# Hawkesley Medical Practice

## Quality Report

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

## Ratings

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

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at Hawkesley Medical Practice on 3 August 2016. Overall the practice is rated as good.

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

- The practice had systems for monitoring and maintaining the safety of the practice and the care and treatment they provided to patients.
- The practice had systems for reducing the risks to patients from healthcare associated infections.
- Patients' needs were assessed and the practice planned and delivered care in line with best practice guidance.
- The practice had established a well-trained team with expertise and experience in a range of health conditions.
- Patients said that they were treated with kindness, dignity and respect and that GPs and nurses involved them in discussions about their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the way that services were delivered as a result of complaints and concerns.
- Patients told us that they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by GP partners and the practice manager. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

# Summary of findings

- The practice had recognised the interplay between health and social issues and had introduced a service from the Citizens' Advice Bureau (CAB) whereby an advisor came to the practice every Monday in order to help patients with a variety of non-clinical issues including housing, benefits and employment.

The areas where the provider should make improvements are:

- Establish a system for uncollected prescriptions.
- Take action to ensure that emergency evacuation drills are carried out.
- Continue to monitor and ensure improvement to patient survey results.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The practice is rated as good for providing safe services.

- Staff told us that they understood how to raise concerns and report incidents and near misses. There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received support, information, and a written apology. They were told about any actions to improve processes to prevent a recurrence.
- Risk management was comprehensive. Certain risk assessments were carried out by NHS Property Services, who owned the building, such as Legionella and the Fire Safety Management Plan.
- The practice had clearly defined and embedded safeguarding systems in place to help ensure the safety of children and adults whose circumstances might make them vulnerable. We saw that these systems had been put into practice when necessary.
- Infection control and general cleanliness at the practice was well organised.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure, incapacity of GPs or building damage.

**Are services effective?**

Good

The practice is rated as good for providing effective services.

- Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness.
- According to data from the Quality and Outcomes Framework (QOF) 2014/15, patient outcomes were at or above average compared to the national average.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.

# Summary of findings

- Clinical staff had additional expertise in a variety of specialisms, including mental health, diabetes, asthma and chronic lung disease.

**Are services caring?**

Good

The practice is rated as good for providing caring services.

- We observed that the practice had a patient-centred focus.
- Data from the National GP Patient Survey published in July 2016 showed that patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with kindness, dignity and respect and that GPs took the time to listen to them. They told us that they were involved in decisions about their care and treatment. Information from patients who completed CQC comment cards reinforced the high degree of care provided and their involvement in considering their treatment options.
- Information for patients about the services available was easy to understand and accessible.
- We saw that staff treated patients with compassion and courtesy, and maintained patient and information confidentiality.
- The manager of a local nursing home emphasised the continuity of care provided by the GPs as part of their excellent service to the residents at the home. A GP visited patients every week, thus ensuring continuity of care.

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Birmingham South Central Clinical Commissioning Group to secure improvements to services where these were identified. For example, the practice had piloted a weekly service provided by the Citizens' Advice Bureau.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who worked with the practice team to improve services and the quality of care. For example, a new telephone system had been installed in response to suggestions from the PPG.

# Summary of findings

- Patients could access appointments and services in a way and at a time that was convenient for them. For example, contraceptive services were available during extended hours and telephone slots were available during morning surgery.
- In acknowledgement that it can be difficult for many patients to pre-book and keep appointments, the practice allocated 60% of the daily slots for book on the day appointments.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

**Are services well-led?**

Good

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by the GP partners and management team. The practice had a number of policies and procedures to govern activity and held regular meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients, which it acted on. There was an active Patient Participation Group, which influenced practice development.
- Staff told us that they were encouraged to develop their skills and improve the standard of service delivery.

# Summary of findings

## The six population groups and what we found

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

### Older people

Good

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

- The practice offered proactive, personalised care to meet the needs of this population group.
- Home visits and urgent appointments were available for those with enhanced needs.
- Patients who were housebound were able to have flu immunisations at home.
- The practice had responsibility for patients at a local nursing home. A GP undertook a weekly ward round, so that continuity of care was provided.
- All patients who were over the age of 75 had been offered a health check in the last 12 months.
- The practice followed the Gold Standard Framework for end of life patients. Meetings were held every two to three months and attended by the GP lead, a hospice nurse specialist, district nurses, a case manager and GP trainees.

