University Medical Practice

Quality Report

University Medical Centre
5 Pritchatts Road
Edgbaston
Birmingham
B152QU
Tel: 0121 687 3055
Website: www.theump.co.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the University Medical Practice on 17 January 2017. Overall, the practice is rated as good.

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

- There was an open and transparent approach to safety and the practice had an effective system for reporting and recording significant events, and learning from them.
- Risks to patients and staff were assessed and well managed. Effective governance arrangements were in place.
- All staff were actively engaged in monitoring and improving quality and patient outcomes.
- Staff assessed patients' needs and delivered care and treatment in line with current evidence based guidance. They had the skills, knowledge and experience to deliver effective care and treatment.
- Staff had been very proactive in identifying and meeting the needs of their atypical patient population. They were highly committed to delivering services that recognised individual needs, promoted equality and provided flexibility, choice and continuity of care.
- Data from the NHS National GP Patient Survey of the practice, published in July 2016, showed patients rated the practice higher than others for almost all aspects of care.
- Data from the NHS National GP Patient Survey also showed that the practice had performed better than the local CCG and national averages in relation to telephone access and appointment availability.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Staff were very committed to supporting patients to live healthier lives through a targeted and proactive approach to health promotion.

Summary of findings

- A culture had been created which encouraged and sustained learning and improvement at all levels.
- The provider had a clear vision and strategy for the development of the practice and they were committed to providing their patients with good quality, safe care. There was strong clinical leadership and clear and effective governance structures were in place.

However, there were also areas where the provider should make improvements. The provider should:

- All staff should complete information governance and health and safety training.
- Review the complaint response letter template to make sure it complies with recognised guidance and contractual obligations for GPs in England.
- Continue to improve the uptake of cervical screening for females aged between 25 and 64 years of age and maintain an accurate and up-to-date patient population list.
- Develop a system by working with the local clinical commissioning group to mark the records of parents or guardians of at-risk children to alert clinical staff.

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 for reporting and recording significant events. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned when things went wrong and shared with staff to support improvement.
- There was a system for dealing with safety alerts and sharing these with staff.
- The practice had clearly defined systems and processes that helped keep patients safe. Individual risks to patients had been assessed and were well managed. Effective medicines management systems and processes were in place. Required pre-employment checks had been carried out for staff recently appointed by the practice.
- The premises were clean and hygienic, and effective infection control processes were in place.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Staff were very committed to supporting patients to live healthier lives through a targeted and proactive approach to health promotion.
- The practice used the information collected for the Quality and Outcomes Framework (QOF), and their performance against national screening programmes, to monitor and improve outcomes for patients. The practice's overall achievement, for 2015/16, was similar to, the local clinical commissioning group (CCG) and England averages.
- Patients' needs were assessed and care was planned and delivered in line with current evidence based guidance.
- Quality improvement activities, including clinical audits, were carried out to improve patient outcomes.
- Staff worked effectively with other health and social care professionals to ensure the range and complexity of patients' needs were met.
- Clinical staff had the skills, knowledge and experience to deliver effective care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

- There was a strong, visible, person-centred culture. Staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Data from the NHS National GP Patient Survey of the practice, published in July 2016, showed patients rated the practice higher than others for almost all aspects of care. Patients showed high levels of satisfaction with the quality of GP and nurse consultations, and, in particular, expressed a high level of trust and confidence in the GPs who treated them. Most patients who completed a CQC comment card, provided very positive feedback about the quality of the care and treatment they received.
- Information for patients about the range of services provided by the practice, was available and easy to understand.
- Staff had made arrangements to help patients and their carers cope emotionally with their care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Staff were highly committed to delivering services that recognised individual needs, promoted equality and provided flexibility, choice and continuity of care. The practice had developed services that helped to meet the needs of their atypical population. Whilst the practice provided appropriate care and treatment for the small number of patients that were not students, staff also delivered services that recognised the specific needs of students who made up 90% of their population. For example, staff provided a medically supported examination sitting service, to enable students to complete their examination schedule. The practice collaborated with other services and organisations, including the University of Birmingham student support services, to help provide students experiencing poor mental health, with access to a range of appropriate interventions.
- Results from the NHS National GP Patient Survey of the practice, published in July 2016, showed that the practice had, overall, performed better than the local CCG and national averages, particularly in relation to telephone access and appointment availability. For example: 93% of patients said they were able to get an appointment to see or speak to someone the last time they tried, compared with the local CCG average of 81% and the national average of 85%; 79% found it easy to get through to the surgery by telephone, compared with the local CCG average of 60% and the national average of 73%; 100% of patients described their overall experience of using the

Summary of findings

practice as good, compared with the local CCG average of 83% and the national average of 85%. Most patients who provided us with feedback expressed no concerns about access to appointments.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand. Complaints were taken seriously and staff took action to address them.

Are services well-led?

Good

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients.
- A culture had been created which encouraged and sustained learning and improvement at all levels. Staff felt supported and respected.
- The practice had a governance framework which supported the delivery of their strategy, and the provision of good quality care. Quality improvement activity was undertaken, to help improve patient outcomes.
- The provider complied with the Duty of Candour regulation, and they encouraged a culture of openness and honesty, and ensured that lessons were learned following significant events.

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 Quality and Outcomes Framework (QOF) data, for 2015/16, showed the practice had performed above, or broadly in line with, most of the local clinical commissioning group (CCG) and national averages, in relation to providing care and treatment for the clinical conditions commonly associated with this population group.
- The practice was able to provide a more personal, comprehensive service to their older patients, as they had much small numbers registered with them than other practices. For example, the majority of patients aged over 75 had been included on a register used by the practice to help avoid unplanned admissions into hospital. Also, care plans had been put in place to help meet the needs of these patients.
- Staff worked in partnership with other health care professionals to ensure that older patients received the care and treatment they needed.

People with long term conditions

Good

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

- The QOF data, for 2015/16, showed the practice had performed above, or broadly in line with, most of the local CCG and national averages, in relation to providing care and treatment for the clinical conditions commonly associated with this population group.
- Patients with long-term conditions were offered regular reviews, to check their health needs were being met and they were receiving the right medication. Longer appointments and home visits were available when needed.
- All twelve housebound patients had a named GP, and had received a comprehensive annual review during the previous 12 months.

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 protect children who were at risk and living in disadvantaged circumstances. For example,

appointments were available outside of school hours. Children who were ill had access to same day care via the daily duty surgeries. Patients were able to access fortnightly, midwife-led ante-natal clinics. Clinicians carried out telephone reviews with new mothers. They also carried out 'new baby' checks, which included relevant immunisations. The family of any child failing to attend a paediatric clinic were contacted by the practice nurse, to find out why and what could be done to ensure attendance.

