Dr Barry Hyman

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?	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 Modality Attwood Green on 2 March 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 a system was in place for reporting and recording significant events. The practice had recorded and analysed significant events to identify areas of learning, and improvements were made to prevent the risk of further occurrence.
- Arrangements were in place to safeguard children and vulnerable adults from abuse, and local requirements and policies were accessible to all staff.
- Staff spoken with were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- The practice had joined a corporate provider (Modality) and had applied to the CQC to ensure this was reflected in their registration. Patients we spoke with said there had been some changes to staff members and the way the service was being delivered as a result of the changes.
- Patients told us that they found it easy to make an appointment and there was continuity of care. Urgent appointments were available on the day when necessary.
- Clinical audits were carried out to demonstrate quality improvement and to improve patient care and treatment.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs. The new provider (Modality) held

Summary of findings

monthly clinical management meetings which were attended by the lead GP. This facilitated management of poor performance and to exchange good practice across the organisation.

- The practice was located on the second floor of a purpose built health centre. The building was accessible and lifts were available for those patients who had difficulty with their mobility.
- There was a clear leadership structure both at corporate level and at practice level and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- Information about services and how to complain was available in various community languages. Improvements were made to the quality of care as a result of complaints and concerns.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

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.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology.
- There was an effective system in place to ensure all alerts were reviewed and acted on appropriately, including alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA).
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- We observed the premises to be visibly clean and tidy. There were adequate arrangements in place to deal with emergencies and major incidents.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were generally above the local CCG and national averages.
- Staff assessed needs and delivered care in line with current evidence based guidance. Clinical audits were carried out and they demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.
- Monthly clinical management meetings were held at the provider level attended by the lead GP. This helped them to manage poor performance and to exchange good practice across the organisation.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. For example, the practice increased access to appointments and the offered more online and telephone consultation as a result of patient requests.
- Patients said they found it easy to make an appointment with the GPs and there was continuity of care.
- For convenience, patients could access services such as the electrocardiographs (ECGs) at the practice. This was part an arrangement with the Clinical Commissioning Group (CCG).
- There were longer appointments available at flexible times for people with a learning disability and for patients experiencing poor mental health. Same day appointments were also available for children and those who needed to see a doctor urgently.
- There were disabled facilities and translation services available. The practice had a hearing loop in place and alerts were added to patients' records where support may be required.
- The practice was located on the second floor of a purpose built health centre. Lifts were available and the practice had good facilities to treat patients and meet their needs.
- Information about how to complain was available in various languages and evidence showed the practice responded quickly to issues raised. Complaints and incidents were discussed and learning was shared with staff.

Are services well-led?

Good

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

Summary of findings

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Its vision and values were displayed in the waiting area and staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- The practice had joined a corporate provider and there was a central governance team who helped to support the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Evidence we looked at confirmed that staff had received inductions and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour. A record of an incident we reviewed demonstrated that the practice complied with these requirements.
- The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group (PPG).
- The practice had joined a corporate provider and had access to the central governance team who helped to support the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.

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 patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice had systems in place to identify and assess patients who were at high risk of admission to hospital. Patients who were discharged from hospital were reviewed to establish the reason for admission and care plans were updated.
- The practice worked closely with multidisciplinary teams so patients' conditions could be safely managed in the community. Patients could be referred to other local practices that were part of the same provider offering additional services such as Urology, Rheumatology as well as Ear Nose and Throat (ENT) services. This provided convenience for patients who did not have to travel to hospital for the service
- The practice was accessible to those with mobility difficulties.

People with long term conditions

Good

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

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was at or below target level, was 94%. This was above the CCG average of 90% and the national average of 91%.
- The practice provided additional diabetic services. A Diabetes Consultant held clinics (mix of face to face and virtual) for more complex cases. This was as part of the Diabetes Inpatient Care and Education (DICE) programme, a CCG funded area of enhanced care.
- Other long term conditions such as chronic obstructive pulmonary disease (COPD), asthma and hypertension showed patient outcomes were above CCG and national averages.

Summary of findings

- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- The provider offered services to support the diagnosis and monitoring of patients with long term conditions such echocardiograms (ECG) and spirometry. Health promotion support was also available such as smoking cessation.

