Dr Patrick Gonsalves

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Requires improvement
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 inspection at Kingstanding Road Surgery on 23 February 2015, when the practice was rated as inadequate and placed into special measures. This was followed up with an inspection on 21 October 2015 to determine if actions had been completed in response to warning notices issued as a result of the previous inspection.

We found on the inspection on 21 October 2015 that improvements had been made but the rating was not changed as a new comprehensive inspection was required in line with CQC process. Therefore, we carried out an announced comprehensive inspection at Kingstanding Road Surgery on 29 January 2016 to determine if sufficient improvements have been made to allow the practice to be taken out of special measures and review the practice rating.

Following the inspection carried out on 29 January 2016 the overall rating of the practice is good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment and that there was continuity of care, with urgent appointments available the same day.
- The practice had adequate facilities and had the appropriate equipment and resources to treat patients and meet their needs.

Summary of findings

- The practice had joined with Modality Partnership and were in the process of amending their CQC registration. This had resulted in a clear leadership structure and management model. Staff reported that they felt supported by management.
- The practice proactively sought feedback from staff and was seeking to engage with patients to gain their views and act on them. For example, by raising awareness in the waiting area regarding feedback. They were taking steps to re-establish the patient participation group.

The areas where the provider should make improvement are to:

- Carry out risk assessments regarding emergency equipment and contents of GPs bags.
- Continue to carry out audit to monitor and demonstrate improvement in patient outcomes.
- Proactively seek to identify carers in the practice.

I confirm that this practice has improved sufficiently to be rated 'Good' overall. The practice will be removed from special measures.

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.

- There was an effective system in place for reporting and recording significant events and safety incidents.
- Lessons were shared to ensure action was taken to improve safety in the practice.
- Since the last inspection there had not been any safety incidents, however, the practice demonstrated openness and honesty regarding issues concerning safety and we saw a process in place for addressing safety incidents and staff were aware of this.
- The practice, under the direction of Modality Partnership, had introduced clearly defined systems, processes and practises to keep patients safe and safeguarded from abuse which staff were aware of and demonstrated commitment to.
- We saw that systems had been introduced that ensured the risks to patients were assessed and well managed.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. Some improved outcomes were evident, and whilst insufficient time has elapsed to demonstrate the full outcomes of the improvements, the systems and processes we saw that had been introduced indicated that improvements should achieve demonstrable positive outcomes evident within six months.

- Systems had been introduced to collate accurate data for the Quality and Outcomes Framework and showed outcomes had improved in the three months since Modality had been working with the practice.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- The practice had carried out clinical audits which demonstrated quality improvement.
- The practice had introduced continued access to training for staff who demonstrated they had the skills, knowledge and experience to deliver effective care and treatment.
- The practice had now introduced appraisals and personal development plans for all staff.

Practice staff had engaged with multidisciplinary team members to understand and meet the range and complexity of patients' needs.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the National GP Patient Survey showed patients rated the practice higher than others for most aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- The practice had introduced information, posters and leaflets for patients in the waiting area and reception about the services available, which were easy to understand and accessible. Carers information was clear and there was signposting information available regarding support organisations.
- We saw staff treated patients with kindness and respect, and maintained confidentiality for both patients and information relating to patients.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice reviewed the needs of its population and was implementing changes to address areas where services required development. The practice engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified, for example, they were reviewing the need for more services to be delivered in the community such as dermatology and rheumatology.
- Patients said they found it easy to make an appointment with a GP and there was continuity of care, with urgent appointments available the same day. Patients also spoke positively about the access to a female GP.
- The practice had the appropriate facilities and equipment to treat patients and meet their needs and there were facilities for patients with mobility difficulties and a disabled toilet.
- The practice had introduced information about how to complain and made this available and easy to understand for patients in the reception area. They had implemented a robust system for dealing promptly with complaints in line with national guidance and we saw this had been implemented and adhered to. The practice ensured that learning from complaints was shared with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had joined with Modality Partnership in December 2015 and had adopted the Modality business and leadership model, using standardised systems. As a result we saw that:

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to this.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings with practice staff and organisational management meetings which allowed sharing of expertise and learning.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. Staff we spoke with were all aware of this and reported they felt involved in the practice and spoke positively about the changes implemented since the partnership with Modality.
- The GPs and practice manger encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents which ensured information was shared with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients, which it acted on. Whilst the patient participation group was not currently active, the practice was taking measures to re-establish the group and was seeking patient views using other methods in the meantime. For example, comments cards and feedback from the Friends and Family Test.
- There was a strong focus on continuous learning and improvement at all levels and we saw staff training was available and that staff engaged in learning opportunities provided.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population, such as screening for frailty to prevent falls.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs. Housebound patients who required a flu vaccination were visited at home by the practice nurse who also carried out a health review at that time.
- The practice were pro-actively identifying patients with heart failure to improve the way they structured their care.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- The nurse and GP led care in chronic disease management and were well supported by reception staff who were proactive in calling patients who had been prioritised for review to increase attendance and uptake of the service offered.
- Longer appointments and home visits were available when needed.

All these patients had a named GP and structured annual reviews were being arranged to check their health and medicines needs were being met. For those patients with the most complex needs, the practice liaised with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations.
- Children and young people were treated in an age-appropriate way and were recognised as individuals, and we spoke to a patients during our inspection who confirmed this.

Summary of findings

- Cervical screening was offered to patients and a female doctor and nurse were available to encourage uptake, which was comparable with the national average.
- Appointments were available outside of school hours and patients told us the practice was responsive to childhood illness and always saw children urgently if necessary.
- The practice had taken steps to establish improved joint working with midwives, health visitors and other members of the primary health care team. They had made contact with community colleagues and put measures in place to continue contact if issues arose and ensure sharing of information.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering services such as smoking cessation as well as a health assessments and new patient medical assessments.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability and all patients in this group had been seen.
- The practice offered longer appointments for patients with a learning disability.
- The practice had made contact with members of the multi-disciplinary teams to make themselves known and encourage improved communication regarding the case management of vulnerable people.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations, such as alcohol abuse support.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- The practice were working to improve the accuracy of all disease registers including that of patients diagnosed with dementia.
- They were developing relationships with the multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.
- The practice told patients experiencing poor mental health about how to access various support groups and voluntary organisations such as IAPT and MIND.
- There was a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia and we saw that staff had undertaken dementia awareness training.

Summary of findings

What people who use the service say

The national GP patient survey results published in January 2016. The results showed the practice was performing in line and above the local and national averages in many areas. 382 survey forms were distributed and 109 were returned. This represented 7% of the practice's patient list.

- 90% found it easy to get through to this surgery by phone compared to a CCG average of 62% and a national average of 73%.
- 85% were able to get an appointment to see or speak to someone the last time they tried (CCG average 81%, national average 85%).
- 85% described the overall experience of their GP surgery as fairly good or very good (CCG average 83%, national average 85%).
- 66% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 74%, national average 78%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 39 comment cards which were all positive about the standard of care received with the exception of two which expressed dissatisfaction with communication in the practice and one expressed a long wait for the GP when at the practice. However, almost all patients expressed satisfaction and specifically commented on the kind and courteous staff, some patients remarked they had been with the practice for many years and had always felt well cared for.

We spoke with four patients during the inspection. All four patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Patients commented that it was helpful to have a female GP at the practice.

Areas for improvement

Action the service SHOULD take to improve

- Carry out risk assessments regarding emergency equipment and contents of GPs bags.
- Continue to carry out audit to monitor and demonstrate improvement in patient outcomes.
- Proactively seek to identify carers in the practice.

Dr Patrick Gonsalves

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 adviser and a practice nurse specialist adviser.

Background to Dr Patrick Gonsalves

Kingstanding Road Surgery has to date been a single-handed GP practice which provides primary medical serves under a general medical services (GMS) contract to a population of approximately 1,471 patients in the Kingstanding area of Birmingham. The registered provider Dr Gonsalves, has been absent from the practice since October 2015, since which time Modality Partnership had been caretaking the practice. In December 2015 Dr Gonsalves joined the Modality Partnership, although the registration details with the Care Quality Commission remained unchanged at the time of the inspection. However, the practice has now made an application to amend the registration details.

The practice has a slightly higher number of patients between the ages of 40-55 and 60 to 80 years. Data from Public Health England shows that the area is one with significantly lower levels of deprivation compared to the rest of England.