- The practice offered contraceptive and sexual health advice, and information was available about how patients could access specialist sexual health services.
- The practice had a comprehensive screening programme. Nationally reported information showed they had performed in line with the national averages, in relation to breast and bowel cancer screening, but less well regarding cervical screening rates. The uptake of cervical screening for females aged between 25 and 64, attending during the target period, was much lower at 49.8%, than the national average of 81.4%. Clinical staff had a good understanding of the reasons behind their lower cervical screening rates, and had put an improvement plan in place to address this.
- The practice offered a full range of immunisations for children. Publicly available information showed they had performed less well in delivering childhood immunisations to under two year olds, when compared to the target set by NHS England. The practice's immunisation rates, for the four immunisations given to children under the age of two, were 86.1%. These were below the 90% standard target set by NHS England. There was a small number of children registered with the practice and this can have a disproportionate impact on the immunisation rates. Also, the practice's immunisation rates were affected by the challenges they faced delivering vaccinations to the children of overseas students.

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 majority of patients registered with the practice were students. The practice provided a range of services which reflected this. For example, each autumn staff engaged with the University and Students' Guild to help raise awareness of

Summary of findings

Meningitis and, staff promoted the MenACWY vaccination to all new students registering with the practice. The practice also provided a full range of health promotion and screening that reflected the needs of patients who were not students.

- Staff worked closely with staff from the university to help mitigate the effect of issues affecting the academic progress of students.
- Signposting directed students to appropriate specialised services. Students had access to long-acting, reversible and emergency contraceptive services, as well as testing for sexually transmitted diseases.
- Patients were able to book appointments and request prescriptions online, and the practice provided two Saturday morning influenza vaccination clinics during the winter, for working patients and their families.
- Clinical staff actively used the e-referral service, which helped students to access secondary care treatment nearer to their own home.
- The QOF data, for 2015/16, showed the practice had performed either above, or broadly in line with, most of the local CCG and England averages, in providing recommended care and treatment to this group of patients.
- Information on the practice's website, and on display in their patient waiting areas, informed patients how to access the out-of-hours service.

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 registers of patients living in vulnerable circumstances. For example, staff maintained a register of patients with learning disabilities, which they used to ensure they received an annual healthcare review.
- Staff understood their responsibilities regarding information sharing and the documentation of safeguarding concerns, and they regularly worked with multi-disciplinary teams to help protect vulnerable patients. Staff were aware of how to contact relevant agencies in normal working hours and out-of-hours, to help ensure patients were safe.
- Arrangements had been made which helped patients who were homeless to register using a temporary address, such as that of a day care centre.
- Appropriate arrangements had been made to meet the needs of patients who were also carers.

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).

- Performance for three of the mental health related indicators was similar to both the local CCG and national averages, but performance for the other three indicators was below both of these averages. For example, the percentage of women aged between 25 and 65, with the specified mental health conditions, whose notes included a record that a cervical screening test had been performed during the preceding five years, was higher than the England average (100% compared to 89%). However, the data also showed that the percentage of patients with the specified mental health conditions, who had had a comprehensive, agreed care plan documented in their medical record, during the period from 1 April 2015 to 31 March 2016, was lower than the England average (80.8% compared to 88.8%).
- The practice collaborated with other services and organisations to help provide students experiencing poor mental health with access to a range of appropriate interventions. For example, the practice worked closely with the university's Counselling and Health and Wellbeing (CHWB) service, to help ensure patients were able to obtain specialist advice and support. Staff piloted the mental health digital peer support service 'Big White Wall' which is a digital mental health and well-being support service, which enables patients to access safe, anonymous and professionally moderated support. The practice had actively worked with the new local mental health service provider, 'Forward Thinking Birmingham' (FTB), to help provide patients, aged 18 to 25 years of age, with accessible and responsive mental healthcare.
- The practice had a system in place which helped ensure that patients with mental health problems who had attended accident and emergency department were followed up by the duty doctor, to see whether any additional support was needed.

Summary of findings

What people who use the service say

As part of our inspection we asked practice staff to invite patients to complete Care Quality Commission (CQC) comment cards. We received 45 completed comment cards, the majority of which were very positive about the standard of care and treatment provided. Words used to describe the service included: safe and hygienic; excellent; very good; very polite and helpful; ace; good communication; well run and efficient; remarkably good; professional and polite staff. However, nine patients told us that, although they were happy with the care and treatment they received, they found it difficult to obtain a same-day appointment.

Data from the NHS National GP Patient Survey of the practice, published in July 2016, showed patients rated the practice higher than others for almost all aspects of care. In particular, patients were very satisfied with appointment availability and the way in which the GPs listened to them. They also expressed a very high level of trust and confidence in the GPs who treated them. Of the patients who responded to the survey:

- 100% had confidence and trust in the last GP they saw, compared to the local CCG average of 96% and the national average of 95%.
- 95% said the last GP they saw treated them with care and concern, compared to the local CCG average of 84% and the national average of 85%.
- 100% said the last GP they saw was good at listening to them, compared to the local CCG average of 88% and the national average of 89%.
- 95% said the last GP they saw was good at giving them enough time, compared to the local CCG of 86% and the national average of 87%.
- 94% had confidence and trust in the last nurse they saw or spoke to. This was below the local CCG and national averages of 97%.
- 98% said the last nurse they saw was good at listening to them, compared to the local CCG of 89% and the national average of 91%.
- 89% said the last nurse they saw treated them with care and concern. This was the same as the local CCG average, but below the national average of 91%.
- 94% said the last nurse they saw was good at giving them enough time, compared to the local CCG of 91% and the national average of 92%.
- 85% found receptionists at the practice helpful, compared with the local CCG average of 84% and the national average of 87%.
- 92% said the last appointment they got was convenient, compared with the local CCG average of 91% and the national average of 92%.
- 93% were able to get an appointment to see or speak to someone the last time they tried, compared with the local CCG average of 81% and the national average of 85%.
- 79% found it easy to get through to the surgery by telephone, compared with the local CCG average of 60% and the national average of 73%.
- 82% said they usually waited 15 minutes or less after their appointment time, compared to the local CCG average of 60% and the national average of 65%.

(375 surveys were sent out. There were 34 responses which was a response rate of 9.1%. This equated to 0.16% of the practice population.)

Areas for improvement

Action the service SHOULD take to improve

- All staff should complete information governance and health and safety training.
- Review the complaint response letter template to make sure it complies with recognised guidance and contractual obligations for GPs in England.