### People with long term conditions

Good

**People with long-term conditions**

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

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- During the annual flu clinics, additional staff were available to undertake opportunistic screening, which resulted in long term conditions being diagnosed. The nurses administered the vaccinations and a GP was on duty to see patients as required.
- The practice was supported by a case manager for the care of patients with long term conditions. The practice nurses used a case management model where this was considered to be beneficial and the patient was in agreement.

# Summary of findings

- Patients who were at risk of developing diabetes were monitored annually and invited to take part in lifestyle educational sessions to help them reduce their risk of developing diabetes.
- A GP was the clinical lead for diabetes for the Birmingham South Central Clinical Commissioning Group (CCG). A GP and a practice nurse had completed the Warwickshire Diabetes course, which meant that they had additional expertise in this field.
- The percentage of patients with diabetes on the register, in whom the last diabetic reading was at an appropriate level in the preceding 12 months was 76% which was slightly below the national average of 78%.
- Patients with inflammatory arthritis were monitored in the practice under a shared care agreement with secondary care and their blood tests were monitored before prescriptions were issued. There was liaison with rheumatology specialists and staff attended training.
- A practice nurse was the lead for the asthma and chronic lung disease service. The nurse held diplomas in asthma and chronic lung disease, plus a certificate in spirometry.
- A home visit service was offered for patients with severe respiratory conditions who were unable to attend appointments at the practice.

**Families, children and young people**

Good

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 78% which was slightly lower than the CCG average of 80% and slightly lower than the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- Same day appointments were available for any unwell child under the age of five years.
- Clinical rooms were all situated on the ground floor with easy access.

# Summary of findings

- An immunisation clinic was held every Wednesday. No appointments were necessary and the clinic ran at the same time as the health visitor's baby clinic.
- Due to the high demand for sexual health and contraceptive services, the practice had a GP and an advanced nurse practitioner who could offer coil and implant fitting and screening for sexually transmitted infections.
- There was regular liaison with midwives, health visitors, social workers and school nurses in order to ensure that accurate records and registers were maintained.

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

Good

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.
- Extended opening hours were provided to enable working age people to attend without having to take time off work. Evening appointments were offered with GPs and nurses. Cytology appointments were also available during these times.
- One of the annual flu clinics was held on a Saturday morning, which provided more flexibility for working age patients.
- Patients could book routine GP appointments online as well as request repeat prescriptions at a time that was convenient for them.
- Telephone consultations could be booked, which provided additional flexibility.
- NHS health checks were offered to patients aged between 40 and 75 years.

**People whose circumstances may make them vulnerable**

Good

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

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. There were no homeless people registered at the time of our visit, but the practice was able to explain how they would be seen. Staff knew many of the most vulnerable patients by name.

# Summary of findings

- There was a residential care facility in the local area for patients with moderate to severe learning disabilities. Approximately 40 residents who lived in the six houses were registered with the practice. A GP visited regularly. Care plans were in place and annual reviews were undertaken at the home.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- The practice had high levels of children at risk of harm and all members of staff had received child safeguarding training appropriate to their role. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- Staff were alert to the signs of domestic abuse and were able to support patients by signposting them to the relevant agencies.
- The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 53 patients as carers, which represented 1% of the patient population.

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

Good

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

- 83% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the national average of 84%.
- 76% of patients with poor mental health had a care plan documented in the last 12 months, which was lower than the CCG average of 91% and lower than the national average of 88%. This was one of the areas targeted for improvement in 2016.
- Patients were able to access Improving Access to Psychological Therapies (IAPT) services through the Birmingham Healthy Minds (BHM) service either on referral by a GP or by self-referral. The BHM service was an NHS primary care psychological therapies service, which was available at the practice.
- Patients up to the age of 25 with poor mental health could be referred to the Forward Thinking Birmingham service, which provided support, care and treatment tailored to the patient's needs.

