit of children's immunisations during 2015.

Effective staffing

The GPs were up to date with their appraisals and had completed their revalidation or were preparing for this. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by General Medical Council (GMC) can the GP continue to practice and remain on the performers list with NHS England.

The practice was a teaching practice and the three partners were qualified to train GP trainees. The practice was also a training practice and the lead GP was currently supporting one medical student on placement at the practice.

All staff had protected time for learning and development. Staff attended learning events at the practice and days arranged by the clinical commissioning group (CCG). The practice nurse and the lead GP had completed the Warwick Medical School Certificate in Diabetes Care qualification and attended regular updates in diabetes. Staff told us the partners supported them in their learning and frequently paid for courses. The practice nurse had completed training in relevant subjects including chronic heart disease care, family planning, cervical screening and immunisations. The practice had introduced a structured induction programme for non-clinical staff.

The senior partner had a Drug and Alcohol Misuse qualification and attended regular updates. The female GP was qualified and had a special interest in sexual and reproductive healthcare and attended regular updates.

We looked at mandatory training records and these showed staff had done mandatory training in expected topics. There was a suitable induction programme for new staff which was updated in May 2015. The practice nurse confirmed that they received annual appraisals from the senior partner which identified plans for the year, training

needs and professional development. They planned to use their next appraisal to discuss and plan for the new requirement for nurses to apply for re-validation in the same way as GPs. Non-clinical staff had not had full annual appraisals since 2013. The new practice manager had completed short appraisals with these staff and planned to complete full appraisals with them by December 2015.

Coordinating patient care and information sharing

The information staff needed to plan and deliver care and treatment was available through the practice's computer systems. This included care plans, clinical templates and test results. Information such as NHS patient information leaflets was also available. Hospital communications and test results were dealt with by the relevant GP who updated the patient's records. When a GP was away the other GPs ensured their work was covered. Staff were familiar with the practice's procedures for recording and sharing information about patients.

The practice worked in partnership with social services, district nurses, health visitors and palliative care teams and took part in multidisciplinary team meetings every two months. The practice referred patients to the most appropriate local mental health services. This included a specific counselling services tailored to the needs of Asian women. The practice had systems for sharing information about patient care with the out of hours GP service and the ambulance service. We spoke with two external health and social care professionals during the inspection. They described the practice's communication and joint working with them as excellent. They both gave us examples of ways the practice worked with them to improve patients' health and social care outcomes.

Consent to care and treatment

Clinical staff obtained patients' consent to care and treatment 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 (MCA). The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff had completed training about MCA and Gillick competence. The Gillick test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. The GPs and practice nurse were able to demonstrate that they had a good awareness and knowledge of their responsibilities and of the circumstances when they would need to take these into account. They were aware of the Duty of Candour for NHS staff which enshrines in law an obligation to be open and transparent with patients.

At a previous inspection we found that the practice was not obtaining appropriate consent for non-medical circumcision. The practice confirmed that they no longer provided this procedure. For other procedures we saw that the GPs used appropriate consent forms and attached these to patients' notes. The practice had completed an audit of patient records to confirm that the GPs were doing this. Patients' wishes regarding being resuscitated were discussed with them and/or their families in appropriate circumstances. Do not attempt resuscitation forms were completed when this was what patients wanted.

Health promotion and prevention

The GPs, practice nurse and health care assistants provided a range of health checks, vaccination programmes and long term condition reviews. Health promotion information was available on the practice website and in leaflets provided in the waiting room or printed from NHS sources by the GPs and nurses to give direct to patients. Information on the practice website could be translated into a wide range of languages.

The practice held a GP led baby clinic every two weeks. These were timed to follow health visitor appointments at a community clinic the day before. Data for 1 April 2014 to 31 March 2015 showed that childhood immunisation rates were better than CCG averages by between one and 13%. The practice nurse told us they had changed their approach to arranging these. Rather than sending letters they used a list of eligible children and contacted families direct to book a convenient appointment. They described using interpreters for this in situations where a clear explanation was needed in the parent's first language. Immunisation rates for the vaccinations given to under two year olds ranged from 92.6% to 96% and five year olds from 94.8% to 99%. The MMR vaccination rate was 5% higher than the CCG average for children under two and 13% higher for five year olds. The practice was aware of and sensitive to the reluctance of some patients in the community to childhood vaccinations because of the presence of pork gelatine in vaccines. The practice had sought to educate families through face to face discussion

Good

Are services effective?

