Halcyon Medical Limited

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.

Contents

Summary of findings

Overall summary

Halcyon Medical Limited in Birmingham is a city centre GP practice with a patient population of 10,210. The practice is located inside a large high street chemist store in a modern, purpose built facility.

We found the practice was safe, effective, caring, well-led and responsive to patients' needs. There were systems in place to learn from incidents and respond to safeguarding concerns. The practice was clean. Equipment and medication were fit for purpose and there were appropriate procedures in place to maintain this.

The services provided were designed to promote patients' health and wellbeing. The practice worked collaboratively with other health providers to ensure this.

Patients were listened to and involved by respectful staff. There were appropriate procedures in place to include patients in their care.

Appointments were accessible and arrangements were in place to see student patients at the local university. The service acted upon patients' comments and complaints.

An open culture and management structure meant that staff were engaged, understood their objectives and knew about decisions that affected their work. Risks to patients were managed appropriately.

During our inspection we spoke with patients and read comments they left for us. Patients said they received good care and were very positive about the staff in particular.

Organisations we contacted such as the local Clinical Commissioning Group (CCG), the General Medical Council (GMC) and the local Healthwatch had no concerns about the practice.

The practice population of 10,210 mainly consisted of working age people (city centre professionals) and students (6919 students were registered at the practice). Only 14 patients were aged 75 or over and 1418 patients identified as of Chinese origin.

We found that the practice provided specialised care plans, a named GP and targeted vaccination programmes to effectively care for older people.

The practice responded to the needs of patients with long term conditions. They operated with checked and accurate patient lists and systems of alerts and recalls to ensure patients received their care. Audits were targeted to improve patient care.

Mothers, babies, children and young people were protected because the service had appropriate systems in place to identify and report child protection concerns.

Working age people had their needs considered with the provision of appointments at set times outside of normal working hours. The practice had a number of systems in place to ensure students had their care needs met, including the provision of a surgery on the university campus during term time.

Patients whose circumstances may lead them to have poor access to primary medical services were able to register at the practice through the use of temporary resident registration.

The practice had procedures in place to assist in keeping people with mental health issues and limited understanding safe. These included a counsellor and psychologist service and referral pathways for students reporting low mood or depression.

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.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found that the practice was safe. The structure of management and meetings ensured that staff were informed about risks and decision making. There were incident and significant event reporting procedures in place that encouraged learning and action was taken to prevent recurrence of incidents when required. Systems were in place to identify and respond to concerns about the safeguarding of adults and children. Cleanliness, equipment and medication were monitored and maintained. Staff at the practice only completed the tasks they were qualified to do. Patients were protected from the risk of harm and/or unsafe treatment.

Are services effective?

The practice was effective. The practice reviewed, discussed and acted upon best practice guidance and information to improve the patient experience. The practice provided a number of services designed to promote patients' health and wellbeing. There were appropriate systems to ensure staff received the relevant checks, that their skills and abilities were monitored and that poor performance was managed when necessary. The practice took a collaborative approach to working with other health providers. Patients received a coordinated and targeted approach to their care, provided by competent staff in a suitable and timely manner.

Are services caring?

The practice was caring. On the day of our inspection, we saw staff interacting with patients in reception and outside consulting rooms in a respectful and friendly manner. There were a number of arrangements in place to promote patients' involvement in their care. Patients told us they felt listened to and included in decisions about their care.

Are services responsive to people's needs?

The practice was responsive. There were services targeted at those most at risk such as older people, those with long term conditions and students reporting mental health concerns. Appointments, including those required out of normal working hours or in an emergency were readily available. Student patients could receive health checks and care on the university campus. A number of suitable methods were available for patients to leave feedback about their experiences. The practice demonstrated it responded to patients' comments and complaints and where possible, took action to improve the patient experience.

Summary of findings

Are services well-led?

The practice was well-led. Staff were aware of individual accountabilities and responsibilities and understood their own roles and objectives. Staff felt engaged in a culture of openness and consultation. An appropriate management and meeting structure ensured that staff were aware of how decisions were reached and of their roles in implementing them. The management structure ensured that risks to patient care were anticipated, monitored, reviewed and acted upon. The practice listened to representatives of the patient population.

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
The practice responded to the care needs of older people. Older patients had access to a named GP, a multi-disciplinary team approach to their care and received targeted vaccinations. The practice offered an enhanced service in an effort to reduce the unplanned hospital admissions for this patient group despite not having enough older patients to meet the additional funding criteria.

People with long-term conditions
The practice responded to the needs of patients with long term conditions. They provided patients with long term conditions with an annual review, a nominated lead for their care needs and targeted immunisations such as the flu vaccine. Patients with diabetes received Doppler tests (a Doppler ultrasound test uses reflected sound waves to see how blood flows through a blood vessel. It helps clinicians evaluate blood flow through major arteries and veins, such as those of the arms, legs, and neck) from a qualified health care assistant at the practice. All patients with diabetes were referred to the local retinopathy department for eye examinations.