At the time of this inspection, in the absence of the GP provider the practice had clinical sessions provided from two male GPs from the Modality Partnership and a regular locum female GP, there was an interim practice manager also provided from Modality, a practice nurse, and four reception staff.

The practice is open Monday to Friday mornings from 8am to 1pm and afternoons from 3.30pm until 6.30pm, with the exception of Thursdays when the practice closes at 4.30 and Mondays when extended hours appointments are provided until 7.30pm.on Mondays. When the practice is closed between 1pm and 3.30 patients are given the number to call to access a doctor if they need one urgently. The practice has opted out of providing out-of-hours services for their own patients and this is provided by an external out of hours service. Patients are advised of how to contact the out of hours (OOH) service outside of practice opening hours via an answer phone message which also provides medical cover between 1pm and 3.30pm.

Why we carried out this inspection

In our previous inspection in February 2015, the practice was rated as inadequate overall. Practices placed in special measures are inspected again within six months of the final report being published. We inspected the practice again in October 2015 to ensure that actions regarding the warning notices issued had been completed and found that they had been. Therefore, in line with CQC process we carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a new rating for the service under the Care Act 2014.

Detailed findings

How we carried out this inspection

Before inspecting the practice, we reviewed a range of information which the practice had sent to use and information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 29 January 2016.

During our inspection the registered provider was still absent from the practice, therefore we spoke a range of staff from Modality Partnership who are working at the practice including the medical director and a GP as well as the regular locum GP. We also spoke with the interim practice manager from Modality and the practice manager who will be managing the practice in the near future and the governance manager from Modality as well as the practice nurse and two reception staff.

- We observed how staff dealt with patients attending the practice and their relatives.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

During our inspection in February 2015 the practice did not have a system in place to deal with significant events. However, the practice had introduced a robust system and staff we spoke with were all aware of the process of how to report incidents. We saw that the Modality Partnership had reported and investigated three incidents and had produced a log of these with documented actions. Clinical significant events were investigated by GPs and non-clinical events by the practice manager. These were reported at clinical meetings and staff were made aware of the outcomes to ensure learning had taken place and to prevent recurrence. Clinical staff within the Modality Partnership received external peer review from other GPs in the partnership.

Staff told us they would inform the practice manager of any incidents and there was a recording form available in reception for staff to complete. Non clinical staff were made aware of any significant event outcomes at their meetings which were held bi-monthly.

We saw that safety records, incident reports and national patient safety alerts had been actioned and saw the practice had been incorporated in the group organisational meeting where safety alerts and issues had been discussed. We saw the last meeting had taken place in January 2016. Lessons were shared to make sure action was taken to improve safety in the practice. For example, there had been an delay in referral to secondary care which had been investigated and identified as a training issue which resulted in additional staff training to prevent recurrence.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again. For example, we saw how a patient had been affected by a prescription error which, whilst, had not been attributable to the practice staff, they had ensured that the appropriate action had been taken. An explanation had been given to the patient who was supported by the practice by referral for specialist advice as a precautionary measure.

Overview of safety systems and processes

During the time since October 2015 when Modality Partnership had become involved with the practice they had introduced clearly defined systems, processes and practices to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The practice manager had contacted the health visitor to establish a relationship with them in order to make them aware of any safeguarding concerns regarding children and links had also been made with the district nursing staff and community matron. Staff demonstrated they understood their responsibilities, for example a member of the reception staff was able to give an example of when they noted a child had attended A&E many times and they had highlighted it to the GP. All staff had received training relevant to their role and GPs were trained to Safeguarding level 3. The practice had contact with the midwife who attended the practice fortnightly and staff knew where to contact the health visitor if they needed to. The contact details for the health visiting team were also made available in the reception area for patients to access. Staff told us that alerts were put on the computer system to inform staff if patients were vulnerable.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service check (DBS check). (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). We spoke with staff regarding their chaperoning role and they were able to demonstrate the correct procedure and where to stand.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy and patients reported that they found the practice clean and tidy. The practice had cleaning schedules in place and in addition to checking these were completed, the practice manager told us

they carried out a monthly walk around of the premises to check the standard of cleaning. The practice nurse was the infection control clinical lead was new to this role and we saw that they had received training to assist them to carry out the role effectively. They liaised with the local infection prevention teams at the CCG to keep up to date with best practice.. The practice were carrying out monthly infection control audits and we saw evidence to demonstrate this and the audit compliance rate was 96%. There was an infection control protocol in place and staff had received up to date training for example, hand hygiene training organised by the CCG.

