Care Quality Commission

Trust Headquarters (The Health Exchange)

Inspection report

Trust Headquarters B1
50 Summer Hill Road
Birmingham
West Midlands
B1 3RB
Tel: 0121 465 3965
www.bsmhft.nhs.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 location   Inadequate ●

Are services safe?	**Inadequate** ●
Are services effective?	**Inadequate** ●
Are services caring?	**Requires improvement** ●
Are services responsive?	**Inadequate** ●
Are services well-led?	**Inadequate** ●

Overall summary

This service is rated as Inadequate overall.

The key questions at this inspection are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Requires Improvement

Are services responsive? – Inadequate

Are services well-led? – Inadequate

We carried out an announced comprehensive inspection at The Health Exchange on 25 July 2018, in response to concerns received.

At this inspection we found a lack of a coherent plan for developing and monitoring the service and its contract:

- The service did not operate an effective programme of quality improvement activities to measure performance or clinical effectiveness and were unable to demonstrate how they accessed national available data.
- The service had oversight of some governance arrangements and used them to drive service delivery. However, we found that cohesive working between the service, Trust and commissioners as well as a clear understanding of the service was limited and this impacted on the services ability to develop effective governance arrangements. For example, management of staffing levels; clinical support as well as effective IT systems.
- The service was unable to demonstrate awareness of the day to day management of infection control as well as an established programme of ongoing or periodic infection control audits. The service did not have a system for monitoring or checking whether general cleaning was being carried out in line with the Trust's cleaning policy.
- The service had some arrangements in place to enable appropriate actions in the event of a medical emergency. However, not all potential medical emergency situations were considered and a risk assessment to mitigate potential risks had not been carried out.
- There were areas of environmental safety where the service did not carry out risk assessment to mitigate risk. For example, the service were unable to provide

assurance that a legionella risk assessment had been carried out as well as fire drills. Following our inspection, the provider sent evidence of a legionella risk assessment carried out in February 2016 and explained that an annual review had been carried out following our inspection.

- The service had clear systems to report and investigate safety incidents so that they were less likely to happen. When incidents did happen, the service learned from them and improved their processes.
- Clinical staff ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Although the service operated an appointment system which allowed easy and flexible access to appointments during opening hours, the July 2017 national GP patient survey results were mainly below local and national averages for questions relating to access to care and treatment and the service had not analysed the results.
- There was a focus on continuous learning from incidents at all levels of the service.

The areas where the provider **must** make improvements are:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider **should** make improvements are:

- Take action to ensure advance training carried out by clinical staff is recognised and staff complete training recognised by the service as mandatory in a timely manner.
- Take action to gain patient feedback and explore effective ways to act on feedback in order to improve patient satisfaction.

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

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

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

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The team included a GP specialist adviser and a second CQC inspectors.

Background to Trust Headquarters (The Health Exchange)

Birmingham & Solihull Mental Health NHS Foundation Trust is the registered provider of The Health Exchange which is located at the William Booth Centre, William Booth Lane, Birmingham City Centre. The Trust has a number of other locations which fall under the scope of registration. We did not visit any of the other locations as part of this inspection.

The service provides a range of primary care services for homeless patients in Birmingham with some enhanced services to meet the specialist requirements of the homeless population. An enhanced service is above the contractual requirement of the service and is commissioned in order to improve the range of services available to patients. The service offers a full general practice service to those who are homeless or vulnerably housed who are aged 16 and over and not pregnant.

The patient list size is 1,025 of various ages registered and cared for at the service. Services to patients are provided under an Alternative Provider Medical Service contract with Birmingham and Solihull Clinical Commissioning Group. APMS is a contract between general practices and the CCG for delivering primary care services to local communities.

The service is open between 9am and 5pm Mondays to Fridays, except for Bank Holidays when the service is closed. The service is closed each day between 12:30pm and 1pm.

GP consulting hours are available between 9.30am to 12.00 and 1.30pm to 4pm Mondays to Thursdays, except Wednesdays when GP consulting is available between 9am and 11am. GP services are not available on Fridays; however, Advanced Nurse Practitioners appointments are available for urgent prescription requests. Patients who require GP support on Fridays are signposted to the local walk-in centre.