Mothers, babies, children and young people
Mothers, babies, children and young people were safe and protected in the provision of their care. Systems were in place and adhered to for identifying and protecting patients at risk of abuse. There were six week post natal checks for mothers and their children. Programmes of cervical screening for women over the age of 25 and childhood immunisations were used to respond to the needs of this patient group.

The working-age population and those recently retired
The practice encouraged feedback and participation from patients of working age through the virtual patient participation group (an online community of patients who work with the practice to discuss and develop the services provided). The practice responded to the needs of working age patients with extended opening hours on Monday and Tuesday evenings until 7pm, Saturdays from 10am to 2pm and Sundays from 11am to 2pm. A repeat prescription service was available online. The practice proactively engaged with the local student community. Practice staff visited the university to register patients, provide health checks and hold clinic sessions. There were regular health promotion updates provided for student patients.

Summary of findings

People in vulnerable circumstances who may have poor access to primary care The practice had working links, agreements and systems that enabled patients in vulnerable circumstances to access primary medical care. These included a system of temporary registration for those in need and links and informal arrangements with a local health exchange, day centre and children's hospital to receive or refer patients for care. Translation services were available to assist patients to understand their care.	
People experiencing poor mental health The practice ensured that patients with mental health issues received the appropriate care. Patients had a specialised care plan, an annual review and a nominated lead for their care needs. Patients had access to a counsellor and psychologist service at the practice and referral pathways were in place for students experiencing mental health issues.	

Summary of findings

What people who use the service say

During our inspection, we spoke with six patients, reviewed 36 comment cards left by them and spoke with a representative of the patient participation group (PPG). The PPG is a group of patients who work with the practice to discuss and develop the services provided. Patients told us that the care they received at the practice was good and that when other health providers were involved the referral process worked for them. They said they felt staff were respectful and friendly and were particularly positive about the manner and approach of the nursing team.

The results of the last patient survey completed in December 2013 showed that 99% of the 100 respondents felt listened to by the nurses and GPs and 96% felt fully involved in the decisions made about their care.

Areas for improvement

Action the service SHOULD take to improve

Ensure that the content of all clinical and multi-disciplinary team meetings is recorded.

Ensure that all staff are informed of the details and review of all reported incidents and significant events.

Outstanding practice

Our inspection team highlighted the following areas of good practice:

Through an informal arrangement with the nearby Birmingham Children's Hospital, the practice responded to the needs of patients in vulnerable circumstances. Parents of children staying at the hospital could access GP appointments and nurse led clinics at the practice whilst maintaining their permanent GP registration elsewhere.

By maintaining a close working relationship with a local university the practice delivered effective, caring and responsive care to the local student population. The delivery of care was further supported by the provision of health promotion, advice and clinical support specific to the needs of those patients There was a multi-disciplinary team approach to providing the services in ways that students could best access them.

Halcyon Medical Limited

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 second CQC inspector and a GP and practice manager acting as specialist advisers.

Background to Halcyon Medical Limited

Halcyon Medical Limited provides a range of primary medical services from a modern, purpose built facility within a large high street chemist at 67 – 69 High Street, Birmingham, B4 7TA. The practice serves a population of 10,210 of which 6,919 are students at a local university. The area served has a higher than average deprivation rate compared to England as a whole. The practice population is ethnically mixed with 29% of patients identifying as white British and 14% identifying as Chinese. There are also a large number of overseas students registered at the practice. The full clinical staff team includes a medical director, two salaried GPs, a sessional GP, a locum GP, two trainee GPs, one FY2 (foundation year two placement), a sixth year medical student, two nurse prescribers, four nurses and two health care assistants. The team is supported by a business manager, a deputy manager, a finance manager, a reception supervisor, five reception staff and two medical secretaries.

Why we carried out this inspection

We inspected this practice as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before our inspection visit, we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the practice. We carried out an announced inspection visit on 8 August 2014. During our inspection we spoke with a range of staff including the medical director, a sessional GP, GP trainees, nurses, a nurse prescriber, health care assistants, the reception team and the deputy manager. We spoke with patients and a representative of the patient participation group (the PPG is a group of patients who work with the practice to discuss and develop the services provided). We observed how patients interacted with staff. We reviewed the practice's own patient survey and CQC comment cards used by patients to share their views and experiences of the service with us.

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

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

Detailed findings

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Are services safe?

Our findings

Safe Track Record

The staff we spoke with demonstrated an understanding of their roles in reporting incidents and significant events and were clear on the reporting process used at the practice. The senior staff understood their roles in discussing, analysing and reviewing reported incidents and events. We saw that the relevant guidance and reporting forms were available to all staff.

Records were available at the practice that demonstrated a recent safeguarding concern had been reported and managed in accordance with the practice's policies and the appropriate agencies were informed and involved.

