Summerfield Group Practice

Quality Report

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

Ratings

Overall rating for this service	Good
Are services effective?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We previously carried out an announced comprehensive inspection at Summerfield group Practice on 7 November 2016. The overall rating for the practice was good; however, the practice was rated as requires improvement for providing effective services. The full comprehensive report on the November 2016 inspection can be found by selecting the 'all reports' link for Summerfield group Practice on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 6 December 2017 to confirm that the practice had carried out their plan to make improvements in relation to the effectiveness of quality improvement activities; the management, monitoring and improvement of outcomes for people; as well as improving patient satisfaction in areas such as access we identified in our previous inspection on 7 November 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice continues to be rated as good.

Our key findings were as follows:

- Since our previous inspection, the practice improved their use of quality assurance activities. For example, clinical audits demonstrated quality improvements.
- Data from the 2016/17 Quality and Outcomes Framework showed patient outcomes were comparable to local and national averages in most areas. However, outcomes for diabetes care were lower than local averages. Staff were aware of areas which required further improvements and unverified data provided by the practice demonstrated that they were working towards 2017/18 targets.
- Staff were aware of the complexity of the patient population group and worked with other health care professionals to improve engagement and increase the uptake of national screening programmes.
- Since our previous inspection, the practice implemented measures to ensure all equipment calibration checks were carried out and contracts for annual checks were in place.
- Data provided by the practice showed that the carers register had eight patients (0.1% of the practice list). Staff we spoke with during our inspection, explained low identification of carers was reflective of the young patient population. Since our previous inspection, the practice had reviewed their carers list and a designated member of staff was in charge of maintaining and updating carers' records. There were posters in the reception area and the new patient registration form supported the identification of carers.
- During our previous inspection, staff explained the practice had increased their phone lines in order to improve access and patient satisfaction.
- Data from the national GP patient survey published July 2017 showed that 54% found it easy getting through to the practice by phone, compared to local

Summary of findings

averages of 60% and national average of 71%; demonstrating a 2% improvement since our previous inspection. The practice also carried out their own survey which identified 76% of patients found it easy to get through by phone and 23% found it hard.

However, there were also areas of practice where the provider should make improvements. For example:

- Establish a system for sharing national guideline updates and learning from quality assurance activities.
- Continue working with community health teams and establishing effective processes to improve the uptake of national screening programmes and the uptake of childhood immunisations.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summerfield Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector and a GP specialist advisor.

Background to Summerfield Group Practice

Summerfield Group Practice is located at Summerfield Primary Care Centre, 134 Heath Street Winson Green, Birmingham, B18 7AG. The practice is situated in a multipurpose modern built building, shared with other neighbouring practices (one of which is an urgent care centre) and community health teams providing NHS services to the local community. Further information about Summerfield Group Practice can be found by accessing the practice website at www.summerfieldgroupppractice.co.uk

Based on data available from Public Health England, the levels of deprivation in the area served by Summerfield Group Practice showed the practice is located in a more deprived area than national averages, ranked at one out of 10, with 10 being the least deprived. (Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial). The practice serves a higher than average patient population aged under the age of 44. The number of patients aged 45 to 75 and over is below local and national averages. Based on data available from Public Health England, the Ethnicity estimate is 6% Mixed, 40% Asian, 22% Black and 3% other non-white ethnic groups.

The patient list is 6,800 of various ages registered and cared for at the practice. Services to patients are provided under an Alternative Provider Medical Services (APMS) contract with the Sandwell and West Birmingham Clinical Commissioning Group (CCG). APMS is a contract between general practices and the CCG for delivering primary care services to local communities.

The surgery has expanded its contracted obligations to provide enhanced services to patients. An enhanced service is above the contractual requirement of the practice and is commissioned in order to improve the range of services available to patients.

On-site parking is available with designated parking for cyclists and patients who display a disabled blue badge. The surgery has automatic entrance doors and is accessible to patients using a wheelchair and push chairs.

Practice staffing comprises of two GP partners (both male). The partners rarely work clinical sessions at this practice; however, they provide managerial and clinical support to the practice manager and GPs at the practice. The clinical team also includes six locum GPs (4 male and 2 female), and a practice nurse. The non-clinical team consists of one practice manager and a team of administrators, secretaries and receptionists.

The practice is open between 8am and 8pm Mondays to Fridays.