# Summary of findings

- Longer appointments were available for patients with poor mental health.
- The clinical staff were sensitive to the lifestyle of some patients, which made it difficult for them to pre-book appointments or to attend appointments on time. Adjustments were made wherever possible, so that the patient was seen.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. Liaison with community mental health teams was viewed as an important part of patient care.
- Patients with poor mental health were offered regular reviews. Screening was offered for conditions that their lifestyle or medicine might put them at greater risk of developing.
- The practice carried out advance care planning for patients with dementia.
- The practice had a system in place to follow up patients who had attended A&E where they may have been experiencing poor mental health.
- Staff showed that they clearly understood how to support patients with mental health needs and dementia.

# Summary of findings

## What people who use the service say

The National GP Patient Survey results were published on 7 July 2016. The results showed that the practice was performing in line with local and national averages, apart from the results for the ease of making appointments. 333 survey forms were distributed and 110 were returned. This represented a 33% completion rate and 2% of the total practice population.

- 46% of patients found it easy to get through to this practice by phone compared to the CCG average of 70% and the national average of 73%.
- 75% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 81% and the national average of 85%.
- 86% of patients described the overall experience of this GP practice as good compared to the CCG average of 82% and the national average of 85%.
- 73% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 75% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 38 comment cards which were highly complimentary about the standard of care received, although there were adverse comments about the difficulties in making appointments. Patients praised the GPs, who they said were exceptional and highly professional, as well as considerate. Nursing staff were considered to be excellent and receptionists were polite and welcoming.

We spoke with five patients during the inspection and two members of the Patient Participation Group (PPG). A PPG is a group of patients registered with the practice who worked with the practice team to improve services and the quality of care. All seven patients said that they were happy with the care they received and thought that staff were approachable, committed and caring.

We read comments from some of the Friends and Families Test cards. Patients wrote that staff were helpful and pleasant and that GPs listened to them and discussed treatment.

## Areas for improvement

**Action the service SHOULD take to improve**

The areas where the provider should make improvements are:

- Establish a system for uncollected prescriptions.
- Take action to ensure that emergency evacuation drills are carried out.
- Continue to monitor and ensure improvement to patient survey results.

# Hawkesley Medical Practice

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist advisor and an Expert by Experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

## Background to Hawkesley Medical Practice

Hawkesley Medical Practice is registered with the Care Quality Commission (CQC) as a partnership provider and delivers a full range of family medical services, as well as providing a minor surgery service. Hawkesley Medical Practice holds a General Medical Services (GMS) contract with NHS England. (The GMS contract is a nationally agreed contract between general practices and NHS England for delivering primary care services to the local communities).

At the time of the inspection, Hawkesley Medical Practice was providing medical care to approximately 4,800 patients.

The practice is located in purpose built premises in Kings Norton, Birmingham, and is situated in an area with high levels of social and economic deprivation. The building is owned by NHS Property Services, who are responsible for the common areas of the site. The Birmingham South Central Clinical Commissioning Group arranged for a consultant to inspect the building in February 2016. Recommendations included a full refurbishment for the treatment room and the removal of a carpet in a consulting room. At the time of the CQC inspection, these recommendations had not been actioned.

The practice has a large car park on site and there is a bus stop on the opposite side of the road.

All consulting rooms are on the ground floor of the building and the automated front door provides easy access for patients with mobility problems.

There are two GP partners (both male) and two salaried GPs (one male, one female). The GPs are supported by a practice manager, an assistant practice manager, an advanced nurse prescriber, three practice nurses, one health care assistant and administrative and reception staff.

Hawkesley Medical Practice is an approved training practice for trainee GPs. (A trainee GP is a qualified doctor who is training to become a GP through a period of working and training in a practice). There are two GP trainers. A trainee had just finished and one was due to start at the practice the day after our inspection.

The practice is open from 8.30am to 7.30pm on Mondays and Tuesdays, from 8.30am to 6.30pm on Wednesdays and Fridays and from 8.30am to 1.30pm on Thursdays. Appointments are available during these times.