(for example, treatment is effective)

and by providing leaflets informing patients that Islamic clerics allow for the provision of vaccinations for Muslim children. They told us they had also communicated with the CCG to raise awareness of the need for the development of more appropriate culturally sensitive vaccines.

The practice nurse worked closely with the district nurse team to manage and co-ordinate the flu vaccination programme. This included deciding who would see each patient. Flu vaccination rates for the over 65s during the 2013/14 flu season were 83.82% compared with the national average of 73.24%. They told us that their figures for the 2014/15 flu season were 86.7%. The practice provided information that vaccination rates for at risk groups 66.37% compared with the national average of 52.29%.

The practice's uptake for the cervical screening programme during 2014 was 82.61%, which was comparable to the national average of 81.88%. They were involved in a project with Sandwell and Birmingham Hospitals NHS Trust and the CCG to increase the uptake of breast screening.

The practice had relatively low prevalence of chronic obstructive pulmonary disease (COPD). The practice had identified that many of their population were reluctant to say they smoked. Because smoking status is the main prompt for screening for COPD, patients being reluctant to declare they smoked reduced screening opportunities. In addition, the practice age profile was much younger than the national average so the prevalence of heart and breathing related conditions would be expected to be lower. The practice was involved in a local respiratory quality improvement programme (RQUIP). This was a local improvement scheme aimed at improving diagnosis, treatment and outcomes for patients with a range of respiratory diseases including COPD. The lead GP was able to demonstrate that through participation in this scheme the practice was diagnosing more new cases than expected compared to the CCG average.

The practice held in house smoking cessation clinics for those patients who acknowledged that they smoked and wanted to stop. They had achieved maximum QOF points for this and out-performed targets set by the Stop Smoking Service. The practice had recorded the smoking status of 99.38% of patients with heart conditions or experiencing poor mental health compared with the national average of 95.29%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that staff were friendly and polite towards patients and treated them with dignity and respect. There were curtains around treatment couches to protect patients' privacy and dignity during examinations and treatment. We saw that staff closed the doors to consultation and treatment room doors when seeing patients and that conversations taking place in these rooms could not be overheard. Reception staff were very aware of patients' privacy when speaking with them at the reception desk and patients were offered somewhere more private to speak if they wished. All staff had signed to confirm they had read the practice's confidentiality policy.

All 46 patients who filled in CQC comment cards and the 10 we spoke with were positive about the way staff at the practice treated them and the care they received. The overall picture provided was of a thoughtful, caring and responsive service where patients felt well cared for. Patients told us the practice team was friendly and that they felt their GP listened to them. They described the practice team as competent, respectful and re-assuring. Several patients described how well the GPs provided care for their young children. Two of the patients we spoke with were members of the patient participation group (PPG). They commented that the senior partner was viewed by patients as going the extra mile.

Results from the national GP patient survey published in January 2015 contrasted with what patients told us as they showed lower satisfaction levels than the national average in respect of patients feeling they were treated well, for example:

- 71.8% said the GP was good at listening to them compared to the CCG average of 86.5% and national average of 87.2%.
- 69.9% said the GP gave them enough time compared to the CCG average of 84.6% and national average of 85.3%.
- 83.3% said they had confidence and trust in the last GP they saw compared to the CCG average of 91.5% and national average of 92.2%
- 67.2% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 82.8% and national average of 82.7%.
- 68.2% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 76.8% and national average of 78%.
- 76.2% patients said they found the receptionists at the practice helpful compared to the CCG average of 84% and national average of 86.9%.

However, the NHS Friends and Family Test results for the eight months from November 2014 to June 2015 were consistently high for whether patients would recommend the practice with a score of 100% in three of the months, and 90%, 92% and 94%. The lowest scores were 80% and 89%.