GP consulting hours varied between the clinical staff but usually ranged from 9am to 12.30pm and 2pm to 7.30pm Mondays, Wednesdays, Fridays; and 2pm to 6.30pm Tuesdays and Thursdays. The practice is part of the Primary Care Commissioning Framework (PCCF) and work jointly with other practices to improve access. This enabled access to appointments from four neighbouring practices between 8am and 8pm Mondays to Saturday.

The practice has opted out of providing cover to patients in their out of hours period. During this time, services are provided by Primecare who provides out of hours services.

Detailed findings

Why we carried out this inspection

We undertook a comprehensive inspection of Summerfield Group Practice on 7 November 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as good; however, required improvement for providing effective services. The full comprehensive report following the inspection 7 November 2016 can be found by selecting the 'all reports' link for Summerfield Group Practice on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Summerfield Group Practice on 6 December 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the effectiveness' of the quality of care provided to people and to confirm that areas where the practice were performing below local and national averages had improved.

Good

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 7 November 2016, we rated the practice as requires improvement for providing effective services as the arrangements in respect of sharing NICE guideline updated; management and improving outcomes for people; the use of quality assurance activities and the uptake of national screening programmes needed improving.

These arrangements had improved when we undertook a follow up inspection on 6 December 2017. The practice is now rated as good for providing effective services.

Effective needs assessment, care and treatment

The practice carried out monthly clinical meetings. Staff we spoke with explained that since our previous inspection NICE guidelines were added to the standing agenda item. Meeting minutes we viewed did not demonstrate that guidelines were being discussed during clinical meetings. Staff we spoke with explained clinicians had access to guidelines online; however, the practice had not established a process which provided them with assurance that guidelines were being accessed to improve awareness and compliance with recommendations.

Clinical audits were completed and audits we viewed demonstrated improved outcomes for patients. During our inspection, the lead GPs explained following our feedback they were implementing a more structured process which would enable them to better monitor that NICE guidelines and standards have been put into practice.

Older people:

- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan. Data provided by the practice showed that over a 12 month period the practice had offered 50 patients a health check. Forty five (90%) of these checks had been carried out.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Since our previous inspection, the practice introduced face-to-face joint clinics which involved a diabetic specialist nurse and a community Diabetologist (an expert or specialist in the study and treatment of diabetes mellitus) to improve care monitoring and care provided. Unverified data we viewed during our inspection showed that the practice was currently performing at 64%; clinicians continued working towards improving QOF performance and were on track to achieving their 2017/18 targets.
- Overall performance for diabetes related indicators remained at 74% since the previous 2015/16 QOF year which was lower than the CCG average of 89% and national average of 91%. We looked at the most recently published data in detail and found that performance for some areas such as, foot examinations, referral to a structured education programme and patients recorded as had received a flu vaccination remained either above or comparable to local and national averages. However; patients whose last measured total cholesterol was within recommended range was 65% (2% decline since our previous inspection), which was below local and national averages. 2017/18 unverified data showed that at the time of our inspection, 64% of patients were within recommended range and the practice were on track to achieve 2017/18 targets.
- 61% of patients had a HbA1c (a measure of how well diabetes is being controlled) reading within a specific range in the preceding 12 months, compared to CCG average of 80% and national average of 79%. This demonstrated a 4% decline since the previous QOF year.
- Exception reporting rates for patients with atrial fibrillation treated using recommended therapy remained above local and national averages. For example, 50%, compared to local averages of 19% and national average of 15%. We looked at anonymised records of all patients on the register, none were excluded and records showed that these patients were well managed.
- Long-term conditions such as Asthma and Chronic Obstructive Pulmonary Disease (COPD) and

Good

Are services effective?

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hypertension were managed in line with local and national targets. Smoking cessation advice was given during all consultations and referral pathways to external services had been established.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Data provided by the practice showed that uptake was below local and national averages. For example, 74% of two year olds were fully immunised and 72% of five year olds received their full course of immunisations. Members of the nursing team pro-actively encouraged parents to attend clinics, worked closely with child health and communicated with health visitors.