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.
- The practice was located on the second floor of a purpose built health centre and was suitable for children and babies and lifts were available.
- There were policies, procedures and contact numbers to support and guide staff should they have any safeguarding concerns about children. The practice discussed any safeguarding concerns as part of two monthly multidisciplinary meetings with relevant health professionals.
- We saw positive examples of joint working with midwives and health visitors. The practice provided immunisation clinics for children and provided postnatal checks.
- Immunisation rates were low for all standard childhood immunisations. The practice was aware of this and was working to address this.
- Appointments were available outside of school hours.
- The practice's uptake for the cervical screening programme (in the preceding five years) was 81%. This was comparable to the CCG average of 80% and the national average of 81%.

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 had a significantly higher than national average working age patients registered at

Summary of findings

the practice. The practice had increased the number of online and telephone consultations as a result of feedback from patients. It also offered early morning appointments from 7am to 8am on Mondays.

- Patients could access appointments and services in a way and at a time that suited them. Appointments could be booked over the telephone, face to face and online.
- The practice provided an electronic prescribing service (EPS) which enabled GPs to send prescriptions electronically to a pharmacy of the patient's choice.
- The practice offered a range of health promotion and screening that reflects the needs for this age group. This included NHS health checks.

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 homeless people, travellers and those with a learning disability.
- The practice was located near the city centre of Birmingham and staff were aware of and could demonstrate understanding of some of the barriers faced by vulnerable patients.
- Staff had attended external training to understand the barriers (to healthcare) faced by patients from vulnerable groups.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients and held meetings with the district nurses and community teams.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- The practice's computer system alerted GPs if a patient was also a carer. There were 41 patients on the practices register for carers; this was 1% of the practice list. There was supportive information in place for carers to take away as well as information available through the practice website. The practice offered annual reviews and flu vaccinations for anyone who was a carer.

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).

Summary of findings

- The practice carried out advance care planning for patients living with dementia. Seventy percent of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months. This was below the CCG average of 84% and the national average of 84%. We asked the practice to provide us with data from 2016-17 which showed that 83% of patients diagnosed with dementia had their care reviewed in a face to face meeting. Although this demonstrated improvement, this was unverified and unpublished data.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia. We looked at some mental health care plans and saw that some had input from external mental health teams.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 94%, compared to the CCG average of 91% and the national average of 89%.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health. The GP told us that they initially followed this up with a telephone call.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice was performing above local and national averages. Of the 357 survey forms that were distributed, 97 were returned. This represented 3% of the practice's patient list.

- 90% of patients described the overall experience of this GP practice as good compared with the CCG average of 75% and the national average of 85%.
- 71% of patients described their experience of making an appointment as good compared with the CCG average of 62% and the national average of 73%.
- 86% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 64% national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 26 comment cards and almost all were positive about the standard of care received. Comments included; staff were friendly, helpful and the GP was nice and caring. Patients also stated that they had experienced excellent service and the doctors and staff were always helpful and respectful.

We spoke with two patients during the inspection on the telephone. Both were members of the Patient Participation Group (PPG) and they told us that they were satisfied with the care they had received. PPG members also told us that since the practice had joined a corporate provider they had noticed some changes to the practice in the way the service was being delivered but were satisfied with the care they had received.

Dr Barry Hyman

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.

Background to Dr Barry Hyman

Modality Attwood Green also known as The Hyman Practice is located near the city centre of Birmingham with an approximate patient population of 2900. Modality Attwood Green is located on the second floor of a purpose built health centre in Birmingham, B15 1LZ. Many of the patients include those working within the city centre of Birmingham.

The practice is registered with the Care Quality Commission to provide primary medical services. The practice had joined a corporate provider (Modality) and had applied to the CQC to ensure this was reflected in their registration.

The practice has a general medical service (GMS) contract. Under this contract the practice is required to provide essential services to patients who are ill and includes chronic disease management and end of life care.

Compared to the national average, the practice has a significantly higher proportion of patients aged between 20 and 40. Conversely the practice has a significantly lower than average patient population between the ages of five to 20 and 35 and over.

Based on data available from Public Health England, the levels of deprivation (Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial) in the area served by practice is below the national average, ranked at two out of 10, with 10 being the least deprived.

The practice is open between 8am to 6.30pm Monday to Friday. The practice is also offered early appointments on Mondays from 7am to 8am and provided convenience for many working age patients registered with the practice.

The practice has opted out of providing out-of-hours services to their own patients. This service is provided by the external out of hours service provider (Primecare).