South Doc provides cover when the practice does not answer the phones between 8am and 8.30am, 1pm to 3pm and on Thursday afternoons. At all other times when the practice is closed patients are asked to ring Primecare. Alternatively, patients can go to the walk-in centre in Selly Oak, Birmingham, which is open from 8am to 10pm seven days a week.

## Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as

# Detailed findings

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

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.

## How we carried out this inspection

Before our announced inspection of Hawkesley Medical Practice on 3 August 2016, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We also reviewed nationally published data from sources including NHS Birmingham South Central Clinical Commissioning Group (CCG), NHS England and the National Patient Survey published in July 2016.

During our inspection, we spoke with members of staff including a GP, an advanced nurse practitioner, the practice manager and members of the reception team. We also spoke with the manager of a local care home.

We spoke with seven patients, two of whom were members of the Patient Participation Group (PPG). A PPG is a group of patients registered with the practice who worked with the practice team to improve services and the quality of care.

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

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

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

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

Good

# Are services safe?

## Our findings

### Safe track record and learning

- There was an effective system in place for reporting and recording significant events. Staff told us that they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received support, information, a written apology and were told about any actions to improve processes to prevent a recurrence.
- The practice carried out a thorough analysis of the significant events and shared learning with their own team and with practices in the locality. Significant events were a standing agenda item at the practice meetings, which were held twice a month.
- We noted that appropriate action was taken as a result of significant events. For example, we were told of an incident where a GP could not gain access to a patient's home because a key code system was in place. After investigation, the practice was allowed to have the code, so that GPs could carry out home visits for patients living there.

There was a clear system in place to act on patient safety alerts, for example, from the Medicines and Healthcare products Regulatory Agency (MHRA). Alerts were received by a GP, who circulated them as appropriate and carried out audits if necessary. The GP also uploaded all alerts to the clinical forms folder in a secure Dropbox file. We saw that an audit had been carried out in response to MHRA guidance on new contraindications relating to medicines issued for an overactive bladder. Patients prescribed this medicine were identified and invited to attend for a review, which included a blood pressure check, in accordance with the guidance.

### Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. A GP was the lead member of staff for safeguarding, supported by the advanced nurse prescriber. Vulnerable patients were coded on the practice's clinical computer system. The GPs attended safeguarding meetings and provided reports where necessary for other agencies. Multi-disciplinary meetings were held every quarter, which were attended by a GP, the nurse prescriber, a health visitor, and a school nurse. Staff had all received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to an appropriate level to manage child protection or child safeguarding (level three). Staff clearly understood their responsibilities with regard to safeguarding. We were told how they had identified and escalated concerns about the safety of a vulnerable adult. Adults and children could be referred to the Birmingham Multi-Agency Safeguarding Hub (MASH).
- A notice in the reception area advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and we saw 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).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy. The advanced nurse prescriber was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received training from the infection control lead in May 2016. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements

identified as a result. The last audit had been carried out in July 2016. We saw that actions had been taken to correct issues identified in the audit. For example, a box of supplies which had been left on the floor was removed.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. We viewed the rheumatology protocol for the group of medicines commonly used to treat patients with rheumatoid arthritis and saw that onsite phlebotomy (taking blood samples) was offered, followed by an appointment or phone call. No controlled drugs were held on the premises. We noted that there was no system in place for notifying GPs if patients did not collect prescriptions. The practice carried out regular medicines audits, with the support of the local Clinical Commissioning Group (CCG) medicines management team, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Blank prescriptions were securely stored and there were systems in place to monitor their use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. Mentorship and support was provided by the GPs for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The Health Care Assistant was trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- There was a sharps injury policy and staff knew what to do if they accidentally injured themselves with a sharp medical device such as a needle. The practice recorded the Hepatitis B status of staff. All instruments were single use. We saw the contract for the collection of clinical waste and waste for collection was securely stored.
- We saw the recruitment policy which specified the procedures for recruitment. We reviewed five personnel files and found that appropriate recruitment checks had been undertaken prior to employment in accordance with the policy. For example, proof of identity, references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

### Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office. The practice carried out regular checks for extinguishers and emergency lighting, and the last fire risk assessment was carried out in 2015. The practice had not carried out a fire drill since October 2014. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was calibrated to ensure it was working properly. We saw that the most recent portable appliance test was carried out in February 2016. Items which failed the test were replaced. The last calibration was carried out in November 2015. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and Legionella. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and skill mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. Staff told us that they provided cover for each other during periods of sickness or annual leave.

### Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there was a sufficient range of emergency medicines available in the treatment room to cover the services provided.

Good

# Are services safe?

- The practice had a defibrillator available on the premises and oxygen with adult masks. We were told that the practice had taken the decision not to stock paediatric masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure, incapacity of GPs or building damage. The plan included emergency contact numbers for staff. The practice had a reciprocal arrangement with another practice in the event of loss of premises. The practice manager held a hard copy of the plan offsite.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

### Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. The QOF is a system intended to improve the quality of general practice and reward good practice. Data from 2014/15 showed:

- The practice achieved 94% of the total points available. This was slightly below the Clinical Commissioning Group (CCG) average of 96% and the national average of 95%.
- Exception reporting was 9%, which was in line with both the CCG and national averages of 9%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).
- The percentage of patients with diabetes on the register, in whom the last diabetic reading was at an appropriate level in the preceding 12 months was 76% which was slightly below the national average of 78%. Exception reporting was 10%, which was below both the CCG and national averages of 12%.
- 76% of patients with poor mental health had a comprehensive care plan review completed within the last 12 months. This was below the CCG average of 91% and below the national average of 88%.

In order to improve the practice's achievement, a designated QOF lead had been appointed and a white board was used to highlight QOF areas that needed attention. A practice nurse now had responsibility for the reviews for patients with long term conditions. Exception reporting had not been used effectively in the past, which explained the low mental health results for 2014/15. The 2015/16 unpublished results showed an improvement in the overall achievement from 94% to 99%, and a reduction in exception reporting from 9% to 1%. This was the highest score that the practice had ever achieved. The result for the osteoporosis indicator increased from 67% to 100% in 2015/16.

The practice participated in local audits, national benchmarking, accreditation, and peer review.

There was a system for undertaking regular clinical audits, which were used to improve patient care. Recent two-cycle audits included a review of patients with atrial fibrillation (a heart rhythm disorder) who were prescribed anti-clotting medicine and a review of patients prescribed a medicine issued for overactive bladder (this was in response to a patient safety alert regarding contraindications to the particular medicine).

Audit findings were used to improve services to patients. For example, the audit for patients who were prescribed the medicine for an overactive bladder was going to be repeated in six months, so that any patients who had not had a blood pressure test since the medicine was started could be invited to attend the practice for a review. This was in line with current guidance. The audit had resulted in improved monitoring of these patients, because all those taking the medicine who had not had a blood pressure test were now flagged up and investigated on a regular basis.

### Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, fire safety, health and safety and confidentiality.

Good

# Are services effective?

## (for example, treatment is effective)

- The practice kept a detailed log of training for all staff, so that all role specific or mandatory training could be tracked. Regular meetings were held for staff, which were also used to cascade learning. For example, practice meetings were held twice a month, and the GPs and nurses met twice a month. Reception staff meetings took place once a quarter. We viewed minutes of practice meetings and saw that items such as significant event discussions were appropriately documented.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- Staff learning needs were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and were encouraged to use e-learning training modules and attend in-house training.
- Clinical staff had additional expertise in a variety of specialisms, including mental health, diabetes, asthma and chronic lung disease.

### Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

### Consent to care and treatment

- Clinical staff we spoke with demonstrated that they understood the importance of obtaining informed consent and had received training about the Mental Capacity Act (2005) (MCA). The MCA provides a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make decisions for themselves.
- Clinical staff were very aware of the requirement to assess children and young people using Gillick competence and Fraser guidelines when providing care and treatment. Gillick competence was used to decide whether a child (16 years or younger) was able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Fraser guidelines relate specifically to contraception and sexual health advice and treatment.