The service has opted out of providing cover to patients in their out of hours period. During this time, services are provided by NHS 111.

Staff comprises of a salaried GP as well as GP support from a neighbouring practice two days per week, a practice nurse, two substance misuse nurses one of which is an independent prescriber, two community psychiatric nurses, a support worker and a psychotherapist. The non-clinical team consists of a team manager and two administrators/receptionists.

Birmingham & Solihull Mental Health NHS Foundation Trust is registered to provide surgical procedures, maternity and midwifery services, treatment of disease, disorder or injury, family planning, diagnostic and

screening procedures. The Health Exchange is registered under the Trust registration to provide treatment of disease, disorder or injury. The Trust was inspected in March 2017 and rated overall requires improvement. During our March 2017 inspection, we found that legal requirements were not being met and the Trust was issued with requirement notices and required to provide a report stating what actions they are going to take to meet the legal requirements.

The Health Exchange has not previously been inspected.

Are services safe?

We rated the service as inadequate for providing safe services.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse, however systems to manage Infection Prevention Control (IPC) required improvement.

- The service had appropriate systems to safeguard children and vulnerable adults from abuse. There was a lead member of staff for safeguarding who attended multidisciplinary team meetings and played an active role in care management for vulnerable groups.
- The service training matrix showed that most staff received up-to-date safeguarding and safety training appropriate to their role as part of the Trust training schedule. For staff who had not completed the Trust's recognised training we saw that training had been scheduled.
- Learning from safeguarding incidents were available to staff.
- Staff who acted as chaperones were trained for their role. Staff explained that they 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.). However; we were unable to confirm this during our inspection, as staff files were not kept at the service.
- Although recruitment files were not available to view during our inspection, staff explained systems in place to ensure appropriate checks at the time of recruitment and on an ongoing basis carried out by the Trust. Our March 2017 Trust inspection, confirmed that appropriate recruitment checks were being carried out.
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- The service was unable to demonstrate local awareness of an established programme of ongoing or periodic infection control audits. The last audit was carried out in April 2015. Staff explained that an infection control walk around was carried out June 2018 and actions to improve compliance such as maintaining a log to

evidence that equipment is being cleaned regularly had been implemented. Following our inspection, the provider sent evidence of quarterly cleaning audits as well as daily decontamination of healthcare equipment.
- The service had arrangements to ensure that facilities and equipment were safe and in good working order. The service appeared clean; however, staff were unable to demonstrate how they monitored that general cleaning was being carried out by external contractors at the required frequency as detailed in the Trusts cleaning policy.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

Systems to assess, monitor and manage risks to patient safety were not always adequate.

- The service was equipped to deal with most medical emergencies and staff were suitably trained in emergency procedures. In the absence of some emergency medicines the service did not carry out a risk assessment to mitigate risks. Following our inspection, we were told that an updated stock of emergency medicines would be delivered to the service.
- The service used staff rotas to manage staffing levels and used GPs from a local GP practice who were experienced in supporting vulnerable patients. However, staff we spoke with were concerned about staffing levels and clinical support. For example, patients had access to a nurse prescriber on Fridays who prescribed within their clinical competencies; however, no GP sessions were available on Fridays and arrangements with out of hours providers had not been established to cover Fridays or in hour closure times.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- There were panic buttons in the reception area, staff carried pin point alarms and an instant messaging system on the computers alerted staff to any emergency. There were systems in place to deal with violent patients and the service operated a zero-tolerance policy (a policy where staff are protected and have the right to care for others without fear of being attacked or abused).

Are services safe?

- When there were changes to services or staff the service assessed and monitored the impact on safety. Information was then shared with members of the management team.
- The service had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients; however, systems to enable the service to share information with out-of-hours providers had not been established.

- The clinical system did not support the use of special patient notes (SPN). SPN are recorded by GPs to ensure the right information is available to the right people such as out of hours services who are unlikely to have any prior knowledge of the patient that they need to assess. SNP reflect the care needs, choices and preferences of the patient. Clinical staff explained the module for completing SPN had not been included in the clinical system. Staff told us that this had been discussed with the Trust and was being addressed. However, no contingency plan had been put in place to manage SPNs during this time.
- The service had systems for sharing information with staff and other agencies such as local addiction, homeless, and asylum seekers services to enable them to deliver joined up safe care and treatment.
- The care records we saw showed that information needed to deliver safe care and treatment was available to staff.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The service had systems for appropriate and safe handling of medicines.