Summary of findings

- Continue to improve the uptake of cervical screening for females aged between 25 and 64 years of age and maintain an accurate and up-to-date patient population list.
- Develop a system by working with the local clinical commissioning group to mark the records of parents or guardians of at-risk children to alert clinical staff.

University Medical Practice

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 and a practice manager.

Background to University Medical Practice

The practice is part of the NHS Birmingham Cross City clinical commissioning group (CCG). We visited the following location as part of inspection: University Medical Centre, 5 Pritchatts Road, Edgbaston, Birmingham, B15 2QU.

The University Medical Practice provides care and treatment to 20,180 patients of all ages, based on a General Medical Services (GMS) contract. The practice has a large student population, (almost 90% of patients are university students), but also provides care and treatment of patients who are not students. Approximately 50% of patients were aged between 18 and 25 years of age and, 89% were below 45 years of age. Sixteen per cent of patients were from China. The practice had a high patient list turnover, over 20% a year. The practice had no patients registered with them that lived in nursing homes and only two patients that lived in a residential home.

The area in which the practice is situated is in the sixth least deprived decile. Figures show that 89.9% of the practice's patients are in paid work or full-time education compared with the England average of 62.5%. The percentage of patients with a long-standing health condition is higher than the national average, 59.6% compared to 53.2%. There are fewer patients with caring responsibilities than the England average, 5.3% compared to 17.8%.

The practice occupies purpose built premises that are located on the edge of the university campus in Edgbaston. There are 20 consulting rooms, a minor operations suite and two meeting rooms. All treatment and consultation rooms are located on the ground floor. The practice has eight GP partners (five male, three female), a GPR (trainee doctor, female), a foundation year two trainee doctor (female), two nurse practitioners and two practice nurses (female), a practice manager (male), and a team of 11 administrative and reception staff. Three of the GP partners acted as University Medical Officers, in addition to their roles and responsibilities at the practice. The practice was a training practice and had recently begun offering training placements to army foundation doctors.

The practice is open Monday to Thursday, between 8:30am and 6pm, and on Fridays between 8:45am and 5:30pm. When the practice is closed patients can access out-of-hours care via Prime Care, and the NHS 111 service.

Approximate GP appointment times are: Monday: 8:30am to 12:40pm and 2:40pm to 5:20pm; Tuesday: 8:30am to 1pm and 1:50pm to 5:20pm; Wednesday: 8:30am to 12:10pm and 2:20pm to 5:20pm; Thursday: 9am to 1pm and 1:50pm to 5:20pm; Friday: 8:30am to 11:40pm and 1:50pm to 5pm. A limited number of daily lunch time appointments are also available.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

Detailed findings

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. 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.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 17 January 2017. During our visit we:

- Spoke with a range of staff, including the managing GP partner, two GPs, the practice manager, two nurses and some of the administrative staff. We also spoke with the patient who chaired the practice's patient participation group.
- Observed how staff interacted with patients in the reception and waiting area.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients 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

There was an effective system in place for reporting and recording significant events.

- Staff had identified and reported on nine significant events during the previous 13 months. Significant events were formally reviewed four times a year, to look for common trends and themes. An annual significant event summary was produced, to help disseminate learning. Individual significant events were reviewed during weekly partners' meetings, to ensure they had been appropriately responded to at the time of the event. The sample of records we looked at, and evidence obtained from interviews with staff, showed the practice had managed such events consistently and appropriately. Copies of significant event reports could be accessed by all staff on the practice intranet system. Staff we spoke with were clear about how they would raise concerns or report on any incident that occurred.
- The practice's approach to the handling and reporting of significant events ensured that the provider complied with their responsibilities under the Duty of Candour regulation. (The Duty of Candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.) Where relevant, patient safety incidents had been reported to the clinical commissioning group (CCG) via the local incident and adverse event reporting system.
- The practice had systems for responding to safety alerts and sharing these with staff, and for recording, investigating and learning from incidents. It was evident from the sample we looked at that the practice took appropriate action in response to safety alerts.

Overview of safety systems and processes

The practice had a range of clearly defined and embedded systems and processes in place which helped to keep patients and staff safe and free from harm. These included:

- Arrangements to safeguard children and vulnerable adults. Policies and procedures for safeguarding children and vulnerable adults were in place. Staff told us they were able to easily access these. One of the GPs acted as the children and vulnerable adults safeguarding lead, providing advice and guidance to team members when required. Staff understood their safeguarding responsibilities and said they knew what to do if they were concerned about a patient's wellbeing.

  Safeguarding was an integral part of clinical staff and partner meetings. Relevant staff were notified if there were any changes to the needs of at-risk patients. Multi-disciplinary meetings took place every three months. These meetings were used to review the risks associated with vulnerable patients, including those with cancer and palliative care needs. In addition to this, the safeguarding GP lead met informally with the practice's health visitor every two weeks. At-risk patients were clearly identified on the practice's IT system via relevant codes, so clinical staff could take this into account during consultations. However, the medical records of parents of at-risk children were not currently highlighted to alert clinical staff to this. All staff had received safeguarding training relevant to their role. For example, the GPs had completed level three child protection training.
- Chaperone arrangements to protect patients from harm. All the staff who acted as chaperones were trained for the role and had undergone a Disclosure and Barring Service (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.) The chaperone service was advertised on posters displayed throughout the building.
- Maintaining appropriate standards of cleanliness and hygiene. There was an identified infection control lead and infection control protocols were in place. These protocols could be easily accessed by staff on the practice's IT system shared drive. Staff had completed infection control training appropriate to their roles and responsibilities. The practice had completed an infection control audit using a CCG self-assessment tool, in September 2016. An action plan had been put in place to address the shortfalls identified by the audit. A second audit, completed in December 2016, showed an improvement in compliance against expected standards, with the overall compliance score rising from

90% to 98%. Sharps bin receptacles were available in the consultation and treatment rooms. Those looked at had been signed and dated by the assembler. Clinical waste was appropriately handled.