The practice's weekly multi-disciplinary clinical meeting was used for staff to review and take action on all reported incidents, events and complaints. We looked at minutes of the meetings from throughout 2014 that demonstrated this happened as and when required. However, we found that some meetings were not recorded. Details of any discussions and decisions made in those meetings were not available for all staff to see. Some reception staff reported there were occasions when feedback on incidents and events was not communicated to them.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Significant event analysis is used by practices to reflect on individual cases and where necessary, make changes to improve the quality and safety of care. We looked at examples of how staff had used the procedure to report incidents and significant events relating to clinical practice and/or staff issues. The minutes of the multi-disciplinary clinical meetings available at the practice demonstrated that all incidents and near misses were discussed. The meetings included discussion on how the incidents could be learned from and any action necessary to reduce the risk of recurrence. An annual significant event analysis completed at the practice was used to review all the incidents and events in that period and enable staff to reflect on their learning experiences. We saw that during the investigation of incidents, the relevant patients were involved in the process and informed of any actions taken or outcomes achieved.

The practice had nominated leads for receiving and distributing clinical and non-clinical safety alerts to all staff. We saw recent examples of how the alerts were distributed to all staff by email and stored on a shared computer file for additional reference. The staff we spoke with displayed an awareness of how safety alerts were communicated and told us they were receiving them regularly. A recent safety alert on the Ebola virus had resulted in all staff being made aware of the process flowchart and systems for patient segregation and management should the need arise.

Reliable safety systems and processes including safeguarding

There were systems in place for staff to identify and respond to potential concerns around the safeguarding of vulnerable adults and children using the practice. We saw the practice had safeguarding policies in place and one of the GPs was the nominated lead for safeguarding issues. The staff we spoke with demonstrated a clear knowledge and understanding of their own responsibilities, the role of the lead and the safeguarding processes in place. From our conversations with them and our review of training documentation, we saw that all staff, including GPs, had received, or were booked to receive safeguarding and child protection training.

Monitoring Safety & Responding to Risk

From our conversations with staff and our review of documentation we found the practice had a system in place to ensure that all staff received safety alerts. The practice had nominated leads for receiving and distributing clinical and non-clinical safety alerts to all staff. The practice's weekly multi-disciplinary clinical meeting was used for staff to review and action all reported incidents and events. We looked at minutes of the meetings from throughout 2014 that demonstrated this happened as and when required. An annual significant event analysis completed at the practice was used to review all the incidents and events in that period and enable staff to reflect on their learning experiences.

There was documentary evidence to demonstrate all staff at the practice had completed Cardiopulmonary resuscitation (CPR) training. We looked at the emergency medical equipment and drugs available at the practice including oxygen, defibrillators and adrenaline. All of the equipment and drugs were within their expiry dates and receiving regular checks to ensure this.

Are services safe?

Medicines Management

The risks to patients from the unsafe use and management of medicines were minimised and controlled. We saw there was a nominated lead for medicines management who ensured that a system was in place to order and check all medicines and receive and store vaccinations at the required temperature. An electronic monitoring system was used to ensure that stock of medicines and vaccines at the practice were regularly recalculated and checked. The checks included twice daily monitoring of the temperature at which the vaccines were stored. All of the staff we spoke with were aware of the system in place and how to use it. We checked the medicines and vaccines and found them to be stored securely at the appropriate temperature and within their expiry dates. Our check of the stock levels matched with the practice's own monitoring system.

Cleanliness & Infection Control

Systems were in place to maintain the appropriate standards of cleanliness and protect people from the risks of infection. We saw that the practice appeared clean and cleaning checklists were in place to monitor the standards of cleanliness. Hand wash facilities, including hand sanitiser were available throughout the practice. The records we looked at showed that staff were assessed on their hand washing standards and technique and were trained on infection control issues. The patients we spoke with, or who completed a comment card for us were positive about the standards of cleanliness at the practice. The practice had a nominated lead for infection control issues. The staff we spoke with were aware of their and the lead's responsibilities.

There were appropriate processes in place for the management of sharps (needles) and clinical waste. An audit of cleanliness and infection control completed at the service in February 2014 demonstrated that where issues were identified, appropriate action was taken to rectify them. This had included the removal of dirty toys from the practice and the introduction of a colour coded system for cleaning equipment.

Staffing & Recruitment

The staff we spoke with understood what they were qualified to do and this was reflected in how the practice had arranged its services. The practice had calculated minimum staffing levels and skills mix to ensure the service could operate safely, which included its weekend surgeries. Each GP's diary was calculated six weeks in advance to assist with this. The staffing levels we saw on the day of our inspection met the practice's minimum requirement and there was evidence to demonstrate the requirement was achieved throughout 2014.

Dealing with Emergencies

The practice had procedures in place to respond to emergencies and reduce the risk to patients' safety from such incidents. We saw that the practice had a business continuity plan in place. The plan covered the emergency measures the practice would take to respond to any loss of premises, records and utilities among other things. The relevant staff we spoke with understood their roles in relation to the contingency plan.