### Supporting patients to live healthier lives

The practice identified patients who might be in need of extra support. For example, patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation advice. Patients were signposted to the appropriate service.

The practice's uptake for the cervical screening programme was 78% which was slightly lower than the CCG average of 80% and slightly lower than the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice ensured that a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The uptake for bowel cancer screening in the last 30 months for patients aged 60 to 69 years was 41%, which was lower than the CCG average of 46% and

Good

# Are services effective?

## (for example, treatment is effective)

lower than the national average of 58%. The uptake for breast cancer screening in the last 36 months for patients aged 50 to 70 years was 65%, which was the same as the CCG average and lower than the national average of 72%.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 77% to 97%, which was in line with the CCG averages of 79% to 96%. The childhood immunisation rates for five year olds ranged from 78% to 97%, which was in line with the CCG averages of 83% to 95%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74 years. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

# Are services caring?

## Our findings

### Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 38 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with two members of the Patient Participation Group (PPG). A PPG is a group of patients registered with the practice who worked with the practice team to improve services and the quality of care. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. They told us that staff went out of their way to help and could handle challenging patients very well. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the National GP Patient Survey published in July 2016 showed that patients felt that they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 90% of patients said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 88% and the national average of 89%.
- 93% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 91% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 85%.
- 96% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 88% and the national average of 91%.
- 86% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.

### Care planning and involvement in decisions about care and treatment

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

Results from the National GP Patient Survey published in July 2016 showed that patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were higher than local and national averages. For example:

- 92% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 86%.
- 88% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and the national average of 82%.
- 93% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 85%.

Staff told us that translation services were available for patients who did not have English as a first language. We saw a notice in the reception areas informing patients that this service was available. Interpreters were provided by the

Good

# Are services caring?

Birmingham Integrated language and Communications Services. Family members were discouraged from acting as interpreters, although in acute situations this was sometimes unavoidable.

### Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 53 patients as carers, which represented 1% of the patient population. The advanced nurse prescriber was the practice lead for carers and was working to identify more carers. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP would contact them and offer advice on how to find a support service. GPs would try to attend the funeral where possible.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and the Birmingham South Central Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that required same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately or were referred to other clinics for vaccines available privately.
- There were disabled facilities, a hearing loop and translation services available. GPs and nurses collected patients from the reception area, so they could help those with mobility problems.
- The practice had recognised the interplay between health and social issues and had piloted a service from the Citizens' Advice Bureau (CAB) whereby an advisor came to the practice every Monday in order to help patients with a variety of non-clinical issues including housing, benefits and employment. The service started in October 2015; 86 registered patients had used the service up until July 2016. Although no formal statistics were available, patients had reported high levels of satisfaction. We were shown two case studies where the conditions of patients with mental health problems improved after issues were resolved due to the intervention of the CAB advisor. A formal evaluation of the service was due to be conducted later in 2016.
- We heard how adjustments were made when patients missed appointments, particularly patients who were considered to be vulnerable or those who had mental health issues. Patients told us that GPs and nurses would follow up patients who did not attend their appointments. On one occasion, a nurse ensured that a check was made on an elderly patient at home when the patient failed to attend for an appointment. On another occasion, a GP checked up on a vulnerable patient after a home visit call was not answered.

### Access to the service

The practice was open from 8.30am to 7.30pm on Mondays and Tuesdays, from 8.30am to 6.30pm on Wednesdays and Fridays and from 8.30am to 1.30pm on Thursdays. Appointments were available during these times. South Doc provided cover when the practice did not answer the phones between 8am and 8.30am, 1pm to 3pm and on Thursday afternoons. In recognition of the demographics of the practice catchment area, 60% of appointments were available to book on the day. Extended hours appointments were offered on Monday and Tuesday evenings until 7.30pm.

In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for patients that needed them.

Results from the National GP Patient Survey published in July 2016 showed that patients' satisfaction with how they could access care and treatment was lower than local and national averages.