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the CCG to share what they knew. We carried out an announced visit on 2 March 2016. During our visit we:

Detailed findings

- Spoke with a range of staff (including the practice manager, the lead GP, and a member of the reception staff as well members of the central governance team). We also spoke with the medical director for the corporate provider.
- Observed how patients were being cared for in the reception area and two patients who used the service on the telephone.
- Reviewed comment cards where patients and members of the public shared their views and experiences.
- Reviewed a sample of the personal care or treatment records of patients of the service.
- Looked at information the practice used to deliver care and treatment plans.

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 living 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 a system for reporting and recording significant events.

- There was an effective system in place for reporting and recording significant events. This was supported by a policy that was accessible to all staff. There was an incident reporting template available on the practice computer system. Staff told us that they would complete the template and inform the practice manager who would investigate the incident and share the learning. If it was a clinical incident, we were told by the practice manager that they would also involve the lead GP and hold an informal meeting on the same day to share learning. This would then be shared with the wider team at formal practice meetings. We looked at the minutes of meetings for January 2017 and saw that learning from an incident had been discussed with staff and action had been taken.
- Records of incidents we looked at showed that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support and a written apology. For example, a record of an incident we reviewed showed that a GP had informed the patient involved, explained the reasons and apologised. The patient was invited to make a written complaint if they remained unsatisfied.
- The practice had had access to a central governance team for further support. We were told that appropriate staff within the governance team (based at another local site) received safety alerts, reviewed them and then forwarded them to all other sites with actions where necessary. For example, the central governance team were able to carry out searches on the practice computer system in response to alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA). We saw examples of emails that were sent to the practice from the central governance team with actions that were required following receipt of alerts. The practice could demonstrate that appropriate actions had been taken as a response to alerts.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff and 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. Minutes of meetings we sampled showed that safeguarding was a standing agenda item for discussion.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. Records we looked at showed that staff had attended training on understanding vulnerable communities.
- Notices outside consultation rooms 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 (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 practice maintained appropriate standards of cleanliness and hygiene.

- The practice was located in a purpose built building owned by NHS property services. We observed the premises to be visibly clean and tidy. Cleaning of the premises was organised by NHS property services. The practice was responsible for the cleaning of medical examination equipment; we saw that a schedule was in place to ensure cleaning was carried out according to specification.
- The practice had access to the new providers central governance team (located at another local site) for further support. We spoke to a compliance officer who was the lead for infection control and they told us that carried out six monthly audits. The last infection control audit had been carried out in October 2016 and they were in the process of carrying out another review. There was one action identified in the October audit

which was to ensure all staff had received appropriate training. Records we looked at confirmed that staff had received up to date training in infection prevention and control.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Records we looked at showed that patients on high risk medicines were being managed appropriately. We saw that there was an effective alert system in place to ensure test results were checked before issuing any medicines.
- Repeat prescriptions were signed by an appropriate person before being given to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. The practice followed the Royal College of General Practitioners (RCGP) toolkit for prescribing and records we looked at showed that the practice was one of the lowest prescribers for antibiotics. The practice participated in drug peer review through one of the five locality commissioning groups that make up Sandwell and West Birmingham Clinical Commissioning Group (CCG).The medical director for the provider also took a lead role in monitoring prescribing. Any concerns identified were discussed during the monthly clinical management meeting.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use. The practice employed a nurse prescriber who could prescribe medicines for clinical conditions within there are of competence.
- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions (PSDs) from a prescriber were produced appropriately.

We reviewed three personnel files of current staff members and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS checks.

Monitoring risks to patients

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

- The practice was located in a health centre and the building was maintained by the landlord (NHS property services). We saw that NHS property services had organised a health and safety risk assessment of the building. Similarly, a fire risk assessment had been organised and regular fire drills were carried out and there were designated fire marshals within the building. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and in good working order. This was organised by the landlord (NHS property services). Other risk assessments carried out by the landlord included control of substances hazardous to health and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We were shown a matrix that was used by the central Human Resources (HR) team to calculate adequate staffing levels based on the practice list size. For example, the matrix indicated that a practice nurse was required for 30 hours a week for the number of patients registered. The practice had employed a nurse to work these hours, however, they had left recently and the practice was in the process of recruiting a new nurse. The practice also employed a nurse prescriber who could cover for the nurse while a new nurse had been recruited. The practice manager told us that if they were short staffed, they could request cover from other sites that were part of the same corporate provider. The practice manager showed us an email they had received on the day from the corporate provider requesting an

administration staff member to cover for unplanned absence at another site. We were told that if staff cover was unavailable internally then locum staff cover would be arranged.