Care planning and involvement in decisions about care and treatment

Patients who filled in CQC comment cards and those we spoke with told us that they felt that their GP and the practice nurse listened to them and explained their care and treatment to them well. Several described the types of health problems they had experienced and gave us examples of their GP making sure they understood their condition and the treatment options available to them. This was again a more positive picture than came across from the results from the national GP patient survey published in January 2015. These showed lower than average satisfaction in respect of questions relating to the patients being involved in decisions about their care, for example:

- 71.1% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81.7% and national average of 82%.
- 67.2% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 76.3% and national average of 74.6%

The temporary practice manager planned to review the results of the GP patient survey as part of their overall strategy to identify where improvements were needed.

Staff at the practice spoke a wide range of languages and also had access to translation services when patients needed this. We highlighted to the practice that there was no information displayed at the practice to make patients

aware of this. Staff felt they knew patients so well that they understood their language needs and accommodated these effectively. However, they acknowledged that additional information would help some patients and said they would provide this.

Patient and carer support to cope emotionally with care and treatment

A number of patients told us, or wrote in comment cards, that the GPs and other members of the practice team had provided considerable support and care when they or a member of their family was ill.

The practice provided contact information for various support groups and organisations on their website and in the waiting room. The practice's computer system was used to identify patients who were carers so that practice staff could provide advice, support and information. There was a practice register of all people who were carers. The practice nurse was preparing to write to all carers registered with the practice to review their needs and provide them with information and had prepared a resource folder with helpful information. The practice nurse carried out the annual reviews for patients with learning disabilities. These were due in the Spring of 2016 and they planned to offer separate appointments for those patients' carers to review their health and support needs.

Staff told us that when families had a bereavement, the practice sent them a sympathy card. We saw information that showed the practice gave consideration to the emotional and cultural wishes and needs of patients at the end of life and after death. They were also responsive to the needs of bereaved families. In particular the practice was mindful of the importance of specific religious observance requirements following death.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

There had been a GP practice at the property since 1945 and it had been run by GPs from the same family since 1981. The current senior partner took over in 2014. They identified a lack of space at the practice and were examining options for improving and extending the building rather than moving to a purpose built practice in another part of the area. This was because the partners were committed to providing a service in the midst of their densely populated catchment area so patients could continue to receive their care close to home. The senior partner explained that because they had many fourth or fifth generation patients the practice was highly valued and respected by members of the community.

The practice participated in a total of seventeen enhanced services and clinical commissioning group (CCG) led local improvement schemes. The senior partner was actively involved in the CCG and a member of the local clinical commissioning board and involved in the design of local improvement schemes.

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care.

- The practice worked with the chair of the patient participation group (PPG) to facilitate the funeral and burial customs of Muslim patients, including when this was out of hours and the practice was closed. Community leaders and patients and their families had the contact details for the chair of the PPG. When a patient died the PPG chair contacted the practice so that death certificates could be arranged without delay and burials could take place. A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care.
- The practice was alert to the potential risks of female genital mutilation (FGM) and forced marriage. They provided patients with information and access to specialist support. They were sensitive to the importance of taking great care to protect patients who asked for help or who they believed might be at risk.
- The practice worked closely with a social work case manager with the aim of identifying and meeting the social needs of the elderly population. They made referrals direct to the case worker who spent time at the practice every week.As a result of recent referrals two patients' circumstances had improved significantly. For example one had been re-housed in safer and more suitable housing. The case manager explained to us that they worked with a number of practices in the region but particularly praised this practice for their engagement with the referral process and their effective communication. A local district nurse also described positive working relationships and excellent communication and co-operation from the practice. They told us about the responsiveness of the practice in preventing unplanned hospital admissions and supporting the community team when patients were discharged.
- The practice booked longer appointments for patients with learning disabilities, long term conditions and in other situations where patients needed additional time due to their individual needs or circumstances. The practice also had easy read action plans available
- Home visits were available for older patients and other patients who were too unwell to visit the practice or had significant mobility problems.
- All staff had completed equality and diversity training and showed a sound understanding of the diversity of the practice population.
- There were disabled facilities for patients with mobility problems and a hearing loop to assist patients who used hearing aids.
- All patients over the age of 75 had a named GP and those aged over 75 identified as being at risk were guaranteed a same day appointment. A walk in service was available for certain patients who had difficulty phoning for appointments. The practice did face to face post-discharge reviews for patients over the age of 75 following hospital admissions.
- The practice team spoke Urdu, Punjabi, Hindi and Bengali which enabled them to communicate direct with most patients in their preferred language although translation services were also used when necessary.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The practice was involved in shared care prescribing scheme for the provision of specialist prescriptions and support for patients with drug and alcohol misuse related treatment needs.
- The practice worked closely with other agencies in the care of patients experiencing poor mental health. This included organisations which understood and were sensitive to the cultural needs of the practice population and provided clinics close to where patients lived.