Equipment

Patients were protected from the risk of unsuitable equipment because the practice had procedures in place to ensure the equipment was maintained and fit for purpose. We looked at documentation which showed the service completed annual checks on its equipment. This included the calibration of medical equipment to ensure the accuracy of measurements and readings taken. All of the equipment we saw during our inspection appeared fit for purpose.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

The practice reviewed, discussed and acted upon best practice guidelines and information to improve the patient experience. A system was in place for National Institute for Health and Care Excellence (NICE) quality standards to be distributed and reviewed by clinical staff. The practice participated in recognised clinical quality and effectiveness schemes such as the national Quality and Outcomes Framework (QOF). QOF is a national data management tool generated from patients' records that provides performance information about primary medical services). We saw that the practice had used this information to improve services for patients with asthma by identifying 205 patients to be seen for an annual review of which 66% were completed at the time of our inspection. The information was also used to identify eight patients with a blood pressure of more than 150 over 90. All eight patients were receiving treatment and being clinically managed as a result.

A coding system was used to ensure the relevant patients were identified for and allocated to a chronic disease register and the system was subject to checks for accuracy. Once allocated, each patient was able to receive the appropriate management, medication and annual review for their condition.

Patients' capacity to consent was assessed in line with the Mental Capacity Act (2005). From our conversations with staff and our review of training documentation we saw that all staff had received Mental Capacity Act (MCA) training. MCA guidance was available on the practice intranet. The staff we spoke with, including the reception staff team, demonstrated an understanding of the MCA and its implications for patients at the practice. Staff were also aware of the Gillick competency test (a process to assess whether children under 16 years old are able to consent to their medical treatment, without the need for parental permission or knowledge). Staff we spoke with gave examples of its use in the practice, particularly in relation to the sexual health and family planning clinics.

Management, monitoring and improving outcomes for people

The practice participated in audit and review to improve patient care. We saw that in January 2014, the practice had participated in an audit run by its local clinical commissioning group (CCG) medicines quality team about high dose inhaled corticosteroid for asthma patients. As a result of analysing all asthma patients' prescriptions and treatment records, the practice identified 32 patients on a high dosage whose treatment could be reduced. There was evidence to demonstrate that all the patients were contacted with details of the reduction in their treatment.

The practice had a system in place for completing clinical audit cycles. Clinical audit is a way of identifying if healthcare is provided in line with recommended standards, if it is effective and where improvements could be made. Examples of clinical audits included those on asthma, urinary tract infection (UTI) and irritable bowel syndrome (IBS). We saw that an audit on the diagnosis and management of IBS in patients at the practice was repeated three times between January 2013 and August 2014. The results demonstrated the practice was doing well in this area. However, a recommendation of the first audit was for patients over 50 years old presenting with IBS symptoms to be monitored and referred to the secondary care colorectal team if their symptoms persisted beyond six weeks. At the last audit, no patients were identified in this category.

We saw that a clinical audit to compare the practice against Health Protection Agency (HPA) guidance for appropriate microscopy and culture requests in the diagnosis of UTIs was completed in August 2014. By analysing its data and requests over a six month period, the practice identified a 37% level of adherence to the HPA guidance. We saw that as part of the recommendations from the audit a presentation was given to clinical staff and process posters were displayed in the consulting rooms. A date was set for the audit to be repeated to measure the effectiveness of the changes made.

Effective Staffing, equipment and facilities

Systems were in place to ensure that people received care from appropriately qualified staff. The staff we spoke with said they could recall completing a series of recruitment checks including criminal records checks, references from previous employers and checks on their professional registration. The staff files we looked at confirmed what staff had told us. Criminal records checks were available for all staff. Where applicable, the professional registrations and revalidations of staff at the service were up-to-date.

Are services effective?

(for example, treatment is effective)

The practice had systems in place to ensure that its staff remained competent and effective in their roles. From speaking with staff and our review of documentation we found that staff received an appropriate induction when joining the service. Staff referred to the induction process as thorough. We saw that all staff at the service were subject to several capability policies which detailed the practice's process for managing poorly performing staff.

There were systems in place to ensure patients received care from competent and effective staff. All of the staff we spoke with said they received an annual appraisal of their performance and competencies. We looked at some examples of these and saw that there was also an opportunity for staff to discuss any training requirements. Staff told us that the training provision at the practice was excellent. The various certificates we looked at demonstrated staff had access to a wide range of training, especially relating to clinical skills. The resulting clinical competence and professional development of staff promoted improved patient care.

The practice had a comprehensive process in place for the mentoring of medical students and GP trainees. From the practice schedules and our conversations with the trainees and more senior GPs at the practice, we saw that the time allocated to the one-to-one supervision of the trainees was considerable. The mentoring was led by the medical director as the most experienced clinician at the practice.

Working with other services

The practice had a collaborative approach to providing care by engaging and communicating with other health providers so that patients were more likely to experience a coordinated approach to their care. Students made up 68% of the practice's patient population. Systems were in place to ensure that where necessary, GP letters and reports were sent to each student's home GP during holidays to ensure their continued care. The practice had established close working links with Addaction (drug and alcohol services) and Sexual Health in Practice (SHIP) to complement its own young people, family planning and sexual health clinic provision. The practice provided direct clinical support to the local university student support services to provide advice on mental health issues and depression. A counsellor and psychologist were also available to come to the practice to ensure continuity of care.