- The systems for storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Blank prescription forms and pads were securely stored. However, the service did not operate an effective system for tracking their use.
- Staff prescribed and administered medicines to patients and gave advice on medicines in line with current national guidance.

- The service did not operate a repeat prescription service and patients were seen by a prescribing clinician whenever they needed a prescription.
- The service was aware of the risks related to higher use of antibiotics due to infections associated with substance misuse, homelessness as well as poor health and nutrition. During consultations clinicians reviewed antibiotic prescribing to ensure prescribing remained appropriate to the patient's needs.
- Clinicians used Patient Group Directions (PGDs) to administer medicines, PGDs had been produced in line with legal requirements and national guidance. (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).
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

There were areas where the service did not have a good track record on environmental safety. For example:

- The service was unable to provide assurance that a legionella risk assessment had been carried out (Legionella is a term for a bacterium which can contaminate water systems in buildings). Steps to prevent and control potential risks had not been established. Following our inspection, the service provided evidence of their legionella management and control policy dated 2015 with a scheduled review date of December 2017. The provider sent evidence of a risk assessment carried out in February 2016 with a recommended review date of February 2017. The provider also provided evidence of water temperature checks which had been carried out.
- The control of substances' hazardous to health (COSHH) risk folder was updated during our inspection, and we saw COSHH data sheets which had not been reviewed since 2015.
- Risk assessments such as fire, and health and safety had been carried out. However, staff we spoke with were unable to recall the last time a formal fire drill had been carried out and records to evidence weekly fire alarm

Are services safe?

checks as well as fire equipment such extinguishers was not provided. Following our inspection, the provider sent evidence of weekly fire alarm checks carried out by the building owners.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so; however, documents we viewed showed that the Trust felt incidents were under reported. Staff explained that insufficient staffing levels and the impact this had on workloads lead to possible under reporting of incidents.

- There were adequate systems for reviewing and investigating when things went wrong at a Trust level. The service learned and shared lessons, identified themes and took action to improve safety in the service.

- The service acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the evidence tables for further information.

Are services effective?

We rated the service and all of the population groups as inadequate for providing effective services overall .

Effective needs assessment, care and treatment

The service had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- During our inspection, we found a number of issues such as no systematic approach to monitoring effectiveness and outcomes as well as the clinical system not being set up for the use of special patient notes which impacted on this population group.
- Staff explained that the service collected data such as Quality Outcomes Framework indicators to monitor and measure performance to improve health outcomes. However, evidence to demonstrate this was not provided.
- The service had a small number of patients who were between the ages of 55 and 75. The service provided proactive, personalised care to meet the needs of this population group.
- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs.
- Clinical staff used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- The service followed up on older patients discharged from hospital. Clinicians ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- The service worked closely with local hostels, homeless service centres' and community nursing teams to ensure effective outcomes for patients.

People with long-term conditions:

- During our inspection, we found a number of issues such as no systematic approach to monitoring effectiveness and outcomes which impacted on population groups.
- Staff explained that the service collected data such as Quality Outcomes Framework indicators to monitor and measure performance to improve health outcomes. However, evidence to demonstrate this was not provided.
- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met opportunistically when they attended the service. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension blood pressure was monitored during appointments and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate. Patients who accessed the service had access to blood pressure monitoring.
- The service was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension). The service offered spirometry (a test used to assess how well patents lungs worked) and nurses received appropriate training. The service liaised with community health care services and partnership agencies to address patients' health care needs.

Families, children and young people:

Are services effective?