Working age people (including those recently retired and students):

- 2016/17 data showed that the practice's uptake for cervical screening was 72%, which was in line with the 80% coverage target for the national screening programme. However, this data demonstrated a 7% decline since our previous inspection.
- The practice had a young transient patient population group with a high number of non-English speaking patients. Staff we spoke with were aware of the barriers and their uptake rates.
- Staff we spoke with explained action taken to improve screening rates. For example, there was a policy to offer telephone reminders and staff followed detailed flow charts which enabled timely follow up invitation letters for patients who did not attend for their cervical screening test. Leaflets were available in various languages and posters were located in reception areas. The practice had a failsafe system in place to ensure results were received for all samples sent for the cervical screening programme; this included following up women who were referred because of abnormal results.
- 2015/16 data showed that the practice was below local and national averages for the uptake of breast and bowel cancer screening. Staff explained that following patient feedback the practice obtained information leaflets in various languages' and staff were opportunistically encouraging patients to engage in testing. During the summer of 2017 the practice promoted an event with other services within the health centre aimed at bowel cancer screening; nurses from the screening team and staff from cancer charities attended the event. Staff we spoke with explained that attendance was quite low; however, they were planning on repeating the event in March 2018. The practice also received support from their patient participation group (PPG) who spoke with patients in the reception area.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. Staff we spoke with explained that due to the young patient population group they were pro-actively offering health assessments and checks including NHS checks to patients aged 25-40. Data provided by the practice showed that between November 2016 and October 2017 53 health checks had been carried out. Staff explained that they carried out an audit to assess the impact of offering these health assessments. For example, patients at risk of developing diabetes were identified and referred to national programs; patients identified with a level of cholesterol which were not high enough to be treated with medicines were referred to well-being services to reduce the risk of medical intervention.

People whose circumstances make them vulnerable:

- There was a lead clinician in charge of end of life care; the practice maintained a list of palliative care patients. An anonymised check showed that patients were well managed; with evidence of care reviews and communication with palliative care teams.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- Data provided by the practice showed that they had 13 patients on the practice learning disability register who were eligible for a health check. Unverified data showed that the number of patients who received a health check since our previous inspection increased from two (14%) to nine (69%). Staff explained that they improved

Good

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(for example, treatment is effective)

their performance by proactively calling patients and their carers in for their reviews. Staff members were in change of managing the patient list and monitored engagement.

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

- Patients diagnosed with dementia had their care reviewed in a face-to-face meeting in the previous 12 months. Although the number of patients reviewed was lower than the national average; the practice had a small number of patients diagnosed with dementia.
- 92% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is comparable to the local and national average. However, data demonstrated an 8% decline since our previous inspection. Unverified data (2017/18 QOF) showed 71 patients on the practice mental health register; 68% had a care plan in the last 12 months, with an 8% exception reporting rate. We saw that patients were being invited in for reviews; clear communication pathways established with the community mental health teams and the practice continued working to improve the completion of care plans.

Monitoring care and treatment

There was evidence of clinical audit being used to drive quality improvement. Staff told us following our previous inspection, the practice had reviewed their programme of quality improvement activities such as clinical audits and had completed five audits. From the audits we viewed, we saw that actions carried were effectively implemented and monitored. For example, a second cycle audit relating to identification of patients with pre-diabetes and referral rates to national diabetes program demonstrated quality improvement. The first audit showed 100% of eligible patients' were offered advice around lifestyle; however, 7% were referred to the national diabetes programme. The second audit carried out November 2016 to October 2017 showed referral rates increased to 98%. Although audits demonstrated quality improvements, the practice did not establish an effective method to share learning throughout the clinical team.

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. The most recent published QOF results were comparable to the previous QOF year. For example, 91% of the total number of points available compared with the clinical commissioning group (CCG) average of 98% and national average of 96%. However, performance for diabetes care was below local and national averages. The practice had a protocol in place for reviewing patients and monitoring QOF performance. This included sending appointment reminder letters to identified patients; which was then followed up by phone calls to encourage patients to attend appointments and required reviews**.** Unverified data provided by the practice demonstrated they were working towards 2017/18 targets; and improving the quality of care provided. The overall exception reporting rate remained below national average, for example 7% compared to the local and national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice). Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.

- Staff we spoke with were aware of QOF performance and able to demonstrate actions taken since our previous inspection to improve areas where performance was below local and national averages. For example, patients diagnosed with diabetes had access to designated specialist clinics. An anonymised sample of records we viewed showed staff were following established protocols for managing QOF indicators and where required appropriate decisions were made to remove patients from QOF calculations

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Since our previous inspection, all clinicians had completed on-line Mental Capacity Act training.
- Clinicians we spoke with during our inspection, understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

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- The practice monitored the process for seeking consent appropriately.