- Appropriate arrangements for managing medicines, including emergency medicines and vaccines. This included carrying out reviews of medicines for patients with long term conditions. The practice had a system for monitoring high-risk medicines. For example, we saw evidence that staff had carried out a recent search of patients prescribed disease-modifying anti-rheumatic drugs (DMARDS.) These are medicines used to slow down disease progression. We saw there were alerts on all of these patients' notes. The alerts contained information about the type and frequency of blood monitoring required. We checked the medical records of a sample of patients prescribed other high-risk medicines, such as Lithium and Methotrexate, and found all were up-to-date.
- All prescription forms were securely stored. Patient Group Directions (PGD) had been adopted by the practice, to enable nurses to administer medicines in line with legislation. These were up-to-date and had been signed. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.)
- Staff carried out daily temperature checks of the vaccine refrigerators and kept records of these. We identified a small number of gaps in the log for one of the refrigerators. We were told that it was highly likely that the checks had been carried out, but just not recorded. However, the practice had taken steps to improve recording. For example, arrangements had been made for the local CCG peer support nurse to deliver a bespoke training session on vaccine management.
- The practice carrying out of a range of employment checks to make sure staff were safe to work with vulnerable patients. We looked at a sample of staff recruitment files. Appropriate indemnity cover was in place for all clinical staff. The provider had obtained information about staff's previous employment and, where relevant, copies of their qualifications, as well as written references. The provider had also carried out DBS checks on each person and obtained proof of their identity.

Monitoring risks to patients

Overall, risks to patients were assessed and well managed.

- There were procedures for monitoring and managing risks to patient and staff safety. For example, the practice had arranged for all clinical equipment to be serviced and, where appropriate, calibrated, to ensure they were safe and being maintained in good working order. A range of other routine safety checks had also been carried out. These included checks of electrical and fire safety equipment, and the completion of a fire risk assessment. Most staff had completed fire safety training. We received evidence, shortly following the inspection, that the remaining staff had updated their fire training the day after our inspection. Fire drills had been carried out during 2016. Health and safety risk assessments had been completed, to help keep the building safe and free from hazards.
- A legionella risk assessment had been carried out during the previous 12 months, and staff carried out weekly checks of the temperature of the water supply, to prevent the spread of legionella. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal.)
- There were suitable arrangements in place for planning and monitoring the number and mix of staff required to meet patients' needs. There were sufficient numbers of nursing and non-clinical staff, to meet current patient demand. New staff had been recruited to cover staff who had left during 2016. Locum GPs were used to cover shortfalls in the GP rota, and a locum pack was in place to help them to work safely.

Non-clinical staff had been trained to carry out all key duties, to help ensure the smooth running of the practice. Rotas were in place which helped to ensure sufficient numbers of staff were on duty to meet patients' needs. Staff were encouraged to take leave during non-term time, to help the practice cope with the significant rise in patients at the beginning of the academic year and the workload demands this placed on the practice team. The non-clinical staff we spoke with told us that, although certain times of the year were particularly busy and stressful, systems and processes had been devised which helped them to respond to patient demand. For example, prior to the start of a new

Good

Are services safe?

academic year, staff prepared new registration packs in advance so they were easily accessible. They told us that at busy times, they could call upon their colleagues to help out.

Arrangements to deal with emergencies and major incidents

The practice had made satisfactory arrangements to deal with emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms, which alerted staff to any emergency.
- All staff had completed basic life support training to help them respond effectively in the event of an emergency.
- Emergency medicines were available in the practice, and these were kept in a secure area. All of the emergency medicines we checked were within their expiry dates and a system was in place to ensure regular checks were carried out. Overall, the arrangements for checking the doctors' bags the GPs took with them in home visits were satisfactory. For example, all medicines were in date. However, in one of the bags, we found a sphygmomanometer (an instrument for measuring blood pressure) that had not been calibrated. This was immediately replaced with a calibrated item on the day of the inspection.
- Staff had access to a defibrillator and a supply of oxygen for use in an emergency. Regular checks were carried out to make sure they were in good working order.
- The practice had a business continuity plan for major incidents. This was accessible to all staff via the practice's intranet system. Outside of working hours, key members of staff could access the plan remotely.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The GPs and nurses made use of standardised clinical templates, to help improve the assessment, treatment and care planning processes. Staff also used guidelines produced by the local clinical commissioning group (CCG), to help drive best practice.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF), and their performance against national screening programmes, to monitor and improve outcomes for patients. The QOF data, for 2015/16, showed the practice had obtained 94% of the total points available to them for providing recommended care and treatment. This was similar to the local CCG average of 95.2%, and the England average of 95.3%.

- Performance for the diabetes related indicators was either better than, or similar to, most of the England averages. For example, the percentage of patients with diabetes, for whom the last blood pressure reading, during the period 1 April 2015 to 31 March 2016, was 140/80 mmHg or less, was higher than the England average (82.4% compared to 77.6%). The data also showed the percentage of patients with diabetes, in whom the last IFCC-HbA1c was 64mmol/mol, during the same period of time, was similar to, the England average (75.8% compared to 78%).
- Performance for three of the mental health related indicators was similar to both the local CCG and national averages, but performance for the other three indicators was below both of these averages. For example, the percentage of women aged between 25 and 65, with the specified mental health conditions, whose notes included a record that a cervical screening test had been performed during the preceding five years, was higher than the England average (100% compared to 89%). However, the data also showed that the percentage of patients with the specified mental health conditions, who had had a comprehensive, agreed care plan documented in their medical record, during the period from 1 April 2015 to 31 March 2016, was lower than the England average (80.8% compared to 88.8%).
- Performance for the asthma related indicators was either better than, or similar to, the England averages. For example, the percentage of patients who had had an asthma review in the preceding 12 months, that included an assessment of asthma control using the three questions recommended by the Royal College of Physicians, was higher than the England average (82% compared to 75.6%). The quality of the asthma management plans we looked at was of an excellent standard.

The practice's exception reporting rate, at 8.7%, was 1.1% below the local CCG and the England averages. (The QOF scheme includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect.) However, the mental health exception reporting rate was higher than the national average, (17.6% compared to 11.3%). Evidence made available to us during the inspection demonstrated the practice had made a significant effort to address this and they had only excepted patients on a clinical basis when attempts to contact them failed.

There was evidence of quality improvement activity, which included clinical and non-clinical audits. The audits we looked at were relevant, showed learning points and evidence of changes to practice. They were clearly linked to areas where staff had identified potential risks to their patients.

We looked at some of those that had been carried out during the previous 12 months. These included two-cycle clinical audits that focussed on, for example: the use of 'sick day rules' and ketones testing for patients with Type 1 diabetes; record keeping in relation to the insertion of sub-dermal contraceptive implants, and the prescribing of a combination of inhalers in patients with asthma medicine. Improvements made as a result of these audits included: the introduction of a checklist to alert clinicians to the need to record current contraception and past gynaecological and menstrual history of patients receiving implants.

Good

Are services effective?

