Warley Medical Centre

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Warley Medical Centre on 3 September 2015. Overall the practice is rated as good.

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

- Incidents were being reported and learning shared with staff. There were systems in place to maintain the health and safety of patients and staff at the practice.
- The practice had effective procedures in place that ensured care and treatment was delivered in line with appropriate standards. The practice was proactive in promoting good health.
- Risks to patients were assessed and well managed including those relating to recruitment checks.
- Patients were treated with dignity and respect. Patients we spoke with and those who completed our comments cards were very positive about their experiences of the care and treatment provided by staff. Patients said they were treated with dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand in the practice and on the practice website. The practice provided services that reflected the needs of the patients.
- Most patients said they found it easy to make an appointment with a GP. However, some said that access was an issue especially with a GP of their choice. Urgent appointments were available the same day and the practice had introduced a walk in clinic to improve access.
- The premises were purpose built and had good facilities to treat patients and meet their needs.
- The staff had established leadership roles and responsibilities with clear lines of accountability.

We saw areas of outstanding practice including:

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- The practice had developed a minor surgery audit which was used to reduce its complication rates.
- The practice had an above average emergency admission rate that was higher than the national average. The practice recognised a significant contributory factor and involved other organisations such as the CCG and the local authority to try and address the issues.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider should

- Develop an overall infection control policy, ensure regular audits are carried out and staff receive training appropriate for their role.
- Make all staff are aware of the contingency plan so that all are aware of the appropriate actions to take when required.

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. The services had a good track record for safety and there was effective recording and analysis of significant events to prevent unnecessary recurrences. Lessons learned were communicated to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were safeguarding measures in place to help protect children and vulnerable adults. Equipment required to manage foreseeable emergencies was available and was regularly serviced and maintained. The practice did not have an infection control policy though other policies linking into infection control such as sharps injury policy and spillage were in place.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were above average for the locality for most areas apart from access. Clinical staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Clinical audits were carried out and changes made to ensure patient care was appropriate for their needs. Systems were in place for regular reviews of patients who had long term conditions. Staff had received training appropriate to their roles and the practice could show that appraisals and had been completed for all relevant staff. Staff worked well with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. We found and patients told us that practice staff were caring and helpful. Patients we spoke with told us they were satisfied with their care and they had confidence in the decisions made by clinical staff. The comment cards patients had completed prior to our inspection provided positive opinions about staff, their approach and the care provided to them. Translation services were available to people whose first language was not English and the practice website could be translated in various languages.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients had access to screening services to detect and monitor certain long term conditions. There were immunisation clinics for babies and children. The practice had recognised through patient

Summary of findings

surveys, analysis of national surveys and feedback that access to appointments was an issue and was implementing strategies to improve in this area. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that staff were aware of the process. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. Patients were cared for by staff who were aware of their roles and responsibilities for managing risk and improving quality. There were clear governance structures and processes in place to keep staff informed and engaged in practice matters. There was evidence of improvements made as a result of audits. The practice had a Patient Participation Group (PPG) and there was evidence of improvements made as a result of feedback from the group. Staff were encouraged and involved in the analysis of incidents and complaints for on-going improvements that benefitted patients.

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 had an above average emergency admission rate that was higher than the national average. The practice recognised that a significant contributory factor was from a single location providing retirement housing and care services for people aged 65 and above. Many of those at the location had been registered with the practice. The practice involved the Clinical Commission Group (CCG) and the provider of the housing and care services. The CCG allocated community matron to assess patients so that they could be housed appropriately and to train staff at the location so that they could recognise where there was a genuine need for emergency admission.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice had a higher than average elderly population with higher prevalence rates compared to national average. Data showed that the practice's achievement for the management of long term conditions was generally higher than local and national average. The practice demonstrated improvement through audits. An audit showed that practice was monitoring 87% of patients on a medicine and a second audit showed improvement wherby100% of patients were being monitored. The practice management of diabetes patients was also better in comparison to the national average.