Arrangements to deal with emergencies and major incidents

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

· There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. We were told about a recent incident where the GP had activated the alert system on the computer and staff had responded appropriately to the alert.

· All staff received annual basic life support training and there were emergency medicines available and staff we spoke with were aware of the location.

· The practice had a defibrillator available on the premises. There was emergency medical oxygen available with adult masks. However, there were no children's masks. Documents we looked at indicated that children's masks were available as they were being checked regularly. Staff members confirmed that they were available but were unable to locate them on the day.

· Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

· The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. It was available on the provider intranet and the practice manager told us that there was a laptop that could be used in the event of power failure so that patient information could be accessed for consultations. If the building was not accessible, other nearby sites (that were part of the same corporate provider) could be used and this would be co-ordinated by one of the directors.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. The new provider held monthly clinical management group meeting attended by lead GPs from each site. Any new guidance including NICE guidance were discussed at this meeting and sent out to relevant clinicians. Clinical staff also told us that they aware able to access guidance online.
- The practice monitored that these guidelines were followed through the monthly clinical management meetings as well as through audits.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 100% of the total number of points available compared with the clinical commissioning group (CCG) average of 94% and national average of 95%. The overall exception reporting by the practice was 8% which was below the CCG average of 10% and the national average of 10%. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.

Data from 2015-16 showed:

- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was at or below target level, was 94%. This was above the CCG average of 90% and the national average of 91%. A Diabetes Consultant held clinics for more complex cases. This was as part of the Diabetes Inpatient Care and Education (DICE) programme, a CCG funded area of enhanced care.
- The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using recognised methods was 93%, compared to CCG average of 88% and national average of 90%.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 94% compared to the CCG average of 91% and the national average of 89%.
- 70% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months. This was below the CCG average of 84% and the national average of 84%. We asked the practice to provide us with data from 2016-17 which showed that 83% of patients diagnosed with dementia had their care reviewed in a face to face meeting. Although this demonstrated improvement, this was unverified and unpublished data.

There was evidence of quality improvement including clinical audit:

- There had been two clinical audits commenced in the last six months and both of these were completed audits where the improvements made were implemented and monitored. For example, the practice had carried out an audit on a medicine for nocturnal cramps in September 2016 and six patients were identified as receiving this medicine on repeat prescription. The practice reviewed patients based on the advice of the Medicines and Healthcare products Regulatory Agency (MHRA) and re-audited after three months. The re-audit carried out in January showed that three patients were no longer on the medicine. Three other patients reviewed were prescribed the medicine appropriately and according to the recent MHRA guidance.

Monthly clinical monitoring group meetings were held at the provider level to review performance and patient outcomes for each practice. They included monitoring of patient outcomes through monitoring of QOF achievements, medicine management (prescribing) as well as vaccination and immunisations. If patient outcomes were not being achieved, they were highlighted to the lead GP with further guidance and support on how improvements could be achieved. This would be monitored at subsequent clinical management group

Good

Are services effective?

(for example, treatment is effective)

meetings, and if further improvements were required then further resources could be made available. For example, we were told that the practices' achievement for cervical screening for the current year had been 70% which was below its yearly target of 80%. As a result the new provider had offered further resources through the central governance team. Members of the central governance team helped to identify appropriate patients so that they could contact and encourage them to attend their screening. Consequently we saw that the current achievement (for the current year) was 77%. However, this was not published or verified data.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Staff had access to and made use of e-learning training modules and in-house training. The GP told us that they were given one week of study leave annually to update their knowledge and skills. New staff members shadowed existing staff members to understand their roles responsibilities.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, the practice manager also showed us a reception, administration and secretary skills matrix that they used to identify staff skill levels and to offer appropriate training.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to online resources and discussion at practice meetings.

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.

- This included care and risk assessments, care plans, medical records and investigation and test results. We saw examples of care plans that were in place for patients with dementia, mental health as well as diabetes (templates).
- The practice shared relevant information with other services in a timely way, for example, when referring patients to other services. The practice had a system for processing of referrals with a named staff member responsible for ensuring timely referral. Patients were advised to contact the practice if they had not received an appointment after their referral.