We saw that a system was in place to manage blood test results. The results were reviewed by the GPs who followed a set process of patient contact by telephone and letter for abnormal results. A results phone line was available for one hour daily from Monday to Friday for patients to obtain all other results.

Health Promotion & Prevention

The practice offered a range of services to ensure new patients received a health check. These included a health questionnaire for completion on registration and the provision of a self-service blood pressure and body mass index (BMI) monitoring machine in the waiting area. The practice participated in a local scheme for the management of obesity and operated a clinic for all patients with a BMI of 35 or more.

A practice team of clinical and non-clinical staff attended the local university's Fresher's week to register all new students and complete their health checks. For overseas students in particular, this included the immediate provision of relevant immunisations where possible, or arranging for this to be completed at the practice post registration.

We saw that the practice operated patient registers and nurse led clinics for a range of long term conditions (chronic diseases) and there was a nominated GP lead for each of these. There was also a nurse lead for all palliative care patients and the medical director was the named GP for all patients 65 years and older. To assist in the health management of patients with diabetes, a health care assistant at the practice was qualified to complete Doppler checks. A Doppler ultrasound test uses reflected sound waves to see how blood flows through a blood vessel. It helps clinicians evaluate blood flow through major arteries and veins, such as those of the arms, legs, and neck.

We found that the practice offered a number of services designed to promote patients' health and wellbeing and prevent the onset of illness. We saw various health related information leaflets available for patients in the waiting area. The practice had participated in targeted vaccination programmes for older people and those with long term conditions. These included the shingles vaccine for those aged 70 to 79, and the flu vaccine for people with long term conditions and those over 65. The childhood immunisation programme had reached a 79% take up rate after nine months (the third quarter) of the year.

We saw that all nurses at the practice were qualified to carry out cervical screening and a system of alerts and

Are services effective?

(for example, treatment is effective)

recalls was in place to provide smear tests to women aged 25 years and older. By analysing the data generated by the system the practice had identified low rates of uptake among ethnic minority patients. One nurse was tasked with attending training to assist in increasing the rate of uptake.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We saw that the practice had an equality and diversity policy in place. This detailed the behaviours expected of staff and patients. Review of the policy formed part of each staff member's induction and all staff had received equality and diversity training. During our inspection we found that staff behaviours were in accordance with those expected by the policy. We saw examples of patients receiving respectful treatment from the practice reception staff. We saw the clinical staff interacting with patients in the waiting area and outside clinical and consulting rooms in a friendly and caring manner.

Findings from the practice's patient survey completed in December 2013 showed that 97% of the 100 respondents always felt at ease during any examination by the doctors and nurses. The patients we spoke with were positive about staff behaviours. A total of 36 comment cards were completed by patients. All of the responses received about staff behaviours were positive.

The practice had a counsellor service. Staff were aware that all recently bereaved patients could be referred to the counsellor. We saw how the practice had liaised with the local university following the death of a student. All of the person's peers were offered counselling at the practice regardless of if they were a registered patient there. Empathy and respect for patients who use the service was considered as part of their care.

Involvement in decisions and consent

The practice had made suitable arrangements to ensure that patients were involved in, and able to participate in decisions about their care. All of the patients we spoke with said they felt listened to and had a communicative relationship with the GPs and nurses. We also read comments left for us by 36 patients. Of those who commented on how involved they felt in their care and the explanations they received about their care, all of the responses were positive. The results of the last patient survey completed in December 2013 showed that 99% of the 100 respondents felt listened to by the nurses and GPs and 96% felt fully involved in the decisions made about their care.

We saw the practice had a number of facilities available to promote people's understanding of and involvement in their care. These included various leaflets available in many languages and pictorial format. A full translation service was available either over the telephone or by the attendance of a translator at appointments. We saw that the service had been used 11 times in the first week of August 2014. Due to the location of the practice and a majority student patient population, there were no patients at the practice known to experience dementia or a learning disability.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

The practice had a number of measures in place to respond to patients' differing needs. They provided an enhanced service in an effort to reduce the unplanned hospital admissions for vulnerable and at risk patients including those aged 75 years and older. As part of this, each relevant patient received a specialised care plan and multi-disciplinary team monitoring. As the number of patients in the appropriate categories was short of the 2% of total practice population required for funding, the practice was not receiving any additional financial resource for providing this service.

From its review of patient statistical information, the practice was aware that its patient population was predominantly a student population. Many of the practice's clinics and services were focussed on responding to the needs of that group. These included sexual health and family planning clinics. A counsellor and psychologist visited the practice as part of its focus on depression and mental health issues. The practice sent multi-disciplinary teams to the local university's Fresher's week to register students, provide health checks and to run GP sessions during term time (only to students registered at the practice).