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. Practice staff held a register of patients who had long term conditions and carried out regular reviews. For patients with the most complex needs, GPs worked with relevant health and care

Summary of findings

professionals to deliver a multidisciplinary package of care. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were policies, procedures and contact numbers to support and guide staff should they have any safeguarding concerns about children. The clinical team offered immunisations to children in line with the national immunisation programme. Immunisation clinics were held weekly and the immunisation rates were comparable to local and national averages. Appointments were available outside of school hours and the premises were suitable for children and babies. Most consultation rooms were on the ground floor and those on the first floor were accessible for pushchairs through the use of a lift.

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 practice provided extended opening hours every Mondays from 6.30pm to 8pm for patients who were unable to visit the practice during normal working hours. Clinics were held by four GPs to ensure availability of appointments. The practice offered online services though a very small number of patients had registered for this facility. The practice also had arrangements for patients to have telephone consultations with a GP. The practice was proactive in offering a full range of health promotion and screening that reflected the needs of this age group. This included health checks for patients aged 40 to 70 years of age.

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. It had carried out annual health checks for patients with a learning disability and most of these patients had received a follow-up. It offered longer appointments for these patients. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Home visits were carried out to patients who were housebound and to other patients on the day that had a need. Staff were aware of their responsibilities regarding information sharing, documentation of

Summary of findings

safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. A visiting counsellor held three sessions a week and patients referred by their GP were seen on a one-to-one basis if needed.

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). The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results published on 2 July 2015 showed the practice was performing similar or better than local and national averages apart from getting through to the surgery by phone and access to their preferred GPs. There were 282 questionnaires sent out with 95 being returned. This was a response rate of 34%.

- 29% found it easy to get through to this surgery by phone compared with a CCG average of 63% and a national average of 73%.
- 14% usually got to see or speak to their preferred GP compared with a CCG average of 51% and a national average of 60%.
- 86% find the receptionists at this surgery helpful compared with a CCG average of 82% and a national average of 87%.
- 78% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 77% and a national average of 85%.
- 87% said the last appointment they got was convenient compared with a CCG average of 89% and a national average of 92%.
- 53% described their experience of making an appointment as good compared with a CCG average of 64% and a national average of 73%.
- 59% usually waited 15 minutes or less after their appointment time to be seen compared with a CCG average of 54% and a national average of 65%.
- 56% felt they didn't normally have to wait too long to be seen compared with a CCG average of 47% and a national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 37 comment cards which were all positive about the standard of care received. They stated that staff were caring, the surgery was always clean, they were listened to and received an excellent service. Patients we spoke with on the day were also positive about the service and staff.

Areas for improvement

Action the service SHOULD take to improve

- Develop an overall infection control policy, ensure regular audits are carried out and staff receive training appropriate for their role.
- Make all staff are aware of the contingency plan so that all are aware of the appropriate actions to take when required.

Outstanding practice

We saw areas of outstanding practice including:

- The practice had developed a minor surgery audit which was used to reduce its complication rates.
- The practice had an above average emergency admission rate that was higher than the national average. The practice recognised a significant contributory factor and involved other organisations such as the CCG and the local authority to try and address the issues.

Warley Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Warley Medical Centre

Please note: you can use present tense here to describe the background.

The practice has 11318 patient registered. It is open from 8am to 8pm on Mondays and 8.30am to 6.30pm Tuesdays to Fridays. The practice has opted out of providing out-of-hours services to their own patients. This is provided by an external out of hours service

The practice has five GP partners (two female and three male) with one regular locum GP. There is an advanced nurse practitioner, three practice nurses and a healthcare assistant. The practice team also consisted of a practice manager, a business manager and a team of administration and reception staff. Warley Medical Centre is a training practice for fully qualified doctors to gain experience and higher qualifications in general practice and family medicine.