(for example, treatment is effective)

Other types of quality improvement activities (QIA) were also carried out. These included reviews of: the quality of referral letters; the appropriateness of referrals; the effectiveness of the practice's approach to providing patients with access to test results, and the accuracy of patient contact details. Staff had also carried out medicines related QIA. This had focussed on, for example: the monitoring of patients prescribed anti-psychotic medicines; the prescribing of hypnotics and the storage of vaccines requiring cold storage. The practice had participated in the local CCG's Medicines Wastage campaign, to help reduce the costs associated with unused prescription medicines.

The practice actively participated in, and worked collaboratively with, other practices as part of the local CCG's Aspiring to Clinical Excellence (ACE) scheme. (The ACE scheme encourages practices to work together in provider groups, to help deliver the same standard and quality of primary care for all their patients, as well as additional treatment beyond the usual level of provision.) Staff told us about how their involvement in the scheme had helped improve patient outcomes. For example, staff had screened 68% of patients for atrial fibrillation (AF) during the previous three years. As a result of this, the practice's AF register had increased from 31 to 50 patients, since April 2014. Staff had also carried out pre-diabetic case-finding to help ensure at-risk patients were identified as early as possible. To date, self-management plans had been put in place for 55% patients who had asthma and whose condition was not adequately controlled.

Effective staffing

Overall, staff had the skills, knowledge and experience needed to deliver effective care and treatment.

- The practice had an induction programme for newly appointed staff. Staff we spoke with told us they had received an induction which they found helpful.
- Staff were encouraged and supported to undertake role specific training. For example, the nursing staff had completed additional post qualification training, to help them meet patients' needs. All the staff had completed training in fire safety, safeguarding, basic life support and infection control. Relevant staff had received chaperone training. However, some staff had not completed information governance training. We shared this with the managing GP partner who took immediate action to begin the process of addressing this shortfall. Also, some of the GPs had not completed health and safety training, but action was also being taken to address this.
- All non-clinical staff had received an annual appraisal of their performance during the previous 12 months. Some of the records of appraisal we looked at contained limited action plans in relation to the further development of the staff concerned. We shared this with the practice manager and they agreed to take account of this when carrying out future appraisals. Arrangements had been made for an independent nurse appraiser to carry out all nurse appraisals in December 2016. However, these had been delayed due to unavoidable circumstances. Plans had been made to complete these by the end of January 2017. Appropriate arrangements were in place to support GPs to undergo revalidation with the General Medical Council.

Coordinating patient care and information sharing

The practice's patient clinical record and intranet systems helped to make sure staff had the information they needed to plan and deliver care and treatment.

- The information included patients' medical records and test results. However, we identified that there had been a delay of approximately one week in scanning a small number of contraceptive implant consent forms onto patients' medical records. This was addressed on the day of the inspection. We also found a very small number of unprocessed patient letters. These were immediately reviewed by the practice who were able to demonstrate that although unprocessed, they contained mainly data entry information and no harm had come to the patients concerned as a result of the delay. Key staff met on the day of the inspection and agreed to implement a new procedure to prevent this from happening again. We received evidence shortly following the inspection that the issues we identified had been addressed as part of a significant event meeting, held to prevent a further reoccurrence. In addition, the practice's policy relating to the handling of correspondence had been reviewed and updated. We spoke to some of the non-clinical staff and found no other evidence of delays in processing patient information.

Good

Are services effective?

(for example, treatment is effective)

- Staff shared NHS patient information leaflets, and other forms of guidance, with patients to help them manage their long-term conditions.
- All relevant information was shared with other services, such as hospitals and, for students, their own GPs at home, in a timely way. Important information about the needs of vulnerable patients was shared with the out-of-hours service.
- Staff collaborated with other health and social care professionals, to meet the range and complexity of patients' needs and to assess and plan on-going care and treatment.

Consent to care and treatment

Patients' consent to care and treatment was sought in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of the legislation and guidance, including the Mental Capacity Act (MCA, 2005). When staff provided care and treatment to young people, or adult patients whose mental capacity to consent was unclear, they carried out appropriate assessments of their capacity and recorded the outcome. Clinical staff had completed training in the use of the MCA.

Supporting patients to live healthier lives

Staff were very committed to supporting patients to live healthier lives through a targeted and proactive approach to health promotion.

- Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged between 40 and 74 years. Staff had devised an information leaflet signposting new patients to what they should do in the event that they were, for example, a smoker, a student or needed a prescription urgently. New patients were asked to complete a basic information form to help clinical staff treat them appropriately.
- Staff told us there were suitable arrangements for making sure any abnormalities or risks identified during these checks were followed up by a GP or a nurse.

The practice had a comprehensive screening programme. Nationally reported information showed the practice had performed in line with the national averages in relation to breast and bowel cancer screening, but less well with regards to cervical screening.

- The uptake of breast screening by females aged between 50 and 70, during the previous 36 months, was in line with the national average, 72.8% compared to 72.2%.
- The uptake of cervical screening by females aged between 25 and 64, attending during the target period, was much lower at 49.8%, than the national average of 81.4%. Evidence from the inspection demonstrated the practice was taking active steps to address this.

  Clinical staff demonstrated to us that they had explored the reasons behind the low uptake of cervical screening. This included looking at the ages and ethnicity of non-responders, (51% of non-responders were either Chinese or European students aged between 25 and 35 years), and being more proactive in making it easier for this group of patients to attend. For example, lunch time appointments with a nurse had been introduced. In February 2016, the practice sent a bulk text message inviting patients to book their smear test, but they had received a poor response to this. The practice had recently appointed a nurse with a particular interest in Women's Health and intend to work with them to raise awareness amongst foreign students, of the importance of having regular cervical screening. The managing GP partner told us that, given the transient nature of the post-graduate student population, it was difficult to estimate how many of the eligible women who were registered with the practice were still living in the UK. We were told the practice had recently devised an appropriate search, using their clinical IT system, to help them identify students who had finished their course and left the country. The practice had also recently started the process of 'cleansing' the list of patients eligible for cervical screening, to ensure it only included those that were still living within the practice's boundary.
- The uptake of bowel cancer screening by patients aged between 60 and 69, during the previous 30 months, was similar to the national average, 55.3% compared to 57.9%.

Good

Are services effective?

(for example, treatment is effective)

- The practice offered a full range of immunisations for children. Publicly available information showed they had performed less well in delivering childhood immunisations to under two year olds, when compared to the target set by NHS England. The practice's immunisation rates, for the four immunisations given to children under the age of two, were 86.1% which was below the 90% standard target set by NHS England.