Located near Birmingham Children's Hospital and as part of an informal arrangement with the hospital, the practice was able to temporarily register parents visiting their children from across the country to ensure they had access to primary care services. The temporary registration did not affect each parent's permanent registration with a GP elsewhere. From its city centre location, the practice worked in partnership with a local day centre and health exchange as specialist referral points for rough sleepers to ensure the provision of non-emergency medical provision to that patient group.

The practice had a patient participation group (PPG). The PPG is a group of patients who work with the practice to discuss and develop the services provided. We saw that the group's recent aims were to promote the PPG, provide better access to information in languages other than English and to ensure the practice's website was up-to-date and accessible. We saw all these things were happening during our inspection.

Access to the service

The practice was accessible to patients because it responded to the varying requirements and preferences of its patient population. On the day of our inspection we checked the appointment system and found the longest a patient would need to wait to see any doctor was four days. However, same day appointments were available and we saw these being offered to patients at reception. Eleven open appointments were available each morning between 9.00am and 10.30am Monday to Friday and two appointments per surgery were blocked for emergencies every weekday afternoon.

As well as being open all day Monday to Friday, the practice had extended opening until 7pm on a Monday and Tuesday and operated bookable appointments between 10.00am and 2pm on Saturday and 11am and 2pm on Sunday. This allowed access to services for those who found attending in working hours difficult. In response to patient demand from informal feedback, suggestions and complaints, the practice had changed its appointment booking structure. The previous system of booking three or seven days in advance was changed to allow patients to book up to six weeks in advance or same day booking. The patient response to this was positive. Those patients we spoke with were satisfied with the appointments system.

We saw that the practice's website detailed how the appointments system and repeat prescriptions service operated. Instructions on how to register for the online repeat prescriptions service and how patients could make appointments, including seeing a GP urgently were accessible.

Patients were able to make their repeat prescription requests in person or online through the practice's website. We saw there was a facility for the prescriptions to be signed digitally and submitted electronically to each patient's nominated pharmacy. Those patients we spoke with who had used the repeat prescription service said it was easy to use and efficient.

Meeting people's needs

All of the patients we spoke with felt the practice was good at handling their referrals to other services for such things as further investigations in a timely manner. They felt test results were received and communicated appropriately and their care when other providers were involved was coordinated.

Are services responsive to people's needs?

(for example, to feedback?)

From our conversations with staff we saw that systems were in place to refer patients to secondary care. We were told that patients were always present when referrals were made to promote their own choices in their care. For nurse led clinics there were also systems to monitor attendance at secondary care appointments such as retinopathy and podiatry for patients with diabetes. A system of alerts and recalls was in place and used for those who did not attend. Discharge from hospital was followed up and reviewed by the GPs and appointments were made for patients requiring medications as a result of their discharge.

We saw there was a standard process in place for the practice to receive notifications of patient contact and care from the out of hours (OOH) provider. We saw evidence that the practice reviewed the notifications and took action to contact the patients concerned and provide further care where necessary.

Concerns & Complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

We saw that a leaflet informing patients of how to complain about the service was available in the waiting area. A brief introduction to the complaints process was available on the practice's website. All of the staff we spoke with were aware of the process for dealing with complaints at the practice.

We looked at examples of written complaints received by the practice and saw that the complainants were contacted to discuss the issues raised. As a result, the practice had agreed actions to resolve the complaints to their satisfaction. We saw that where necessary, actions were taken and the complainants formally responded to in writing in accordance with the practice's own procedure.

Are services well-led?

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

Our findings

Leadership & Culture

The practice was seen by all who worked for it as well-led with a culture that facilitated an improved patient experience. The staff we spoke with agreed that the vision and values of the practice were to provide a good, timely and accurate service to patients. The staff were clear on their roles and personal objectives. They demonstrated an understanding of the leadership at the practice with the medical director as the final decision maker based on open discussion and consultation with staff. Weekly clinical meetings, practice staff meetings (held when the practice was closed to enable all staff to attend) and an annual away day were used to involve all staff in developing the strategy and direction of the practice. Staff told us this made them feel valued and supported and felt this contributed to the low turnover of staff.

We saw that the practice had an annual development plan in place based on the needs of its patient population. The plan was developed by incorporating the areas of focus of the local clinical commissioning group (CCG) and feedback from patients and staff. An example of this was the practice's focus on providing more health promotion advice for students. We saw this happening in practice.

Governance Arrangements

The practice had decision making processes in place. Staff at the practice were clear on the governance structure. They understood that the medical director held the position of overall decision maker and he was supported in this by the business manager. All staff both contributed to and learned from practice processes and issues from clinical and practice staff meetings and events. We saw there were nominated GP leads for safeguarding, patients with long term conditions and mental health issues and nurse leads for such things as infection control and medicines management. The leads showed a good understanding of their roles and responsibilities and all staff knew who the relevant leads were.

Systems to monitor and improve quality & improvement (leadership)

The practice had systems in place to monitor and improve quality. We saw that the practice reviewed all the comments and complaints it received and where necessary, took the appropriate action to improve the patient experience. There were systems in place to report all incidents and significant events. The staff we spoke with understood the systems and how they worked. All of the reported incidents and events were reviewed and actioned by the practice's multi-disciplinary team.