- The practice did not keep medicines on the premises with the exception of emergency drugs and vaccinations. No medicines were carried in the GPs bags used for home visits as the practice. The arrangements for emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice had a system for checking and recording fridge temperatures which was appropriate.
- The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Prescription were securely stored in a locked cabinet, although, we noted there was no process for recording the serial number.. However, the practice addressed this immediately and provided evidence to confirm this had been implemented showing a form that was completed when a prescription was taken. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. We saw evidence of these and noted they were appropriate and in date.
- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment with the exception of one member of staff where proof of previous employment was still required, although the staff member had been employed prior to the involvement of Modality Partnership. The practice manager had reviewed this and taken measures to ensure the staff member was suitable for employment. All other areas of the recruitment process were complete. We saw that for all other staff for example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service had been carried out.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available and the practice manager was the lead for this. The practice had commissioned a full fire assessment with a report which contained actions. As a result the practice had implemented monitoring and staff training in line with the recommendations. All electrical equipment had been checked to ensure the equipment was safe to use and clinical equipment had been calibrated and checked to ensure it was working properly. The practice had commissioned the service of an external contractor to carry out both equipment and electrical testing and we saw this had been done within an appropriate timescale. There was a system in place to ensure this was automatically carried out at regular intervals. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings) and had an employment safety handbook as well as a safety checklist.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice rarely used locum staff other than the regular locum we spoke with on the day. However, if there were staffing issues they were managed by the practice manager who told us resources could be acquired centrally. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

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

Good

Are services safe?

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. The GPs also had a foot press button in their consulting rooms to alert staff.
- All staff had received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks although we noted there were no child pads for the defibrillator. A first aid kit was also available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurse assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. They had access to web-based learning tools containing evidence based best practice They followed a defined locality led approach to care and treatment agreed by the clinicians within Modality Partnership.

We saw that NICE guidance was a standing agenda item at clinical group meetings and issues that had arisen which may have affected care as well as raising awareness to new guidance were discussed. For example, we noted the clinical group had discussed diabetes care plans and missed referrals to secondary care and had had a presentation on the significant event relating to this. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs. We saw that a link was provided for staff to access the new guidance in the agenda of clinical meetings.

Management, monitoring and improving outcomes for people

The practice had not previously submitted information for the Quality and Outcomes Framework (QOF) and therefore we were unable to make comparisons from the year 2014 to the end of March 2015. (QOF is a system intended to improve the quality of general practice and reward good practice). However, since the involvement of Modality Partnership from October 2015 the practice demonstrated they were reviewing and updating disease registers and were introducing systematic processes of maintaining registers such as diabetes, chronic obstructive pulmonary disease and mental health. We saw they had identified and prioritised initial specific areas of focus and the practice could demonstrate progress as a result of this. For example, areas such as depression, cancer, dementia, diabetes and cytology.

From October 2015 we noted month on month improvement from 77% in November 2015 to 81% January 2016 with a target of 92% for the end March 2016 for diabetes management. Similarly cervical cytology screening was at 70% in November 2015 and had increased to 75% in January 2016 with a target of 80%. The practice had involved all staff in progressing this work. The GPs and nurse had developed a system to identify and prioritise patients and the reception staff contacted patients by phone or letter to promote uptake of the service. We saw that the practice had been monitoring monthly to determine where to focus and assess their progress and effectiveness. All staff reported being involved in this process.

Modality Partnership had introduced comprehensive care plans and templates to facilitate this ongoing work. Performance was discussed at the practice monthly clinical meetings as well as at the Modality clinical management group meeting to determine actions to be taken in areas of lower achievement. In view of the short time that had elapsed since the partnership with Modality was formed, the long term improvements were yet to be fully demonstrated. However, the systems and processes that had been introduced together with the commitment from the staff and good leadership indicated during that improvements should be evident in the next six months.