Staff worked together with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Records we looked at indicated that meetings took place with other health care professionals on a monthly basis to discuss and review patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. The practice had a register of vulnerable groups such as the homeless and travellers as well as those with drug or alcohol dependency. The practice told us that they had a total of 74 patients on the register and records we looked at confirmed that staff had attended training to understand the barriers faced by these patients.

The practice took an active approach to joint working and engaged well with other health and social care services. The practice had joined a corporate provider which offered community services (through referral) such as Dermatology, Urology, Gynaecology, as well as Ear Nose and Throat (ENT) services at other nearby sites (run by the corporate provider). This provided convenience to patients as they did not need to travel to hospital. The practice told us that they had offered 141 appointments for Dermatology and Rheumatology in the past year thereby avoiding the need for these patients to attend secondary care (hospital).

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

Good

Are services effective?

(for example, treatment is effective)

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Records we looked at showed that staff had attended training for mental capacity.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and sign posted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition such as diabetes, Chronic Obstructive Pulmonary Disease (COPD) and those requiring advice on their diet, smoking and alcohol cessation. Where relevant, patients were signposted to the other services. For example, staff members told us that they had links on their computer system for the route2wellbeing website. This was a web portal with information on local voluntary and community health and care services.
- The waiting room also provided detailed information for carers and how to access various services such as for mental health services.
- The practice's uptake for the cervical screening programme (in the preceding five years) was 81%. This was comparable to the CCG average of 80% and the national average of 81%.
- The practice encouraged its patients to attend national screening programmes for bowel and breast cancer. Breast cancer screening rates for 2015/16 (for last 36 months) were at 59% compared to the CCG average of 66% and the national average of 73%.
- Bowel cancer screening rates (for last 30 months) were at 43% compared to the CCG average of 45% and the national average of 58%. The practice achievement was monitored through the monthly clinical management meeting dashboard.
- Childhood immunisation rates for the vaccinations given to children up to the age of two were below local CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 78% to 83% which was below the 90% standard target. For five year olds, vaccination rates were from 69% to 88%. The CCG average for five year olds was from 86% to 94% and the national averages were from 88% to 94%. The practice was aware of the low vaccination rate and was taking action to improve. This was also monitored during the monthly clinical management meeting. The practice told us that there were a number of factors which contributed to the lower achievement. This included a significantly lower than average younger population as well as a transient patient population. We were told that some newly arrived patients (to the country) also declined vaccinations. The practice was able to produce a list of all children that were currently due vaccinations and was able to provide explanations why these had not been vaccinated. For example, one patient from the list had declined the vaccine, two patients had not responded following contact from the practice; one patient had left the practice and another had only recently joined. The practice was also working with the health visitor so that they could explain to parents (who were resistant) on the importance of the vaccination programme.
- The practice held a register of patients from vulnerable groups, this included four patients with learning disabilities. So far, one patient had a reviewed this year and plans were in place to review others. There were 24 patients on the mental health register and 94% had received an annual review. The practice also had five patients on the dementia register and all (100%) had received a review. The practice was located near the city centre of Birmingham and had a significantly higher working age patients compared to the national average. Conversely the practice has a significantly lower than average patient population between the ages of five to 20 and 35 and over.
- Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74 and for people aged over 75. Appropriate follow-ups on the outcomes of health assessments and checks were

Good

Are services effective?

(for example, treatment is effective)

made, where abnormalities or risk factors were identified. Patients were also signposted to relevant services to provide additional support. Carers were also offered health checks and the flu vaccination.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff members we spoke with were also able to discuss another example where a patient with mental health needs was treated with dignity and compassion.

We received 26 patient Care Quality Commission comment cards. Almost all cards were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with two patients who were members of the patient participation group (PPG). They told us that changes had taken place to the practice since it had joined a corporate provider. This included changes to staff members but they were satisfied with the care they had received so far. They told that their dignity and privacy was respected and comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 94% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 83% and the national average of 89%.
- 89% of patients said the GP gave them enough time compared to the CCG average of 82% and the national average of 87%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and the national average of 95%
- 90% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 80% and the national average of 85%.
- 93% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 87% and the national average of 91%.
- 91% of patients said the nurse gave them enough time compared with the CCG average of 87% and the national average of 92%.
- 97% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 96% and the national average of 97%.
- 86% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 91%.
- 94% of patients said they found the receptionists at the practice helpful compared with the CCG average of 81% and the national average of 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 from the comment cards we received was also positive and aligned with these views. Care plans we looked at were personalised.