The practice participated in quality and productivity audits for its local CCG. For example, the practice had researched and provided an annual report to the CCG on the various referral pathways for its patients. An action for the practice was to ensure that all its student patients reporting mental health issues, including low mood and depression had a referral pathway established. The report demonstrated the practice had ensured all patients reporting such issues had their care managed at the practice or were referred to partner agencies such as the community mental health team, Healthy Minds or independent health care providers.

Patient Experience & Involvement

The practice had mechanisms in place to listen to the views of patients and those close to them. The practice had a patient participation group (PPG). The PPG is a group of patients who work with the practice to discuss and develop the services provided. There was also an online virtual patient participation group (vPPG). The vPPG is an online community of patients who work with the practice to discuss and develop the services provided. We saw that through meetings or emails the groups were able to feedback their views on a range of practice issues. A member of the PPG we spoke with felt the group was valuable. However, substantial improvements to the patient experience achieved through the group were limited and the patient representative numbers were low.

The practice had distributed a patient survey from October to December 2013 and responses were received from 100 patients. The results showed that 98% of patients were happy with the amount of time each GP spent with them and 99% felt listened to during their appointments.

From our conversations with staff we found that once a month a section of the weekly multi-disciplinary team meeting was dedicated to the review of end of life care patients. This included contact with and input from the carers of those patients or those closest to them.

Practice seeks and acts on feedback from users, public and staff

The work of the PPG was described in an annual report. This was accompanied by a plan of improvements the group would work towards achieving. We saw that the

Are services well-led?

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

group's recent aims were to promote the PPG and virtual PPG, provide better access to information in languages other than English and to ensure the practice's website was up-to-date and accessible. We saw all these things were happening during our inspection.

The staff we spoke with said the results of the patient survey, patient complaints and other patient feedback were discussed in their meetings so they were clear on what patients thought about their care and treatment. They said the practice away day and their regular meetings were opportunities for them to share their views on the practice.

We saw that following patient feedback, patient complaints and the results of the patient survey the practice had changed its appointment booking structure. The previous system of booking three or seven days in advance was changed to allow patients to book up to six weeks in advance or same day booking. The patient response to this was positive. Those patients we spoke with were satisfied with the appointments system.

Management lead through learning & improvement

The practice management team reviewed, managed and learned from incidents and best practice knowledge to improve the patient experience. From our conversations with staff and our review of documentation we found that staff discussed how the practice could learn from and reduce the risk of recurrence of incidents and significant events. The practice completed an annual review of all incidents and events to reflect on their learning experiences.

We saw that as part of its work with the local clinical commissioning group (CCG) to reduce unnecessary attendances at A+E, the practice had written to its patients. This was to inform patients that appointments at the practice were available seven days a week. As a result, the practice was able to demonstrate a 10% reduction in the amount of its patients attending A+E unnecessarily.

Identification & Management of Risk

We saw that the practice had an established process for management, communication and decision making. The clinical staff and business manager met regularly. Identifying and managing risk through such things as discussions on patient care, incident reporting, significant event analysis, complaints and audit was standard practice at those meetings. There were processes in place such as wider staff meetings, the practice's intranet, shared drives and email dissemination and events such as the annual away day to ensure all staff were aware of the discussion and decision making from those meetings.

The practice identified and managed the risk of staff absence and its impact on patient care. Before our inspection, two GPs had left the practice with eight weeks' notice. The practice had responded with an assessment of the need for locum GPs at the same time as commencing a recruitment process. At the time of our inspection one vacancy had been placed (the person was recruited and had started). During this period of recruitment the medical director had postponed his retirement until the succession of a senior GP was available.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice was responsive to the needs of older people. At the time of our inspection, of a patient list of 10,210 only 14 were aged 75 years or older.

The practice provided an enhanced service in an effort to reduce the unplanned hospital admissions for vulnerable and at risk patients including those aged 75 years and older. As part of this, each relevant patient received a specialised care plan and multi-disciplinary team monitoring. As the number of patients in the appropriate categories was short of the 2% of total practice population required for funding, the practice was not receiving any additional financial resource for providing this service.

All of the patients received their care from the medical director, the named GP for all patients 65 years and older. This system allowed the practice to provide more consistent care to patients in that age group.

The practice provided two targeted vaccinations to older people. The shingles vaccine was available to those aged 70 to 79 and the flu vaccine to those aged 65 and over. The take up rate for the flu vaccine for those in that age group was 83.3%.

Clinical staff at the practice worked in partnership with community teams such as district and Macmillan nurses to provide effective palliative care to patients. Monthly dedicated clinical meeting sessions were used to manage the care of end of life patients and involve their carers and those closest to them.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice responded to the needs of patients with long term conditions. The practice operated patient registers for a range of long term conditions (chronic diseases) and there was a nominated GP lead for each of these. Each patient with a long term condition received an annual review. The practice provided a programme of flu vaccinations to all at risk groups including those patients with long term conditions.