The practice had engaged in clinical audits to demonstrate quality improvement although these had not been complete audits due to the short time scale that Modality had been involved in the practice. However, two single cycle audits had been undertaken regarding medicines which had resulted in actions being taken to improve quality of care. For example, we saw where patients had been provided with more information regarding their medications and record keeping had been improved as a result. The practice had also participated in a local audit regarding antibiotic prescribing in line with the pan Birmingham Primary Care anti-microbial prescribing guidelines which alerted them to more efficient and effective prescribing and pre-empted the introduction of an action plan to address areas of improvement.

The practice participated in local audits, national benchmarking, accreditation, peer review and research and received peer review from other GPs in practices in the Modality Partnership. Information about patients' outcomes was used to make improvements, for example, we saw that diabetes care plans and missed referrals had been discussed at the clinical management group meeting to determine actions necessary.

We saw the practice had a system for coding of admissions to hospital and reviewed these to determine the need for

Requires improvement

Are services effective?

(for example, treatment is effective)

follow up by the GP. Care plans were in place for those patients who had had contact with the paramedics. The practice carried out reviews to highlight anomalies and identify areas of focus for investigation, education and quality improvement, for example, higher than anticipated diagnoses of cancer. Whilst some audit work was in progress there had been insufficient time to demonstrate improved outcomes for patients.

Effective staffing

During our inspection in February 2015 there was little recognition of the benefit of appraisal and there were gaps in training and therefore insufficient evidence that staff were equipped to carry out their role and able to provide effective care and treatment.

When we inspected the practice on 29 January 2016 we found that changes had been implemented and all staff had access to online training and we saw evidence that this had taken place for all staff. Following our discussions with staff we found they had the skills, knowledge and experience to deliver effective services for patients. For example, all staff had undertaken mandatory training such as cardio pulmonary resuscitation (CPR), safeguarding, infection control, conflict resolution, dementia awareness, equity and diversity and fire safety in addition to other areas which they identified as useful in their role. The nurse had completed mental capacity act training.

The practice now had an induction programme for all newly appointed staff. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. The practice had sought the services of a specialist human resources company to assist with this process that had carried out a health and safety assessment and provided an employment safety handbook which staff received on joining the practice.

The practice could demonstrate how they ensured role-specific training and updating for relevant staff, for example, for those reviewing patients with long-term conditions such as coronary heart disease. We noted the practice nurse was undertaking training in electro cardio gram recording (ECG) and had already completed cytology, immunisation and smoking cessation update training in 2015. As well as online training, staff were able to access other training from external sources when necessary as well as protected learning time and they were able to access training from the local hospital trust lunch time sessions which were open to GPs and nurses.

The practice had introduced appraisal for staff all since October 2015 and staff we spoke with confirmed they had received an appraisal and reported it had been a positive process and they had been able to identify training and development needs, for example one member of staff had identified the need for training in the Choose and Book process. The nurse told us they were supported with protected time for attending training courses relating to their role. Staff told us that as well as appraisal they felt they could approach the practice manager at any time if they felt they needed any training or development and it was not necessary to wait for appraisal. Staff received training that included safeguarding, fire procedures, basic life support and equity and diversity and we saw records to demonstrate this.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. Clinical staff told us they were developing systems regarding follow up after hospital admissions but were initially commencing a two week follow up of patients discharged from hospital with chronic obstructive pulmonary disease. They received information electronically to facilitate this process and the practice told us work was ongoing for other areas. GPs and the nurse had access to and referred to other services when appropriate and necessary and shared relevant information with other services in a timely way, for example when referring patients to hospital or other community services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. We saw evidence that practice meetings took place on a monthly basis and members of the multi-disciplinary team were invited. The practice manager had made contact with other members of the primary care team such as the health visitor and invited them to practice

meeting, but told us that if they did not attend any information that was relevant would be conveyed to them by telephone and that the practice manager was responsible for this.

The practice were also working with other practices in the CCG exploring the development of locality clinics for minor surgery, dermatology, rheumatology provided by GPs with special interest and skills in those conditions which would provide care closer to home.

Consent to care and treatment

The practice staff sought patients' consent to care and treatment in line with legislation and guidance. Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and we saw the nurse had received training in this and the GPs demonstrated knowledge of this.

The practice did not carry out any invasive procedures but had recently introduced consent forms for ear syringing. The nurse demonstrated an understanding of the need for gaining consent when dealing with patients with learning difficulties and dementia and the need for different ways of providing information to patients to ensure understanding of procedures to be undertaken. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. One relative told us they attended an appointment with a young family member and the GP sought consent from the young person before discussing their treatment with them.