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 generally above the CCG averages and in line with national averages. For example:

- 91%% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 81% and the national average of 86%.
- 90% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 76% and the national average of 82%.

Good

Are services caring?

- 87% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 86% and the national average of 90%.
- 84% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 82% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. The practice was located in a health centre sharing the waiting area and reception desk with another organisation providing health services to refuges and asylum seekers. Staff told us that they could book an interpreter who would be available within 24 hours. However, if an interpreter was required urgently, the practice could request support from a neighbouring service. We met with an interpreter in the reception area who had been available all day during the inspection. Staff had also attended training on understanding vulnerable communities to help them recognise the barriers faced by vulnerable patients.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or patients who were housebound included signposting to relevant services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 41 patients as carers (1% of the practice list). We were told that the lead GP managed the carers register and the practice offered flu vaccinations and carers health check (as well and NHS health check). Almost all (98%) carers had been invited for a health check and the patient information system we looked at showed 23% of registered carers had undergone a health check. Carers were also invited to receive flu vaccinations and 24 (59%) had received the vaccination while 20% had declined. We were told that these figures were reviewed by new provider during the monthly clinical management group meeting to improve performance. There was a carers pack available and carers were also referred to appropriate support through the route2wellbeing website.

The practice GP contacted patients if they had suffered bereavement and offered further support. We were given an example of one patient who had experienced two recent bereavements. They were discussed at the multidisciplinary team meeting and the practice had also contacted the district nurse to make them aware so that help and support could be offered to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on a Monday morning from 7am to 8am for working patients who could not attend during normal opening hours.
- The practice was located in the city centre of Birmingham and many of the patients registered with the practice also worked in the city. The practice was aware that many of these patients wanted early appointments as well as more telephone consultations. As a result the number of telephone consultations had been increased. The practice manager told us that they also had a flexible approach to booking appointments as they could offer more telephone consultations if required in place of face to face appointments.
- The practice was aware that patients wanted flexible approach to appointments for immunisation. As a result, the practice had stopped offering specific immunisation clinics which could now be booked at times convenient for patients such as after school.
- There were longer appointments available for patients such as those with a learning disability, carers and patients experiencing poor mental health.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to access travel vaccines available on the NHS. Patients could be referred to other clinics for vaccines only available privately.
- The practice was located on the second floor of a purpose built health centre and lifts were available to ensure access for patients who had a difficulty with their mobility. There were disabled parking and toilet facilities.
- There was a hearing loop, and interpretation services were available.
- The practice offered a range of services to support the diagnosis and management of patients with long term conditions. For example, echocardiograms (ECG) and spirometry.
- For convenience, patients could access other services such as Rheumatology, Dermatology as well as Urology at other sites operated by the provider without the need to travel to the hospital. We were told that often waiting times at the local hospital was longer so this provided further convenience for patients.

The practice provided a range of health care information in the practice and through their website, this included information to signpost patient to other support services, local services such as hospital allergy services as well as providing health guides on such topics as medicines and vaccinations. For example, the practice website provided information on the NHS vaccination schedule.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.30am to 6.30pm Monday to Friday. Extended hours appointments were offered on Mondays from 7am to 8am. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for patients that needed them. Home visits and telephone consultations were also available.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was generally above local CCG and national averages.

- 78% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 71% and the national average of 76%.
- 73% of patients said they could get through easily to the practice by phone compared to the CCG average of 60% national average of 73%.
- 89% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 75% and the national average of 85%.
- 90% of patients said their last appointment was convenient compared with the CCG average of 87% and the national average of 92%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 71% of patients described their experience of making an appointment as good compared with the CCG average of 62% and the national average of 73%.
- 73% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 46% and the national average of 58%.

Patients on the day of the inspection told us that they were able to get appointments when they needed them.

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. Alerts were put on the patient record system if a patient was house bound or had complex needs. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice. Complaints were reviewed at corporate level and resolved locally.
- We saw that information was available to help patients understand the complaints system. For example, patients were informed of the complaints process in the reception waiting area in various community languages including Urdu, Polish and Punjabi.

The practice manager told us that the complaints system prior to them starting was not well organised. However, The practice manager had put the current complaints process in place when they joined the practice in September 2016. Since then they had received three complaints, including a verbal complaint. We saw that they were investigated and discussed in team meetings. Lessons were learned and shared with staff members.