Access to the service

The practice was open Monday to Friday from 9am to 6.30pm and on Saturday mornings. The telephone was answered from 9.15am and between 8am and 9.15 messages were taken by the out of hours service. The GPs operated a triage system between 9.15am and 10.30am when they spoke with patients to assess the need for a face to face appointment. The practice told us that each GP had three pre-booked appointments each day used for planned reviews. Staff telephoned those patients the previous day to remind them to attend. In addition the practice told us they provided 60 to 80 same day appointments every day (mainly during the 4pm to 6pm surgery) and aimed to maintain consistency with this throughout the year. Although this was a high number of appointments in relation to the number of patients registered the senior partner told us they still struggled to meet demand.

The practice was involved in a successful application to the Prime Minister's Challenge Fund by a group of practices to provide increased access outside core practice hours. This aimed to provide appointments at a local 'hub' practice between 8am and 9am, and 6pm to 8pm on weekdays and 8am to 8pm at weekends. This service was available to all patients registered at Charles Road Surgery and the record systems were to be fully integrated so patients' records were available at the hub. The practice informed us that this service had become fully operational since the inspection.

Appointment times to see a GP varied each day as follows:

Monday, Tuesday, Wednesday and Friday – 9.30am -1pm and 4pm to 6.30pm.

Thursday – 9.30am to 1pm (the local out of hours service provided a message service between 4pm and 6.30 and passed information to the practice's on call GP)

Saturday – 9.30am to 11am

Appointments times to see a nurse varied slightly from this. Information about these was detailed on the practice website which also provided a chart showing patients which days and times the GPs and practice nurse were on duty. Whilst the practice did not provide appointments between 1pm and 4pm any urgent patient requests during that time were allocated to one of the GPs to review. The practice told us that usually those patients were then offered an appointment between 4pm and 6pm. Appointments with GPs on Saturdays were book on the day with priority for working patients and children. Appointments with the nurse on Saturdays were mainly for immunisations and long term condition reviews.

The practice had recently introduced online appointment booking. Home visits were provided for patients unable to visit the practice due to illness or mobility problems. The practice identified patients who found making appointments by telephone difficult for whatever reason. These patients' records were flagged so that if they came to the practice without an appointment one of the GPs would see them.

Results from the national GP patient survey published in January 2015 showed that patients' satisfaction with how they could access care and treatment was mixed when compared with local and national averages:

- 83.1% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 81.4% and a national average of 85.4%.
- 94% said the last appointment they got was convenient compared with a CCG average of 90% and a national average of 91.8%.
- 66.5% of patients were satisfied with the practice's opening hours compared to the CCG average of 74.4% and national average of 75.7%.
- 60.3% patients said they could get through easily to the surgery by phone compared to the CCG average of 70.6% and national average of 71.8%.
- 57.1% patients described their experience of making an appointment as good compared to the CCG average of 70.5% and national average of 73.8%.
- 49.8% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 57.1% and national average of 65.2%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Five of the patients we received direct information from, either in a comment card or when we spoke with them, commented on difficulties obtaining appointments or getting through to the practice on the telephone. However, no other patients raised this and most of the others specifically commented that they found it easy to obtain appointments to suit them. The temporary practice manager planned to review the results of the GP patient survey as part of their overall strategy to identify where improvements were needed.

Listening and learning from concerns and complaints

The practice had recently reviewed its system for handling complaints and concerns and the temporary practice manager was working on getting this fully established. The policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

We saw that information about the complaints process was available on the practice website and in leaflets in the waiting room. The temporary practice manager was in the process of developing written information for patients about advocacy services. We noted that the practice had not always made comprehensive records about responses to complaints.