Supporting patients to live healthier lives

The practice told us they were continually developing and validating disease registers and had made progress but told us this work was still in progress and would remain ongoing to enable the practice to identify and understand the needs of the practice population. Support was offered to those in need of extra care. For example, the practice nurse attended the homes of housebound patients to provide a flu vaccination and also carried out an annual review of those patients over 75 years of age. The practice had plans to screen patients over 75 for frailty and risk of falls and to refer to appropriate services those who were at risk. All new patients are also offered a health review on registration.

The practice nurse offered smoking cessation sessions to those patients wishing to stop and also provided clinics for patients with diabetes and these patients were managed by the GP and practice nurse. Baby medical checks were offered at eight weeks of age together with the commencement of routine immunisation programme. The practice had good immunisation rates For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 88% to 100% and five year olds from to 94% to 100% which were above the CCG averages of 79% to 95% and 87% to 96% respectively. The practice's uptake for the cervical screening programme was 75% at the end January 2016, which was comparable to the national average of 81%.

The reception staff were proactive in contacting patients in all groups to invite them to attend for all screening and review of their chronic condition and the practice had a colour coded system to enable staff to identify which disease area patients were being called for. The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available.

Patients with learning difficulties had all been seen by the GP and there was bespoke written communication available for this group of patients to promote better understanding. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening and we saw posters in the waiting area advertising this.

Flu vaccination rates for the over 65s were at 66% at the end of January 2016 with the target being 75% and patients receiving the pneumococcal vaccine was 73% which showed a month on month increase since September 2015. The practice had identified a group of patients with heart failure and were developing a structured care programme for these patients.

Patients had access to appropriate health assessments and checks. Patients with mental health problems were referred to the improving access to psychological therapies (IAPT) service when necessary and patients who had alcohol related admission to hospital were referred to support services in the community following recording of the information in the practice. Any issues following health checks for new patients were referred to the GP for further

Requires improvement

Are services effective?

(for example, treatment is effective)

assessment or treatment. IAPT is a service offering interventions approved by the National Institute of Health and clinical Excellence (NICE) for treating people with depression and anxiety disorders.

The practice discussed with us plans they had for developing care and treatment within the practice but had acknowledged that this was an ongoing process which would take time to achieve and demonstrate outcomes.

However, it appeared from the discussions that this was achievable using the resources available from the Modality Partnership and their management model. Developing and pursuing already identified areas of chronic disease and the engagement in local projects to promote best practice was reported to be their focus along with the establishment and embedding of the robust systems they had recently introduced to support this.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff dealing with patients on the telephone and when they attended the practice and noted they were courteous, friendly and very helpful to patients and treated them with dignity and respect at all times.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- There was a sign in the reception area informing patients that a room was available for private discussion if they needed it and staff confirmed they would use this when necessary.

The majority of patient Care Quality Commission comment cards we received were positive about the service experienced. Patients commented on the good continuity of care and that they felt they were well cared for at the practice. There were comments regarding the caring and helpful reception staff and how they felt the GP listened to them. Patients commented that they felt the practice offered a good service and staff treated them with dignity and respect.

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

- 86% said the GP was good at listening to them compared to the CCG average of 88% and national average of 89%.
- 87% said the GP gave them enough time (CCG average 86%, national average 87%).
- 92% said they had confidence and trust in the last GP they saw (CCG average 95%, national average 95%)
- 86% said the last GP they spoke to was good at treating them with care and concern (CCG average 84%, national average 85%).
- 94% said the last nurse they spoke to was good at treating them with care and concern (CCG average 89%, national average 91%).
- 96% said they found the receptionists at the practice helpful (CCG average 84%, national average 87%)

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

- 84% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 86%.
- 83% said the last GP they saw was good at involving them in decisions about their care (CCG average 81%, national average 82%)
- 89% said the last nurse they saw was good at involving them in decisions about their care (CCG average 84%, national average 85%)

Patients we spoke with gave examples of when the GPs had given choices and explanations regarding treatment options and referral to secondary care services. They told us GPs always explained their condition and the medications they had been prescribed and felt involved in their care.