- During our inspection, we found a number of issues such as no systematic approach to monitoring effectiveness and outcomes as well as the clinical system not being set up for the use of special patient notes which impacted on this population group.
- The service was only available for the homeless and vulnerably housed patients over the age of 16 and not pregnant. Therefore, families or young children were not registered but were directed to other mainstream GP practices. As a result, we did not rate this population group.
- Although the service did not look after children staff recognised that many of their patients had families and prioritised the issues of safeguarding that this highlighted.
- Pregnant women were not able to register as a patient. Registered patients who became pregnant were referred to community midwifes, maternity services and referred to mainstream GP practices for ongoing general health care.
- The service offered pregnancy testing, advice about contraception as well as emergency contraception and implants.

Working age people (including those recently retired and students:

- During our inspection, we found a number of issues such as no systematic approach to monitoring effectiveness and outcomes as well as the clinical system not being set up for the use of special patient notes which impacted on this population group.
- The service had a very small number of female patients. GPs and nurses were trained to carry out cervical screening which were done opportunistically.
- The service operated a call and recall system in collaboration with Public Health England (PHE) for all women eligible for cervical screening based on good practice guidelines. As some patients had no address the service operated a system where patients were required to return three weeks following initial screening or contacted by phone.
- The service also encouraged breast and bowel cancer screening.
- The service had systems to inform patients to have the meningitis vaccine.

- Patients had access to appropriate health assessments and checks. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The service offered a stop smoking service to registered patients. The programme consisted of eight weeks supply of Nicotine replacement therapy and a carbon monoxide check on a weekly basis.

People whose circumstances make them vulnerable:

- During our inspection, we found a number of issues such as no systematic approach to monitoring effectiveness and outcomes as well as the clinical system not being set up for the use of special patient notes which impacted on this population group.
- Staff explained that the service collected data such as Quality Outcomes Framework indicators to monitor and measure performance to improve health outcomes. However, evidence to demonstrate this was not provided.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The service were able to offer care and support for patients at end-stage liver disease who declined treatment in secondary care but continued to drink alcohol.
- Patients were allocated a support worker who delivered a co-ordinated approach with other local services to support patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. Patients received support with securing accommodation, benefit issues and access to food banks.
- The service had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- Substance misuse nurses supported patients and oversaw the homeless service pathway with the local addiction service to enable patients to access substitute prescribing.
- Blood-borne virus checks such as Hepatitis B, C and HIV were carried out on patients upon registration and on an ongoing basis as part of health and risk reviews.

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

Are services effective?

- During our inspection, we found a number of issues such as no systematic approach to monitoring effectiveness and outcomes as well as the clinical system not being set up for the use of special patient notes which impacted on this population group.
- Staff explained that the service collected data such as Quality Outcomes Framework indicators to monitor and measure performance to improve health outcomes. However, evidence to demonstrate this was not provided.
- Patients had access to a community psychiatric nurse and psychological therapist who carried out assessments, management of primary care psychological and social needs; medication management in liaison with GPs and where necessary joint case management with secondary care community mental health teams.
- There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the service had arrangements in place to help them to remain safe. Relapse prevention planning and patient education was provided for patients who regularly moved between primary and secondary mental health provision.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The service operated a weekly mental health drop in session for any patient who wished to speak to someone about how they were feeling. Staff explained due to the high uptake and success of the service there were plans to increase this to twice weekly.

Monitoring care and treatment

Although clinicians carried out some quality improvement activities, the service did not operate a comprehensive clinical audit plan or engage in benchmarking activities to review effectiveness, measure impact and appropriateness of the care provided. For example, the service were unable to demonstrate how they monitored antibiotic prescribing or actions taken to support good antimicrobial stewardship in line with local and national guidance. Staff explained that there was no support available or being provided from medicines management teams to support medicine optimisation or monitoring of prescribing activities. Staff also explained that the clinical system allowed the service

to follow Quality Outcome Framework indicators (QoF); however, data was not being extracted from the clinical system or used to measure performance. Staff we spoke with explained that performance monitoring had not been established or set by the Clinical Commissioning Group and the service were not involved in performance indicator programmes to measure clinical effectiveness. Staff explained that following our inspection, the service would speak with the Trust to extract QoF data from the clinical system.