However, staff told us that the small number of children registered with the practice could have a disproportionate impact on the immunisation rates. Also, the practice's immunisation rates were affected by the difficulties they experienced trying to check whether the children of international students had received the appropriate vaccinations in their own countries.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff were highly motivated to offer care that was kind, promoted patients' dignity and respected cultural differences.

- Throughout the inspection staff were courteous and helpful to patients who attended the practice or contacted it by telephone.
- We saw that patients were treated with dignity and respect. Privacy screens were provided in consulting rooms so that patients' privacy and dignity could be maintained during examinations and treatments.
- Consultation and treatment room doors were closed during consultations, so that conversations could not be overheard.

As part of our inspection we asked practice staff to invite patients to complete Care Quality Commission (CQC) comment cards. We received 45 completed comment cards, the majority of which were very positive about the standard of care and treatment provided. Words used to describe the service included: safe and hygienic; excellent; very good; very polite and helpful; ace; good communication; well run and efficient; remarkably good; professional and polite staff.

Data from the NHS National GP Patient Survey of the practice, published in July 2016, showed patients rated the practice higher than others for almost all aspects of care. Patients showed high levels of satisfaction with the quality of GP and nurse consultations, and, in particular, expressed a high level of trust and confidence in the GPs who treated them. Of the patients who responded to the survey:

- 100% had confidence and trust in the last GP they saw, compared to the local CCG average of 96% and the national average of 95%.
- 95% said the last GP they saw treated them with care and concern, compared to the local CCG average of 84% and the national average of 85%.
- 100% said the last GP they saw was good at listening to them, compared to the local CCG average of 88% and the national average of 89%.
- 95% said the last GP they saw was good at giving them enough time, compared to the local CCG of 86% and the national average of 87%.
- 94% had confidence and trust in the last nurse they saw or spoke to. This was below the local CCG and national averages of 97%.
- 98% said the last nurse they saw was good at listening to them, compared to the local CCG of 89% and the national average of 91%.
- 89% said the last nurse they saw treated them with care and concern. This was the same as the local CCG average, but below the national average of 91%.
- 94% said the last nurse they saw was good at giving them enough time, compared to the local CCG average of 91% and the national average of 92%.
- 85% found receptionists at the practice helpful, compared with the local CCG average of 84% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Results from the NHS National GP Patient Survey also showed patient satisfaction levels regarding involvement in decision-making were much better than the local CCG and national averages. Of the patients who responded to the survey:

- 100% said the last GP they saw was good at explaining tests and treatments, compared to the local CCG average of 86% and the national average of 86%.
- 94% said the last GP they saw was good at involving them in decisions about their care, compared to the local CCG average of 81% and the national average of 82%.
- 93% said the last nurse they saw was good at explaining tests and treatments, compared with the local CCG average of 89% and the national average of 90%.
- 90% said the last nurse they saw was good at involving them in decisions about their care, compared to the local CCG average of 83% and the national average of 85%.

Patient and carer support to cope emotionally with care and treatment

Good

Are services caring?

Staff were good at helping patients and their carers to cope emotionally with their care and treatment. They understood patients' social needs, supported them to manage their own health and care, and helped them, where appropriate, to maintain their independence. Staff worked with student support services, to help their student patients manage the demands that university life placed on them. Notices in the patient waiting room told patients how to access a range of support groups and organisations. Where patients had experienced bereavement, clinical staff would contact them to offer condolences and support, where this was appropriate.

The practice was committed to supporting patients who were also carers.

- Staff maintained a register of these patients, to help make sure they received appropriate support, such as an annual health check. There were 25 patients on this register, which equated to 0.1% of the practice's population. This was low for a practice of this size. However, 90% of patients were students aged between 18 and 35, and were less likely to have caring responsibilities.
- The practice had a designated carers' lead who helped oversee the needs of patients who were also carers. Staff told us patients with caring responsibilities were advised to register with the local Carers' Emergency Response Service and the local carers' hub, to help them access appropriate advice and support. A carers' noticeboard in the waiting area provided information about the sources of support.
- The practice's information leaflet encouraged patients to tell staff if they were also carers.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Staff were highly committed to delivering services that recognised individual needs, promoted equality and provided flexibility, choice and continuity of care. The practice had developed services that helped to meet the needs of their atypical student population and, the involvement of other organisations was integral to this. Examples of the practice being responsive to, and meeting patients' needs included:

- Providing services specifically developed to meet the needs of students, who were the largest group of patients registered with the practice, (almost 90% of patients were university students.) For example, the practice arranged for students to undergo tests at their local hospital during holidays, to avoid clashes with examination timetables. Staff provided a medically supported examination sitting service, to enable students to complete their examination schedule. (This service enabled students who need alternative examination arrangements due to disability or ill health, to complete their examinations at the University Medical Practice under medical supervision.) During the 2016 summer examination period, clinical staff supported 12 students to complete 23 examinations. (Not all of these patients were registered with the practice.) The managing GP partner had taken on an extra role as university medical officer, providing medical advice to help Birmingham University understand what adjustments might be necessary to help students participate fully in their courses, and complete their examination schedule. They also had regular contact with the Director of Student services, to discuss wider student health and welfare matters. They acted as a source of advice and support for other practices who had students registered with them, to help them meet their needs.
- Working in collaboration with other services and organisations to help provide students experiencing poor mental health with access to a range of appropriate interventions. For example, the practice:
- Worked closely with the university's Counselling and Health and Wellbeing (CHWB) service. Staff had built good relationships with these services, which meant they were able to obtain specialist advice and support and, where appropriate, refer students experiencing poor mental health. Staff told us that working collaboratively with the CHWB service had been effective in helping students avoid acute crises and unnecessary admissions into hospital.
- Collaborated with staff from the local community mental health team, who had just begun a three-month trial providing weekly outreach psychiatry and eating disorder sessions at the practice. Information was available at the practice informing students how they could access immediate help from this service and the local talking therapy service. The practice had a system in place which helped ensure that patients with mental health problems who had attended A&E were followed up by the duty doctor, to see whether any additional support was needed.
- Piloted the mental health digital peer support service 'Big White Wall'.(This is a digital mental health and well-being support service, which enables patients to access safe, anonymous and professionally-moderated support.) Over the period June 2015 to 1 January 2017, the practice had prescribed to 81 patients directly and, indirectly to an additional 12 patients, who had accessed the 'Big White Wall' service via the University's Health and Well Being Service. The practice received very positive feedback from the 'Big White Wall' team about their performance in helping to set up and support patients to access the service.
- Actively worked with the new local mental health service provider, 'Forward Thinking Birmingham' (FTB), to help provide patients, aged 18 to 25 years of age, with accessible and responsive mental healthcare. FTB staff provided a weekly out-reach eating disorder and psychiatric clinic at the practice. Information was available in the practice, and on its website, advising students how to the access the 'Pause' walk-in clinic provided by FTB. During 2016, clinical staff had referred 204 patients to FTB for mental health assessment and treatment.
- Working with the Guild of Students to place information about Meningitis and Septicaemia in the bedrooms of 6,000 first year students, at the start of the autumn term, to help raise awareness of Meningitis. Staff also promoted the MenACWY vaccination to all new students registering with the practice. The practice also provided

Good

Are services responsive to people's needs?