Staff told us that translation services were available for patients who did not have English as a first language and the lead GP was also multi-lingual.

Patient and carer support to cope emotionally with care and treatment

We saw notices in the patient waiting room advising patients how to access a number of support groups and organisations. For example, Alzheimer, dementia and cancer support groups. There was also a carers board providing information for patients who were carers which gave details of where to gain support and also how to register themselves as carers with the practice to ensure they were offered additional health preventative measures

Good

Are services caring?

such as flu vaccination. The practice's computer system alerted GPs if a patient was also a carer which showed 10 carers registered, and the practice had included a section in the new patient registration application for patients to inform them if they are a carer.

The practice had introduced a protocol which instructed staff to circulate details of patients who had died to alert the GPs who would then contact the family if appropriate. Reception staff were aware of support organisations and their contact details and provided these to patients when necessary.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice GP lead attended the local meetings with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice were engaged and supported the CCG in proposals to introduce more local community referral services to GPs with special interests in areas such as dermatology and rheumatology to provide care closer to home and prevent unnecessary attendance to hospital out-patient clinics.

- The practice offered later appointments on Mondays from 6.30 pm until 7.30pm for those patients who could not attend during normal opening hours.
- Longer appointments were available for any patients who needed them.
- Home visits were available for older patients and any patients who would benefit from these and those who were unable to attend the practice.
- Same day appointments were available for all patients if they were needed, specifically children and those with serious medical conditions and patients we spoke with confirmed this and expressed satisfaction at the good access to appointments.
- Patients were able to receive travel vaccinations available on the NHS which were provided by the practice nurse.
- There was a disabled toilet and the reception and waiting area were open and allowed free movement of patients with mobility aids. Translation services were available when necessary and one of the GPs was multi-lingual and spoke some of the more common languages of patients attending the practice.

Access to the service

The practice was open Monday to Friday mornings from 8am to 1pm and afternoons from 3.30pm until 6.30pm, with the exception of Thursdays when the practice closed at 4.30pm and Mondays when extended hours appointments were provided until 7.30pm.on Mondays. The practice has opted out of providing out-of-hours services for their own patients and this is provided by an external out of hours service (Primecare). Patients are advised of how to contact the out of hours (OOH) service outside of practice opening hours via an answer phone message. In addition to pre-bookable appointments, urgent appointments were also available for people that needed them. When patients called the practice between 1pm and 3.30pm they were provided with the contact number of the out of hours service who would escalate any urgent problems to the duty doctor during that time.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was in line with or above local and national averages in most areas.

- 72% of patients were satisfied with the practice's opening hours compared to the CCG average of 73% and national average of 75%.
- 90% patients said they could get through easily to the surgery by phone (CCG average 62%, national average 73%).
- 92% of patients said they could get an appointment to see or speak to someone the last time they tried (CCG average 82%, national average 85%).
- 92% of patients described their experience of making an appointment as good (CCG average 67%, national average 73%).

People told us on the day of the inspection that they were able to get appointments when they needed them and comment cards we received also confirmed this view.

Listening and learning from concerns and complaints

The practice had introduced a system for dealing with complaints in December 2015 when they joined with Modality Partnership, which was comprehensive and in line with national guidance. We saw there had only been one complaint since that time but that it had been responded to promptly and handled appropriately in line with their policy. The practice had investigated and determined the response required which was from the GP and this was in progress.

The practice had a complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The interim practice manager was the designated person responsible. They told us they had taken on this responsibility and that the outcomes of complaints were reported centrally and actions and learning points shared with clinical staff at practice meetings and reception staff bi-monthly. Whilst we were unable to see evidence sharing learning from this complaint, the procedure and process of sharing learning

Good

Are services responsive to people's needs?

(for example, to feedback?)

with staff was demonstrated and we were told this was to be discussed at the practice meeting in February 2016. Staff were aware of the complaints procedure and how to direct patients if they wanted to complain.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients, treating patients with dignity and respect in a pleasant atmosphere. Staff we spoke with were aware of the vision and understood their role in delivering this. The practice mission statement was displayed in the reception area.

The practice had joined with Modality Partnership in December 2015, therefore plans were still being developed regarding the future. However, whilst the practice was in a state of transition, the initial priorities had been identified and a robust strategy and supporting business plans had been introduced which reflected the vision and values. For example, the practice had immediately accessed organisational processes to support staff and patients. They had also commenced a progressive structured approach to disease management.