There were some evidence of where the service took part in research projects carried out by the local university and some individual clinical audits. For example, the service had taken part in a research project looking at healthcare issues affecting homeless people in Birmingham. The study showed a high level of multi-morbidity, mental health conditions particularly substance and drug misuse; and infectious diseases, mainly hepatitis C amongst homeless patients. Staff explained that the service had worked hard to set up the Hepatitis C clinic which was held weekly. The service worked in cooperation with a specialist secondary care provider where a consultant attended the service to carry out FibroScaning (a scan to establish the presence of fibrosis or cirrhosis in patients with chronic liver disease). Staff explained that this service was very beneficial for the patient group as patients would often fail to attend their secondary care appointments.

Clinicians carried out an audit between October and November 2016 regarding the monitoring of patients prescribed antipsychotics to check whether patients had received a health check. The service identified that there was no systematic monitoring of patients' attendance for health checks and screening was largely opportunistic. The service carried out a targeted programme of proactive monitoring and introduced the use of primary care templates. A second audit showed some areas of improvement. Staff also explained that the service undertook a review after recognising an increase in human immunodeficiency virus (HIV) and Sepsis in the rough sleeping population. Patients' wounds were swabbed as part of this review to identify a type of infection which has the potential to lead to Sepsis. However, during our inspection, staff were unable to provide data or evidence of this review. Following our inspection, the provider explained that the findings around the two issues were reported to Public Health England.

Are services effective?

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, caring for patients engaged in substance misuse, challenging behaviours, homelessness and blood borne viruses.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The service understood the learning needs of staff and provided protected time and training to meet them. Records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. However, staff we spoke with explained that the Trust training module did not always meet their or the service's needs.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The service shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for patients involved in multiple services. Staff shared information with, and liaised, with community services, social services and support workers. However, the clinical system used by the service did not allow the sharing of special care notes. This meant the service could not share information with out of hour (OOH) services.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, released from custodial

establishments or after they were discharged from hospital. The service worked with patients to develop personal care plans that were shared with relevant agencies.
- The service ensured that 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.
- Staff used opportunistic and efficient ways to deliver more joined up care to patients. For example, communicating with staff from substance misuse clinics, street intervention teams referring patients to Asylum services and operating clinics within local homeless charities as well as drop in centres'.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The service identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Health promotion was provided on an individual opportunistic basis and included diet and nutrition advice. The service offered regular wound care and dressing as part of an open access and specialist clinic.
- Staff discussed changes to care or treatment with patients and their support workers as necessary.
- The service supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately.

Please refer to the evidence tables for further information.

Are services caring?

We rated the service as requires improvement for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The service gave patients timely support and information.
- There was a culture amongst staff to deliver a kind respectful service. Relationships between patients and staff were caring and supportive.
- Sixteen patients responded to the 2017 national GP patient survey. Results showed mixed views for questions relating to kindness, respect and compassion. For example, the percentage of patients who felt involved in decisions about their care was above local and national averages. The percentage of patients who felt listened to and felt nurses were good at explaining test results were below local and national averages.
- Staff we spoke with explained that they were not aware of the national survey and as a result had not viewed or analysed the results.
- The service had not carried out any patient satisfaction surveys or activities to gain patients feedback.

Involvement in decisions about care and treatment

Staff we spoke with demonstrated how they helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and appropriate support worker can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.

- Staff and support workers helped patients find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The service were aware of patients' vulnerability and monitored inappropriate friendships formed with other patients. Staff we spoke with demonstrated situations where they had proactively identified concerning friendships and liaised with support workers as well as hostels to support patients and manage risks.
- The national GP patient survey results were mainly above or in line with local and national averages for questions relating to involvement in decisions about care and treatment.

Privacy and dignity

The service respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues, or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.
- During our inspection we observed that staff were courteous and very helpful towards patients and treated them with dignity and respect.
- Curtains were provided in consultation rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Consultation and treatment room doors were closed during consultations; conversations in these rooms could not be overheard.

Please refer to the evidence tables for further information.

Are services responsive to people's needs?

We rated the service, and all of the population groups, as inadequate for providing responsive services .