All patients with diabetes at the practice were referred to the retinopathy department of the local hospital for eye examinations and a system of alerts and recalls was in place for those who did not attend. To assist in the health management of patients with diabetes, a health care assistant at the practice was qualified to complete Doppler checks. A Doppler ultrasound test uses reflected sound waves to see how blood flows through a blood vessel. It helps clinicians evaluate blood flow through major arteries and veins, such as those of the arms, legs, and neck.

Patients with long term conditions were encouraged to feedback their care experience and participate in the debate about how the practice operated and the services it provided. The practice operated a virtual patient participation group (the vPPG is an online community of patients who work with the practice to discuss and develop the services provided) for those who found attending patient participation group (PPG) meetings at the practice difficult.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice kept mothers, babies, children and young people safe and protected in the provision of their care. The practice had systems in place to identify and protect patients at risk of abuse. There was a nominated GP lead for safeguarding and child protection issues. All the staff we spoke with had received or were booked to receive safeguarding training and in our conversations with them, they displayed a good understanding of how to identify and report concerns.

Records were available at the practice that demonstrated a recent safeguarding concern was reported and managed in accordance with the practice's policies and the relevant agencies were informed and involved.

The practice responded to the needs of mothers and children by offering programmes of cervical screening and childhood vaccinations. All of the nurses at the practice were qualified to carry out cervical screening and a system of alerts and recalls was in place to provide smear tests to women aged 25 years and older. The take up rate for the childhood immunisation programme over a nine month period was 79%.

The practice provided six week post natal checks through joint appointments for the mother and child. These included the provision of physical examinations, weight checks and advice on breast feeding, immunisations and post natal depression.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice responded to the needs of working age people. The practice had designed access to appointments and services to meet the needs of those who found it difficult to attend during the working day. We saw that bookable appointments were available on Monday and Tuesday evenings until 7pm, on Saturdays from 10am to 2pm and on Sundays from 11am to 2pm. Appointments were bookable by telephone and online directly through the practice's website. Patients were also able to arrange their repeat prescriptions online.

We found that working age patients were encouraged to feedback about their care and participate in the debate about how the practice operated and the services it provided. The practice operated a virtual patient participation group (the vPPG is an online community of patients who work with the practice to discuss and develop the services provided) for those who found attending patient participation group (PPG) meetings at the practice difficult.

The practice offered targeted services to promote the health and wellbeing of working age patients. These included a smoking cessation clinic offering advice about stopping smoking and nicotine replacement therapies. The clinic was run by a trained adviser and patients were able to access an initial 20 minute appointment and follow ups. The practice was also opted in to a local enhanced service to provide health checks to those aged 40 years and over.

The local student population made up 68% of the practice's patient list. The practice was proactive in engaging with the student population to ensure their care and health needs were met. The practice sent a multi-disciplinary team to the local university's Fresher's week to register new patients and complete their health checks. As part of this, students (particularly international students) were able to receive the appropriate immunisations either during their health checks or later at the practice. Practice staff were also sent to the local campus in term time to run clinics, but only for students registered at the practice.

The practice offered services targeted to the student population such as sexual health and family planning clinics including advice on sexual activity and contraception. Local links with services such as Addaction (drug and alcohol) and Sexual Health in Practice (SHIP) complemented this provision.

We saw examples of how the practice proactively engaged with the student community on health promotion issues. This included emails to all students on the signs, symptoms and spread of Mumps and Meningitis with the practice's contact details for further advice.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice had working links, agreements and systems that enabled patients in vulnerable circumstances to access primary medical care. Homeless people, migrant workers, people from the gypsy/traveller communities and others who may find accessing GP services difficult were able to access services at Halcyon Medical Limited. The practice operated a system of registering all patients who required access to their services as temporary residents. The practice maintained local links to ensure homeless people and people sleeping rough had access to health services. The Health Exchange Birmingham was used as a specialist referral point and a local day centre provided non-emergency medical attention.

The practice had an informal arrangement with the nearby Birmingham Children's Hospital to provide primary medical care and treatment to the parents of children staying at the hospital from all over the country. Using a system of temporary registration, parents could access GP appointments and nurse led clinics at the practice whilst maintaining their permanent GP registration elsewhere.

A bookable translation service was available at the practice. Patients were able to access telephone translation or have a translator attend their appointments. The service was used regularly to promote patients' understanding of their care. The practice provided health information leaflets in a number of languages other than English and some were available in pictorial format.

At the time of our inspection, Halcyon Medical Limited did not have any patients with an identified learning disability.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

There were procedures in place to ensure that patients experiencing poor mental health received the appropriate care. The practice maintained a register of patients with poor mental health and provided each of those patients with a specialised care plan and annual review. There was a named GP lead for mental health patients. A counsellor and psychologist were available at the practice.

Referral pathways were in place to ensure that students experiencing mental health issues such as low mood or depression were cared for. This was either at the practice or by the community mental health team and independent health care providers. Staff at the practice visited the local university's student support services to provide advice on issues around mental health and depression.