Governance arrangements

Since joining with the Modality Partnership the practice has had in an overarching governance framework which supported the delivery of the strategy and good quality care. The practice staff had access to direction, leadership, clear processes and procedures to support the delivery of safe care. This included:

- A clear staffing structure and we saw that staff were aware of their own roles and responsibilities
- The staff had access to practice specific policies which were implemented and were available to all staff. Staff we spoke with confirmed they had access to these and had been made aware of them by the manager.
- A comprehensive understanding of the performance of the practice was being established. This was using the Modality Partnership model and the performance of all practices was shared across the group in the performance dashboard. We saw evidence that this was an agenda item at the clinical management group meetings held monthly.
- A programme of clinical and internal audit had been introduced and we saw evidence of engagement in CCG audit programmes regarding prescribing and medicines management which was used to monitor quality and to make improvements.
- The practice had introduced robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions such as those regarding, infection control, safeguarding, fire assessment, equipment, premises and health and safety and we saw evidence that these had been carried out. We saw that staff had been trained in areas necessary to carry out their role.

Leadership and culture

The Modality Partnership had an organisational management model which facilitated leadership through GPs with the experience and allocated time to ensure the delivery of high quality care. The organisational structure and systems in place prioritised safe, high quality and compassionate care. Both the GPs and the management team were visible in the practice and staff we spoke with described the introduction of the new the management team as a positive one. They reported that they were approachable and had been helpful in assisting them into adapting to the new systems and ways of working. They reported a good supportive team approach and that the manager and GPs always took the time to listen to all members of staff.

The partners encouraged a culture of openness and honesty and staff we spoke with confirmed this. When there were unexpected or unintended safety incidents the practice gave affected people reasonable support, truthful information and a verbal and written apology. We saw that one of recorded incidents involved a prescription error where the patient received an apology and the incident was reported on the local reporting system and appropriate action was taken. The practice had systems in place for knowing about notifiable safety incidents and was aware of and was committed to comply with the requirements of the Duty of Candour.

The practice had introduced bi-monthly meetings for reception staff and the Modality Partnership held clinical meeting with all their GP partner practices who would feedback all the issues and learning points. The incorporation of all practices in the partnership facilitated an extended shared learning from significant events, complaints, and ensured staff were kept up to date with the latest guidance, safety alerts and practice performance. We saw evidence of the agenda of the latest meeting which confirmed these standard agenda items. Staff confirmed that the practice held regular team meetings and they felt

Are services well-led?

Good

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

involved in the practice. They felt respected, valued and supported both from their colleagues and management and GPs and reported positive improvements in the practice in all areas over the last few months.

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

We saw documentation to demonstrate that the practice had summarised the feedback for the previous 12 months and made suggestions to increase feedback and re-introduce the patient participation group. The practice had identified that feedback from patients could be more actively encouraged and had introduced measures to improve this. They had introduced posters into the waiting area to encourage patients to provide feedback to the service and told us that from December 2015 they had started to respond to patient comments on NHS choices. The practice had also displayed the Friends and Family cards to determine if patients would recommend the practice to relatives. There had been 42 responses 38 stated they were likely or extremely likely to recommend the practice to relatives. Feedback was shared with staff and the negative comments had been taken to the staff meeting for discussion to determine if any action could be taken.

The practice manager told us that a patient participation group (PPG) had been in place but the last record was from April 2015 and the new management had not been able to access the contact details of previous members. Therefore, Modality Partnership were taking steps to re-introduce a new patient participation group and had placed a poster in the waiting room advertising for patients to join. They had briefed reception staff to raise awareness to patients and arranged for notices to be added to prescriptions to make patients aware and encourage membership.

Feedback from staff occurred as and when it was necessary and staff told us they felt they could feedback to management at any time as well as during meetings and appraisal as the practice had an open door policy.

Continuous improvement

The practice told us they were focusing on embedding current improvements which had been introduced and establishing good call and recall systems for chronic disease management, but were also proactive in working with the CCG and other practices to develop services to promote care within the community. The practice was engaging in a local pan Birmingham primary care audit to improve antibiotic prescribing patterns.