Responding to and meeting people's needs

There were some areas where the service organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The service understood the needs of its population and tailored services in response to those needs. For example, staff identified that the service was less busy during the mornings; therefore, vulnerable patients were encouraged to attend morning appointments.
- The facilities and premises were appropriate for the services delivered.
- The service made reasonable adjustments when patients found it hard to access services. For example, Flexible appointments and clinical drop in sessions were available which supported patients who were unable to commit or comply with scheduled appointments.
- The service provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the service. For example, homeless service centres' and local addiction services.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- The service did not always ensure timely access; areas where patient satisfaction was below local and national averages had not been identified and actions to improve satisfaction had not been established which impacted on this population group.
- Support workers and outreach nurses supported patients in the community as well as those who lived in supported living schemes.
- The service was responsive to the needs of older patients and offered urgent appointments for those with enhanced needs. The community nurse carried out clinics at satellite locations for those who had difficulties getting to the service due to limited financial means to access public transport.
- Staff were trained and knew how to recognise signs of abuse in older patients and knew how to escalate any concerns.

- There were systems in place to follow up patients discharged from hospital and clinical staff worked with support workers to ensure any extra social or health needs were addressed.

People with long-term conditions:

- The service did not always ensure timely access; areas where patient satisfaction was below local and national averages had not been identified and actions to improve satisfaction had not been established which impacted on this population group.
- Patients with a long-term condition received regular reviews to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The service also carried out opportunistic screening and reviews as well as operated a re-call system which involved multiple services to ensure patients with the most chaotic lifestyle were seen. For example, patients seen by local homeless and addiction services were reminded and encouraged to attend their GP appointments.
- The service offered assertive outreach to deliver health care to homeless people across the City. This included working and prescribing on the street specifically to engage patients with physical health concerns who were 'rough sleepers' and not registered with a GP. These individuals were also encouraged to register with the Health Exchange for ongoing support.
- Assertive outreach also enabled the service to engage with individuals who may be registered with a mainstream GP, but had disengaged, in order to offer them a temporary service to support their physical health needs. The service communicated with the individual's GP to ensure they remained updated.
- The service held regular meetings with the local district nursing team and consultants to discuss and manage the needs of patients with complex medical issues.
- Weekly podiatry clinics were available at the service to treat patients with conditions affecting their feet, ankle and related structures of their leg.

Families, children and young people:

- The service was only available for the homeless and vulnerably housed patients over the age of 16 and not

pregnant. Therefore, families or young children were not registered but were directed to other mainstream GP practices. As a result, we did not rate this population group.

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

- The service did not always ensure timely access; areas where patient satisfaction was below local and national averages had not been identified and actions to improve satisfaction had not been established which impacted on this population group.
- The needs of this population group had been identified; however, staff we spoke with explained that there were limited resources to offer extended opening hours and Saturday appointments.
- Support workers created a holistic package of care by supporting patients to access voluntary services as well as self-help organisations.

People whose circumstances make them vulnerable:

- The service did not always ensure timely access; areas where patient satisfaction was below local and national averages had not been identified and actions to improve satisfaction had not been established which impacted on this population group.
- The services were provided to patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the service, including those with no fixed abode.
- Once patients secured stable accommodation there were referred to mainstream GP practices. For example, staff explained that regular checks of patient lists were carried out and patients identified as having stable accommodation were reminded to register at their local GP practice.
- Members of the nursing team carried out two primary care clinics on a weekly basis at the local alcohol drop in centre. The nursing team also provided specific support to asylum seekers as part of a Home Office Project to ensure a responsive and safe service provision for this group.

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

- The service did not always ensure timely access; areas where patient satisfaction was below local and national averages had not been identified and actions to improve satisfaction had not been established which impacted on this population group.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The service held dedicated monthly mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP.
- Staff explained that from their outreach work with local hostels the service identified the need to provide a mental health drop in clinic at more hostels within the city. At the time of our inspection, this clinic had not commenced; however, talks with the service were ongoing.

Timely access to care and treatment

Patients were not always able to access care and treatment from the service within an acceptable timescale for their needs.