This was the first time the CQC had inspected the practice. Data we reviewed showed that the apart from access to appointments the practice was achieving results that were above average in in comparison to the local Clinical Commissioning Group (Sandwell and West Birmingham) as well as the national average.

Warley Medical Centre holds a GMS contact with the commissioners of the service (NHS England).

Why we carried out this inspection

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

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

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 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
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable

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

Before visiting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. We carried out an announced visit on 3 September 2015. During our visit we spoke with a range of staff including two GP partners, the practice manager, business manager as well as the administration and reception staff. We also spoke with five patients who used the service including a member of the Patient Participation Group (PPG). We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. We saw evidence that the practice had documented 14 significant events for 2014-15 and 17 significant events for 2013-14. There was significant events template which was completed by relevant staff and forwarded to the practice manager who was the lead. The lead populated the template on an electronic system which was shared with the Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

The practice carried out an analysis of the significant events. Staff members told us that this was done three monthly in staff meetings. Staff told us that significant events along with documented response were given to small groups of staff during staff meeting to discuss and analyse. They then presented their analysis to all the staff with any further learning for implementation.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice.

Where relevant, changes were implemented as a result of significant events. For example, we looked at a significant event from August 2014 regarding a dispensing error identified by a staff member at the practice. This was investigated by the pharmacy as a result of the encouragement received from the practice. The pharmacy responded to the incident and the practice made changes to ensure that any change to a patient's medication was now communicated to the pharmacy.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements to safeguard adults and children from abuse that reflected relevant legislation and local requirements. We saw policies were accessible to all staff which outlined who to contact for further guidance if they had concerns about a patient's welfare. There was a lead member of staff for safeguarding. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. We saw an example where concerns were raised by a GP regarding a child. The practice took action by informing social services, ensuring that the child was seen by appropriate persons at the local hospital by paying for transport by taxi and ensuring the lead at the CCG was informed.
- A notice was displayed in the waiting room, advising patients that nurses would act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). 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.
- There were procedures in place for monitoring and managing risks to patients and staff safety. There was a health and safety policy available and the practice had up to date fire risk assessments. We saw fire evacuation procedures were displayed around the building including the reception area and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also 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.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. There was an infection control clinical lead in the practice and staff members we spoke with were aware of the lead. However, the practice did not have a policy though they had other policies linking into infection control such as sharps injury policy and spillage policy. Annual infection control audits had not been undertaken since November 2012 and most staff had not attended any formal training since February 2014 including the lead in infection prevention and control. We were told that a senior nurse had attended training in March 2015 and staff members we spoke with told us that they discussed infection control procedures during staff monthly meetings.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept

patients safe (this included obtaining, prescribing, recording, handling, storing and security). Prescription pads were securely stored and there were systems in place to monitor their use.

- Recruitment checks were carried out and the four staff files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate DBS checks.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. For example, a staff member we spoke with showed us the weekly rota and told us that they were done four weeks in advance. They further stated that they were trained in different roles and could cover in the event of unplanned absence.

Arrangements to deal with emergencies and major incidents

All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a Automated External Defibrillator (AED) available on the premises and oxygen with adult and children's masks. An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm defibrillator. 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 fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. Some staff members we spoke with were not aware of the plan. The practice manager told us that they had discussed the plan during the monthly team meetings and would be discussing it again.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. This was through clinical meetings and there was a clinical lead at the practice responsible for ensuring adherence to NICE guidance.

Management, monitoring and improving outcomes for people

Data we looked at showed that the practice had a higher than average elderly patient population with a higher than average prevalence rates for some long term conditions. For example, the practice informed us that the prevalence of hypertension (high blood pressure) amongst its registered patients was 18.8% compared to a national average of 13.7%. Similarly, the prevalence for Chronic Obstructive Pulmonary Disease (COPD) was 2.9% compared to the national prevalence of 1.7%. COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections. We found there were appropriate systems in place to ensure patients with long term conditions.