(for example, to feedback?)

a full range of health promotion and screening that reflected the needs of patients who were not students. Signposting was provided to appropriate specialised services. Patients were able to book appointments and request prescriptions online, and the practice provided two Saturday morning influenza vaccination clinics in the winter for working patients and their families. The practice actively used the e-referral service which helped students to access secondary care treatment nearer to their own home. Extended hours appointments were not provided.

- Providing all older patients with a more personal service. This was in part due to the small number of older patients registered with the practice. For example, the majority of patients aged over 75 had been included on a register used by the practice to help avoid unplanned admissions into hospital. Also, care plans had been put in place to help meet the needs of these patients. All twelve housebound patients had a named GP, and had received a comprehensive annual review during the previous 12 months. The nurse practitioner undertook home visits providing phlebotomy, and influenza and pneumococcal vaccinations. Quarterly meetings, involving relevant community healthcare professionals, were held to review the needs of older patients, and patients with end of life needs, to help ensure they were being met. The practice participated in the local clinical commissioning group's (CCG) 'Screening for Risk of Falls' programme, for patients aged over 75 years. A hundred and seventy-nine patients (67%) had been screened since June 2016 and, where appropriate, referred for follow-up intervention.
- Providing appointments outside of school hours. Children who were ill had access to same day care via the daily duty surgeries. Patients were able to access fortnightly, midwife-led ante-natal clinics. Clinicians carried out telephone reviews with new mothers. They also carried out 'new baby' checks, which included relevant immunisations. The family of any child failing to attend a paediatric clinic were contacted by the practice nurse, to find out why and what could be done to ensure attendance. The practice offered contraceptive and sexual health advice, and information was available about how patients could access specialist sexual health services. A fortnightly health visitor clinic took place at the practice, and quarterly multi-disciplinary meetings were held to share information about vulnerable patients and manage risk.
- Making reasonable adjustments to help patients with disabilities access the practice. Disabled access was provided, including disabled toilets had appropriate aids and adaptations, as well as baby changing facilities. Patients had access to four disabled parking bays. The practice had produced a comprehensive easy-read leaflet to help patients with disabilities understand how to use their services. In addition, staff had worked with braille specialists to produce a similar guide for patients with sight impairment. The document was being reviewed by a small number of patients who were braille readers. There was a large contingent of international students, whose first language was not English.
- Making arrangements to meet the needs of vulnerable patients. For example, staff maintained a register of patients with learning disabilities which they used to ensure, where appropriate, that they received an annual healthcare review. Staff understood their responsibilities regarding information sharing and the documentation of safeguarding concerns, and they regularly worked with multi-disciplinary teams to help protect vulnerable patients. Arrangements had been made which helped patients who were homeless to register using a temporary address, such as that of a local day centre.

Access to the service

The practice was open Monday to Thursday, between 8:30am and 6pm, and on Fridays between 8:45am and 5:30pm. When the practice was closed patients were able to access out-of-hours care via Prime Care, and the NHS 111 service.

Approximate GP appointment times were: Monday: 8:30am to 12:40pm and 2:40pm to 5:20pm; Tuesday: 8:30am to 1pm and 1:50pm to 5:20pm; Wednesday: 8:30am to 12:10pm and 2:20pm to 5:20pm; Thursday: 9am to 1pm and 1:50pm to 5:20pm; Friday: 8:30am to 11:40pm and 1:50pm to 5pm. A limited number of daily lunch time appointments were also available.

All consultations were by appointment only and could be booked by telephone, in person or on-line. Patients were able to book an appointment with either a GP or a nurse within 24 hours. GP routine appointments could be booked

Good

Are services responsive to people's needs?

(for example, to feedback?)

up to two weeks in advance, and nurse appointments up to 28 days. Fifteen minute appointments were offered as standard, but longer appointments were available for those that needed them. Reception staff told us that 50% of their appointments were pre-bookable with the remainder being available on the day. Most of the 'on-the-day' appointments were released at 8:45am, with a smaller number at 1:45pm for appointments between 3pm and 5:20pm. We were also told that patients requiring urgent care would always been seen on the same day, by either the duty doctor or the duty nurse. The nursing team provided a walk-in service for patients presenting with minor ailments between 9am and 12:15pm and 2:15pm and 5:15pm. A real-time check of the appointment system indicated that the next routine appointments for a GP or nurse were available within two days of the inspection.

The practice had a system in place to assess whether a home visit was clinically necessary; and the urgency of the need for medical attention.

The majority of patients who provided feedback on CQC comment cards raised no concerns about telephone access to the practice, or appointment availability. However, nine patients told us that it was difficult to obtain same-day appointments.

Results from the NHS National GP Patient Survey of the practice, published in July 2016, showed that the practice had, overall, performed better than the local CCG and national averages, particularly in relation to telephone access and appointment availability. Of the patients who responded to the survey:

- 92% said the last appointment they got was convenient, compared with the local CCG average of 91% and the national average of 92%.
- 93% were able to get an appointment to see or speak to someone the last time they tried, compared with the local CCG average of 81% and the national average of 85%.
- 79% found it easy to get through to the surgery by telephone, compared with the local CCG average of 60% and the national average of 73%.
- 82% said they usually waited 15 minutes or less after their appointment time, compared to the local CCG average of 60% and the national average of 65%.

Listening and learning from concerns and complaints

The practice had a system in place for managing complaints.

- This included having designated senior staff who were responsible for handling any complaints and there was a complaints policy which provided staff with guidance about how to handle them. Information about how to complain was available on the practice's website and was also on display in the patient waiting areas.
- The practice had received seven complaints during the previous 13 months. In the complaint we sampled, we saw staff had offered an apology as well as an open invitation to speak with a GP about the complaint findings. It was clear staff had responded promptly to the patient's concerns and had treated the issues they raised seriously. However, the contents of the complaint response letter template did not comply fully with recognised guidance and contractual obligations for GPs in England.