- Patients had access to initial assessment, test results, diagnosis and treatment. However, there was a period of three-weeks during May 2017 where there was no GP cover and staff were signposting patients to local walk-in centres while support from a local GP practice was being secured.
- Waiting times, delays and cancellations were managed appropriately. For example, staff explained that patients who accessed the drop-in clinics were advised at point of arrival of any delays and expected waiting times.
- Patients with the most urgent needs had their care and treatment prioritised.
- Staff explained that the appointment system was flexible and easy to use on the days the service was open to accommodate the needs of the vulnerable patient group.
- The service's national GP patient survey results were mainly below local and national averages for questions relating to access to care and treatment. Staff we spoke with were unaware of the survey result.
- GP consulting hours were available between 9.30am to 12.00 and 1.30pm to 4pm Mondays to Thursdays, except Wednesdays when GP consulting was available between 9am and 11am. GP services were not available on Fridays; however, Advance Nurse Practitioners

Are services responsive to people's needs?

appointments were available for urgent prescription requests. Staff explained that the service had discussed this with the commissioners as an area of concern. Staff also explained that clinical cover for in hour closures was not in place.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The service learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.

Please refer to the evidence tables for further information.

Are services well-led?

We rated the service as inadequate for providing a well-led service.

Leadership capacity and capability

The service was provided by Birmingham & Solihull Mental Health NHS Foundation Trust who carried out the overarching leadership and management of the service. There was a lack of coherent planned approach to delivering a safe, high quality service. Systems to monitor service delivery and measure performance such as key performance indicators had not been established by the Trust or contract commissioners. This impacted on the service ability to collect and anylise data as part of a structured quality assurance programme.

Staff who managed the day to day activities within the service showed awareness of health and social challenges vulnerable patents faced.

- Service managers and the clinical team were knowledgeable about issues and priorities relating to the quality and future of services and demonstrated that their concerns were continually being raised regarding the limitations they faced in order to deliver an effective service. Staff we spoke with understood the challenges; however, there was a lack of cohesive working at a provider level or clear understanding of the type of service being provided to enable the service to address the challenges.
- Leaders within the service at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

The service had a vision and strategy to deliver high quality, sustainable care. However, it was not evident that the vision and strategy formed part of a shared approach between the Trust, commissioners and the service.

- There was a vision and set of values. The service had a service specification which set out the strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them. However, we found there was not effective joint working between the provider Birmingham & Solihull Mental Health NHS Foundation Trust and this service.

- The strategy was in line with health and social care priorities across the region. The service planned its services to meet the needs of the service population.
- The providers did not have a system to enable the service to monitor progress against delivery of the strategy. For example, staff explained that the service had not been provided with a set of key performance indicators, targets or were not collating data to support any benchmarking or quality improvement activities.

Culture

The service had a culture of high-quality sustainable care; however, this appeared not to be supported by Trust management or commissioners.

- Staff stated they felt respected, supported and valued. They were passionate about supporting the patient group to access care and proud to work at the Health Exchange.
- The service focused on the needs of patients and provided holistic care.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The service was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed at a local level; however, issues were not always addressed in a timely manner when escalated to the provider. For example, staff explained that the need to enable the use of special patient notes had been raised as a concern 18 months ago; however, at the time of our inspection, the IT system did not support the use of special patient notes.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the safety and well-being of all staff. The service held informal as well as minuted staff meetings and staff were actively involved in the day to day running of the service.

Are services well-led?

- The service actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

Oversight of some governance arrangements were not effective and there was a lack of accountability at management level. Systems to promote effective lines of engagement between the service, the provider and commissioners to enable staff locally to share their knowledge of the type of service being offered to homeless people had not been established. As a result, this led to a lack of understanding at provider and commissioner level which resulted in failings in ensuring appropriate oversight and governance arrangements to support service delivery.

- Structures, processes and systems to support governance arrangements and management were set by the providers and understood by staff. However, oversight of some areas were not effective. For example, management of infection control, monitoring the activities of general cleaning contractors, tracking the use of blank prescription and ensuring the IT system supported the type of service being delivered was not effective.
- The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated and holistic person-centred care. For example, staff attended multi-disciplinary meetings and proactively work within the community holding clinics at various satellite locations.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. However, systems for managing infection control at a local level were not effective.
- The provider had established policies, procedures and activities to ensure safety. However, we found that some policies had not been reviewed since 2015; identified review dates had been exceeded and the service were unable to demonstrate how leaders assured themselves that policies were operating as intended. Following our inspection, a copy of their updated version of their incidents policy was provided.