The practice participated in the Quality and Outcomes Framework (QOF). The Quality and Outcomes Framework is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually. QOF results showed that the practice had achieved 99.6% of the total number of points available, with 4.5% exception reporting. The QOF includes the concept of exception reporting to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2013/14 showed:

- Performance for diabetes related indicators was better than the CCG and national average. This was 11% better than the CCG average and 10% above the national average. A GP and a nurse had also attended a specialist diabetes course and a nurse led diabetic clinic was held every Monday from 8.30am to 12.30pm with support from a GP.
- The percentage of patients with hypertension having regular blood pressure tests was 7% better compared to the CCG and 8% above national average.
- Performance for mental health related and hypertension (high blood pressure) indicators were better than the CCG and national averages. For mental health the practice had achieved 100% of eligible points, the CCG average was 91% and the national average was 90%. For the hypertension indicators the practice had achieved 100% of the eligible points, the CCG average was 90% and the national average was 88%.
- The dementia diagnosis rate was 5% above CCG and 6% above national average.

The practice participated in local benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services. For example, the practice was a high prescriber for antibiotics compared to the CCG. We looked at an antibiotic audit which showed that the practice had reduced its prescribing from 37% to 32%. The practice was working towards reducing further by monitoring its prescribing rates and making clinical staff aware.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. We also looked at a medicine audit used to treat various conditions including arthritis. The medicine audit showed that practice was monitoring 87% of the patients on this drug. The practice took action to improve and the second cycle of the audit showed that 100% of patients on the drug were being monitored.

A minor surgery audit was carried out and showed that the practice had reduced its complication rate from minor surgery from that of above average to below average.

Effective staffing

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

- Practice staff included medical, nursing, managerial and administrative staff. We reviewed four staff training

records and saw that all staff had attended training courses that were relevant to their roles. They included safeguarding, annual basic life support and information governance awareness. All staff including nursing staff undertook annual appraisals that identified further learning needs. Staff members we spoke with told us they had in-house training during monthly practice meetings. They also told us that they had access to made use of e-learning training modules until March 2015.

- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

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. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available in the reception area and the waiting areas. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

The practice was following principles of the Gold Standard Framework (GSF) and that this included multiagency meetings. The GSF is a practice based system to improve the quality of palliative care in the community so that more patients receive supportive and dignified end of life care, where they choose. Minutes of meeting we looked at showed that these multidisciplinary meetings were held monthly with palliative care patients being discussed quarterly. They were used to discuss patients with complex needs, including end of life care needs as well as children on the at risk register. They were attended by district nurses and palliative care nurses and decisions about care planning were documented in a shared care record. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. We saw that the staff had attended training on MCA within the last two years. We saw that the practice had also modified and further developed an existing template to screen for dementia and review their health condition.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. For example, a GP partner told us and documents we looked at confirmed that the practice prevalence for diabetes was higher than the national average. The practice developed a diabetes template to better identify and manage patients. Every two months a consultant in diabetes along with a diabetic specialist nurse held clinics for patients with more complex needs. The outcome of these was that the practice was able to better manage the blood glucose level of their patients with diabetes. We saw data which confirmed that 86% of patients had a blood glucose level below 8% compared to the national average of 77%.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 80%, which was above the CCG average of 74% and comparable to the national average of 79%. Patients were reminded to attend screening tests via letters and telephone.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds and five year olds were similar to local and national average. Data we looked at showed that flu vaccination rates for the over 65s were similar to local and national average.

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

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Staff members we spoke with told us that they offered the interview room adjacent to the reception desk if any patients wanted to discuss sensitive issues. A staff member told us that they had recently offered the room to a patient who appeared and was distressed.