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 joined a corporate provider (Modality) and had applied to the CQC to ensure this was reflected in their registration. The new provider had a clear vision to deliver high quality care and promote good outcomes for patients. The new provider had a mission statement which was displayed in the waiting areas and staff knew and understood the values. The practice had a clear strategy and supporting business plan which reflected the new provider's vision and values which was regularly monitored.

Governance arrangements

The practice had a governance framework which supported the strategy to deliver good quality care. There were leads accountable for governance and compliance at the corporate provider level. The corporate provider held monthly clinical management meetings where performance of the practice was reviewed. There was a central governance team which met regularly to discuss issues affecting all the practices. On the day, we spoke with a compliance officer who worked within the central governance team. They told us that their role was to ensure compliance to various policies and procedures. For example, they ensured compliance to infection control and carried out audits. They also ensured appropriate risk assessments such as health and safety and fire risks assessments were up to date and appropriate.

At the practice level, the practice manager and the lead GP worked together to improve any performance issues identified at the monthly clinical management meeting. They were then delegated to appropriate staff members to action. For example, the healthcare assistant and the nurse was responsible for ensuring follow up of patient with long term conditions (QOF). The practice held monthly meetings to discuss any issues and also held ad hoc 'huddle' meetings if there was a need. These huddle meetings could be initiated by any staff if they felt they needed to communicate any concerns without delay. Discussions were not formally recorded for 'huddle' meeting. However, minutes of meetings we looked at referred to discussions that had taken place during the 'huddle' meetings. These included discussion after incidents and complaints and staff members we spoke with confirmed that they could initiate a 'huddle' meeting and feedback any concerns.

Leadership and culture

The lead GP at the practice was able to demonstrate that they had the experience, capacity and capability to deliver high quality, compassionate care. The practice had a corporate team to support the practice to deliver effective care. Any concerns identified were reviewed with advice and resources offered to ensure targets were achieved. For example, we were told that the central governance team helped the practice to achieve their targets for cervical screening.

The practice manager told us that here had been changes to staffing since the practice had joined the new provider. For example, we were told that all previous administration staff had left the practice and a challenge was to build a new team who were aware of the different roles and responsibilities and could deliver quality care to patients. As a result, they had carried out an assessment of staff abilities using a skills matrix so that they could ensure appropriate support and training. All staff had started recently and were not due an appraisal. Plans were in place to hold appraisals when they were due.

Staff told us and records we looked at showed that regular team meetings were held. Staff also told us that there was an open culture within the practice and they had the opportunity to raise any matter at team meetings or through the hoc 'huddle' meetings. Staff members told us that they were confident in raising any matter and felt supported if they did. There were protected in house learning events held twice yearly as well as those held by the Clinical Commissioning Group (CCG) to support staff learning and development.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. Records of incidents and complaints we looked at indicated that the practice had systems to ensure that when things went wrong with care and treatment the practice gave affected people reasonable support, truthful information and a verbal and written apology. The practice kept written records of verbal interactions as well as written correspondence.

Are services well-led?

Good

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

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

Feedback from patients was gathered through the Patient Participation Group (PPG) and through surveys and complaints received. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. There was a poster on display in the waiting area to encourage patients to join the PPG and attend the next meeting scheduled for April 2017.

Poster on a notice board in the waiting area reported on changes to the service that had been made in response to patient feedback 'you said we did'. For example, patients wanted increased access to appointments and flexibility to how appointments were offered. The practice informed patients that they had introduced early Monday morning appointments from 7am to 8am. Patients could also book an appointment with a female GP who was now available Monday to Friday and appointments could be booked with a nurse prescriber.

The practice generally achieved above average satisfaction scores for most elements of the national GP patient survey.

However, the practice manager told us that they monitored the national GP patient survey so that action could be taken to further improve where required. The practice manager showed us an action plan developed outlining areas for improvement. This included increasing access to appointments and increasing number of online and telephone consultations available. We saw that these had been actioned. For example, the practice closed for half day once a week previously. Since joining the provider, the practice was now open from 8am to 6.30pm Monday to Friday, increasing the number of appointments available

The PPG last met in January 2017 and the two PPG members we spoke with on the day told us that their suggestions were listened to and could give us a specific example. The practice manager and the medical director told us that they planned to incorporate the current PPG within the corporate PPG.

The practice had gathered feedback from staff through staff meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff could also call for an ad hoc 'huddle' meeting to discuss or feedback any issues. The practice manager showed us a survey template they planned to use to gather feedback from staff members.