Managing risks, issues and performance

There were some clear and effective processes for managing risks, issues and performance.

- There was areas where the service and provider had not established a joint effective process to identify, understand, monitor and address current and future risks including risks to patient safety. For example, there was no evidence to demonstrate that formal fire drills were being carried out, there was no access to GPs on Fridays and in the absence of some emergency medicines, risk assessments had not been carried out to mitigate risks. Following our inspection, we were told that an updated stock of emergency medicines would be delivered to the service.
- The service had processes to manage current and future performance. Service leaders had oversight of safety alerts, incidents, and complaints.
- Although the service did not operate or follow a programme of quality improvement activities; clinical audit which had been carried out had a positive impact on quality of care and outcomes for patients.
- The service had plans in place and had trained staff for major incidents.
- The service considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The service did not operate an effective process to enable the gathering of appropriate and accurate information. For example, the service were not accessing national available data to measure performance or clinical effectiveness.

- The service were unable to demonstrate how they used quality and operational information to ensure and improve performance. Performance information was not combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings; however, a shared vision regarding how the service gathered information and data had not been established.
- The service did not operate a system which enabled staff to demonstrate how they used performance information which was reported and monitored or how management and staff were held to account.
- The clinical systems were not being used effectively to gain data to monitor performance or demonstrate the standards of care being delivered.
- The service were not required to submit data or notifications to external organisations. For example,

Are services well-led?

staff explained that meetings have been held to explore what type of data which might be required for commissioners and how data might be linked to the Quality Outcomes Framework (QoF). However, an agreement or guidance regarding this had not been established.

- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The service did not have a system which demonstrated how the service involved patients and the public, to support high-quality sustainable services. However, the service had established effective systems to involve staff and external partners.

- The service were unable to demonstrate how they obtained patients feedback or views regarding their level of satisfaction with the service being delivered. However, staff were experienced in supporting vulnerable patients and used their experience to shape services.

- The service were not aware of national GP patient surveys; therefore, had not analysed published results to gain a better understanding of patients level of satisfaction with the service being provided.

- The service was transparent, collaborative with a wide range of community organisations, projects and health services. Staff explained they were open with stakeholders about performance and concerns which impacted on staffs ability to provide effective care.

Please refer to the evidence tables for further information.

Requirement notices

This section is primarily information for the provider

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** How the regulation was not being met: The registered person did not ensure care and treatment was provided in a safe way to patients. In particular: The registered person did not ensure arrangements to take appropriate actions in the event of a clinical or medical emergency were in place. For example, the registered did not carry out a risk assessment in the absence of medicines used to respond to emergencies such as suspected bacterial meningitis, acute severe asthma, severe or recurrent anaphylaxis, nausea or vomiting, severe pain, analgesia or epileptic fits in order to mitigate potential risks. The registered person did not carry out risk assessments such as legionella or gain assurance that equipment such as fire alarms and extinguishers where checked to ensure that the premises used by the service provider are safe to use for their intended purpose. The registered person did not operate a system to ensure control of substances' hazardous to health (COSHH) risk assessment were revised and kept up to date. The registered person did not ensure systems for assessing the risk of; preventing and controlling the spread of infections was operated as intended. For example, a programme of ongoing or periodic infection control audits had not been established and general cleaning logs were not maintained to ensure cleaning remained compliant with Trust general cleaning standards. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: The registered person did not operate effective systems and processes to provide assurance that cleaning contractors were carrying out their activities in line with the providers cleaning policy. The registered person did not establish a system to monitor progress against plans to improve the quality and safety of services, and take appropriate action without delay where progress were not achieved as expected. The registered person did not establish a system for seeking the views of people who use the service about their experience of the service. The provider did not use information about patients experience to make improvement. The provider did not operate an effective system and process to enable timely response to areas where quality and safety were being compromised. For example, responding to concerns relating to staffing levels, information technology (IT) to support service delivery; for example, access to special patient notes to support communication with out of hour (OOH) providers. The registered person did not ensure that their governance system remained effective. For example; policies were not reviewed at their anticipated review date or in a timely manner following their anticipated review date. This was in breach of regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.