The practice provided an overview of their most recent complaints which showed that they took note of patients' concerns and acted on them where necessary. For example, some patients had commented on the attitude of some reception staff and the practice was arranging for all staff to complete customer service training. Most of the concerns patients raised related to access to appointments. The practice explained to us that this was an ongoing situation which they worked hard to improve but that they already provided a high number of appointments in proportion to their patient numbers. We noted that responses to complaints were not always fully documented to support shared learning

Staff told us that complaints were discussed at staff meetings.

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 aimed to provide personalised, patient focussed and ethnically sensitive care from the heart of the community where their patients lived. They recognised and valued the role of education for not only members of the practice team but also for patients. Evidence of this was apparent in all our discussions with the practice team and with the patients and members of the patient participation group (PPG) we met. A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

The senior partner, temporary practice manager and the staff team shared an enthusiasm and commitment for developing and improving the practice. The temporary practice manager had introduced a structured business plan to help the practice prioritise developments.

Governance arrangements

The practice was improving their governance framework to help them manage and develop the service they provided. Features of good governance were already in place but in the past these were not always formalised. During the inspection we found that the practice had made good use of the services of a temporary practice manager to help them identify areas of weakness and make improvements.

- The practice had a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- The partners had an in-depth understanding of the performance of the practice including the areas where they needed to improve.
- The practice used clinical and other audits to monitor quality and to make improvements.
- The temporary practice manager was developing a practice specific 'quality dashboard' to help the practice monitor its performance.
- The practice had good processes for identifying, recording and managing risks.
- The practice commissioned a clinical risk assessment visit by the Medical Protection Society during 2014 to support them in identifying risk and making improvements to patient care.
- The practice engaged with the local clinical commissioning group (CCG), the commissioning programme board.

Leadership, openness and transparency

The senior partner demonstrated that they were a capable and effective leader. They were approachable and had a relaxed relationship with the practice team. They and the other partners had a range of experience, training and commitment to run the practice well and ensure high quality care. Staff were positive about the support they received from the GPs and one member of the team described them as fabulous.

The atmosphere at the practice was calm, warm and friendly and we observed that staff were smiling, laughing and working together well as a team. The practice had a whistleblowing policy and staff were aware of this. They told us they would not hesitate to report any concerns they might have because the partners and other GPs were approachable.

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

The practice had an active PPG. We met with two members of the PPG during the inspection. They felt the practice worked well with them and valued their contribution and that of patients in general. They told us that the practice had made several changes based on NHS Friends and Family feedback and views shared by the PPG. We saw an action plan signed by the PPG and the senior partner detailing the following changes –

- Three receptionists to be on the desk at all times and appointments and medicines requests to be dealt with at separate desks to reduce the time patients were queueing
- A barrier to be put in place to ensure privacy by preventing patients from being too close to the patient being dealt with before them.
- Provision of a self-booking in screen for patients to register that they had arrived.

Are services well-led?

Good

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

The practice was aware that the NHS national GP patient survey reflected lower than average performance in many of the areas covered. The temporary practice manager planned to review these results to help the practice consider what improvements were needed. We saw that the senior partner had used their own 2014 results to contribute to the evidence for their annual appraisal. Their individual survey results showed satisfaction rates between 92% and 100% across 11 topics.

The practice had also provided opportunities for staff to express their views during staff meetings and staff appraisals. Staff told us the partners listened to them and felt they could voice their views.

Innovation

The senior partner was actively involved in the CCG and a member of the local clinical commissioning board. The practice was proactive in considering how they could increase access to services in the evenings and mornings. They told us that in order to be well placed to do this they had joined a local bid by My Healthcare for Prime Ministers Challenge Funding for an extended hours GP scheme. The bid had been successful and the management team for My Healthcare were in the process of finalising collaboration arrangements. After the inspection the practice informed us that the extended hours service was up and running.

Charles Road Surgery was 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; Charles Road Surgery had three. The practice was also a teaching practice and provided placements for medical students who had not yet qualified as doctors.