- 77% of patients were satisfied with the practice's opening hours compared to the national average of 76%.
- 46% of patients said they could get through easily to the practice by phone compared to the national average of 73%.
- 50% of patients described their experience of making an appointment as good compared to the national average of 73%.
- 80% of patients said that the last appointment they got was convenient compared to the national average of 92%.

A new phone system was installed in July 2016. This system had four more lines and a detailed call-in queue messaging facility, which was helping to ease the frustration with making appointments. One patient commented specifically that the new system was a big improvement. It was hoped that the next survey would show a marked improvement in this area.

Patients told us on the day of the inspection that they were able to get an appointment when they needed one and that it was getting easier to get through on the phone.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

Patients who wanted a home visit were asked to phone the practice before 11am. All requests for home visits were triaged by the on-call GP. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, receptionists would message or ring the on-call GP. All receptionists had received in-house training with regard to processing requests for home visits.

### Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager handled all complaints in the practice. A GP was the lead for Human Resource issues and could provide additional advice on handling complaints if required.
- We saw that information was available to help patients understand how to complain in reception and on the practice website.

We looked at four complaints received since April 2015, which were logged on a comprehensive summary sheet. We saw that they had been handled in a timely and open manner and that full explanations had been provided on each occasion. As a result of one complaint, the practice no longer employed a particular locum GP.

# Are services well-led?

Good

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

## Our findings

### Vision and strategy

Delivering high quality care and promoting the best outcomes for patients were priorities for the whole practice team.

There was particular emphasis on vulnerable adults and children in poor social circumstances. The practice staff were aware that premature death and disease were consequences of the high levels of deprivation and they worked hard to provide services to respond to these issues. The response extended to recognising the link between health and social issues and piloting a Citizens' Advice Bureau service to patients.

### Governance arrangements

A broad range of policies and procedures was available on the practice intranet. All staff we spoke with confirmed that they understood their roles and responsibilities within the practice.

- The partners met once a month. Practice meetings took place on the first and third Monday of each month. Lead members of staff attended these fortnightly meetings and circulated updates as appropriate. We viewed minutes of these meetings and saw that actions were documented. The GPs and practice nurses met once a quarter and the reception team also met once quarter. Practice nurses met informally every week and formally twice a month.
- Clinical staff had lead roles and specific areas of interest. These roles included diabetes, mental health, learning disabilities, women's health and minor surgery.
- There were arrangements in place for identifying, recording and managing risks, and implementing mitigating actions.

### Leadership and culture

The partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners and practice manager had an open door policy and always took the time to listen to them.

- The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. We saw evidence that the practice was a learning organisation with a no-blame attitude.
- When things went wrong with care and treatment the practice explained what had happened and offered a full apology. We viewed records of actions taken.
- There was a clear leadership structure in place and staff told us that they were supported by the GP partners and management team. Staff told us that there was an open and honest culture within the practice and that they could raise any issues at team meetings and felt confident and supported when they did so. Staff said that they felt that their contribution to the practice was appreciated by the GP partners and management team.

Staff told us that they appreciated the social events which were arranged at Christmas and at other times of the year. These events provided the opportunity for staff to get to know each other outside of work.

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

The practice encouraged and valued feedback from patients, the public and staff.

- The practice had gathered feedback from patients through the Patient Participation Group (PPG) and through surveys and complaints received. The PPG met once a quarter, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, a new phone system had been installed as a result of complaints about the difficulty in getting through to the practice and the appointment system for Thursday mornings had been changed to urgent book on the day appointments only.
- Staff told us that they could give feedback and discuss any concerns or issues with colleagues and the practice manager.

### Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice

# Are services well-led?

Good

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

team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, the practice was piloting the weekly Citizens' Advice Bureau service.

Hawkesley Medical Practice was a training practice, which evidenced their commitment to learning and development beyond their own organisation. There were two GP trainers, one of whom was also a GP appraiser.

The partners also encouraged development for staff. For example, a GP had received funding from the practice to undertake a 'Train the Trainer' course and the assistant practice manager had attended a leadership and management course. Practice nurses were encouraged to undertake courses to extend their skill base. For example, one of the nurses was studying for a nurse prescriber qualification.