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 their atypical population of patients. We found:

- A systematic approach was taken to working with other organisations to help improve care outcomes and tackle health inequalities. For example, staff had actively worked with the new local mental health service provider, 'Forward Thinking Birmingham' (FTB), to help provide patients, aged 18 to 25 years of age, with accessible and responsive mental healthcare. The practice provided a medically supported examination sitting service, to help students with disabilities and various health conditions complete their examinations in a safe setting. The practice had worked with the Guild of Students to place information about Meningitis and Septicaemia in the bedrooms of 6,000 first year students, at the start of the autumn term, to help raise awareness of these conditions.
- The managing GP partner, clinical staff and the practice manager, were highly motivated and committed to improving the quality of care and treatment provided to patients. This was clearly demonstrated in the presentation they made to us at the beginning of the inspection. The practice's website provided details of their vision and aims regarding the quality of care and treatment they provided for their patients. The provider had identified the future challenges the practice faced and was actively taking steps to address these.
- Staff understood what the managing GP partner was trying to achieve in terms of the quality of service provided to patients.

Governance arrangements

Overall, there was an effective governance framework, which supported the delivery of the managing GP partner's strategy for delivering good quality care. This ensured that:

- There was a clear staffing structure and the staff we spoke with understood their roles and responsibilities.
- Practice specific policies and procedures were implemented and were available to all staff via the practice intranet system. All of those viewed were in date.
- Staff had lead roles, to help ensure key tasks were carried out safely and effectively. For example, nurses held extended roles and were supported to maintain continuous professional development. One of the nurse prescribers acted as the first point of contact for minor illnesses and ran their own clinics.
- A comprehensive understanding of the performance of the practice was maintained. The practice used performance related information to improve patient outcomes. For example, staff had identified that the uptake of cervical screening by women, aged between 25 and 64 years of age, than the national average. In response to this, the practice had developed a targeted improvement plan to increase uptake and this was work in progress, at the time of the inspection. The practice also used Quality and Outcomes Framework (QOF) data to improve patient outcomes, with their overall performance being in line with the local CCG and national average.
- Quality improvement activity was undertaken. Involvement in the local CCG's Aspiring to Clinical Excellence (ACE) scheme had helped improve patient outcomes. For example, staff had screened 68% of patients for atrial fibrillation (AF) during the previous three years. As a result of this, the practice's AF register had increased from 31 to 50 patients, since April 2014. Staff had also carried out pre-diabetic case-finding to help ensure at-risk patients were identified as early as possible.
- Staff were supported to learn lessons when things went wrong. and there was a culture which supported the identification, promotion and sharing of good practice. This was demonstrated on the day of the inspection when These were immediately reviewed by the managing GP partner and practice manager, and we received evidence shortly following the inspection that the issues we identified had been fully addressed as part of a significant event meeting, to help prevent a further reoccurrence.
- Regular planned meetings were held to share information and manage patient risk. These included

Are services well-led?

Good

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

clinical, partners and general staff meetings. Quarterly multi-disciplinary meetings took place, involving key clinical staff, such as health visitors, the specialist palliative care nurse and clinical case manager from the local hospice, and other members of the community nursing team. This helped to ensure the needs of vulnerable patients were regularly reviewed.

Leadership, openness and transparency

On the day of the inspection, the GPs and practice manager demonstrated they had the experience, capacity and capability to run the practice and ensure high quality, compassionate care. Strong clinical leadership was provided by the managing GP partner who demonstrated they prioritised safe, high quality care which placed the patient at the forefront of everything the practice did.

The provider had complied with the requirements of the Duty of Candour regulation. (The Duty of Candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.)

- The managing GP partner and practice manager encouraged a culture of openness and honesty. There were effective systems which ensured that when things went wrong, patients received an apology and action was taken to prevent the same thing from happening again.
- A culture had been created which encouraged and sustained learning at all levels. Staff we spoke with told us they felt supported, valued and respected. They said they would feel comfortable about raising any concerns.

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

The practice encouraged and valued feedback from patients and staff.

- Staff had gathered feedback from patients through their Friends and Family Test survey. A suggestions box in the waiting area also provided an opportunity for patients to leave feedback. In addition, key clinical staff liaised with the Guild President representing the student body on a whole range of issues, such as promoting the Meningitis vaccination and the provision of sexually transmitted disease testing.
- The practice had set up a virtual patient participation group (PPG) in 2011, to help them obtain feedback from patients about their experience of using the surgery. Information about how to join the PPG was available in the patient waiting areas and the practice's website. Although unsuccessful, staff had taken steps to try to improve patient representation on the PPG.
- The practice supported the local provider of sexual health services to assess the quality of the services they provided to their patients. With support from the practice, their PPG devised a survey in 2013/14 to explore patients' views about what improvements were needed. Following on from this, one of the improvements made was the provision of a water dispenser in the waiting area.
- An independent organisation carried out a detailed survey in 2014, to obtain patient feedback about a wide range of issues. Plans were in place for the practice to carry out a more extensive survey to obtain feedback from patients during 2017. The practice was also proactive in responding to feedback from the most recent National GP Patient Survey published in July 2016, and had put an action plan in place to help them understand and address the issues raised.
- The managing GP partner and practice manager actively sought feedback from staff about the day-to-day operation of the practice. The range of meetings held provided opportunities for staff to provide feedback, as did the appraisal system. Staff told us they would not hesitate to give feedback or discuss any concerns and issues with the practice management team.

Continuous improvement

There was a very strong focus on continuous learning and improvement at all levels within the practice, and staff demonstrated they were committed to improving outcomes for patients. For example:

- The practice actively participated in, and worked collaboratively with other practices, as part of the local CCG's Aspiring to Clinical Excellence (ACE) scheme, to help develop and deliver improvements in patient care, and evaluate their effectiveness. Evidence from the inspection indicated that the practice was performing well and likely to meet expected levels of achievement.
- Staff were very proactive in building relationships with other agencies and service providers, to help ensure their patients' needs were met. Staff clearly

Are services well-led?

Good

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

demonstrated they had a forward thinking approach to understanding the needs of different groups of patients and delivering services that recognised and met their needs. For example, staff had worked with other organisations to deliver appropriate mental health services to people aged under 25 years of age. The practice participated in the local clinical commissioning group's (CCG) 'Screening for Risk of Falls' programme, for patients aged over 75 years.

- Quality improvement activities, including clinical audits, were carried out to help improve patient outcomes.
- Staff learned from any significant events that had occurred, to help prevent them from happening again.