All of the 37 patient CQC 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. However, three comments also stated that access to appointments could be improved. We also spoke with five patients including a member of the patient participation group (PPG) on the day of our inspection. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey July 2015 showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice generally scored above local and national average for its satisfaction scores on consultations with doctors and nurses. For example:

- 92% said the GP was good at listening to them compared to the CCG average of 84% and national average of 89%.
- 94% said the GP gave them enough time compared to the CCG average of 82% and national average of 87%.
- 95% said they had confidence and trust in the last GP they saw compared to the CCG average of 92% and national average of 95%
- 85% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 80% and national average of 85%.
- 92% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 90%.
- 86% patients said they found the receptionists at the practice helpful compared to the CCG average of 82% and national average of 87%.

Care planning and involvement in decisions about care and treatment

We spoke with five patients and received 37 comments cards. Patients we spoke with told us that health issues were discussed with them and 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 on the comment cards we received were also positive and aligned with these views.

We reviewed results from the July 2015 national GP patient survey which showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were in line with local and national averages. For example:

- 86% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and national average of 89%.
- 82% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 76% and national average of 81%

Staff told us that translation services were available for patients who did not have English as a first language. The practice website could be translated in various languages and there was facility for patients to register for their appointment in different languages.

Patient and carer support to cope emotionally with care and treatment

We saw an area in the patient reception area displayed notices to inform patients of the various support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer so that they could be more aware of their needs and signposted them to appropriate support groups.

Good

Are services caring?

There was a practice register of all people who were carers and 402 patients (3.5%) of the practice list had been identified as carers. Many of them had been identified as young carers. The practice had good links with other organisations such as carers association. The practice also held an open day event so that they could organise appropriate support for the registered carers.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. We saw different boards staff reception area. One of the boards listed the names of patients that had recently passed away so that staff could update themselves and ensure relatives or carers calling in or attending could be treated sensitively.

A visiting counsellor held three sessions a week and patients referred by their GP were seen on a one-to-one basis if needed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area. For example, before our inspection we noted that the number of emergency admissions was higher than the national average. The practice explained and data we saw confirmed that they practice had a higher than national average older population. The prevalence of various long term conditions was also higher than the national average. To improve, the practice offered all vulnerable and elderly patients access to on call clinical team and same day visits or appointments as needed.

The practice had also recognised that 31% of its emergency admissions were accountable to one extra care facility run by a separate organisation in conjunction with the local authority. The practice worked with the CCG to organise meetings with social services and the director of the location where the patients were living along with the District Nurse team. A community matron was introduced by the CCG so that patients living at this location could be reviewed individually, allocated to a more appropriate location and to enable staff at the location with appropriate training.

- The practice offered evening clinics until 8pm every Mondays. The clinics were held by four GPs so that working patients who could not attend during normal opening hours had access.
- There were longer appointments available for people with a learning disability.
- Home visits were available for older patients and other patients who would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were facilities for people with physical disabilities, a hearing loop and translation services were also available.
- The practice had moved into the purpose built premises in 2003 and most consultations were held on the ground floor. There were two consultation rooms on the first floor mostly for visiting professionals and lift access was available.

Access to the service

The practice was open between 8am to 8pm on Mondays. It was open from 8.30am to 6.30pm Tuesdays to Fridays but the phone lines were open from 8am. The practice was closed for lunch between 1pm and 2pm Mondays to Thursdays and 1pm to 3pm on Fridays.

Results from the national GP patient survey from July 2015 showed that patient's satisfaction with how they could access care and treatment was lower than local and national averages. For example:

- 66% of patients were satisfied with the practice's opening hours compared to the CCG average of 72% and national average of 75%.
- 29% patients said they could get through easily to the surgery by phone compared to the CCG average of 63% and national average of 73%.
- 53% patients described their experience of making an appointment as good compared to the CCG average of 64% and national average of 73%.
- 59% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 54% and national average of 65%.
- 14% usually got to see or speak to their preferred GP compared to the CCG average of 51% and a national average of 60%.

The practice was aware of this and a GP partner stated that this was their main challenge, and they were trying various strategies to improve. This included offering online appointments, however only 1600 patients (14%) had registered for this facility. The practice recognised that they needed to address this area with more education for patients regarding the type of appointments available and how to book. Staff were being trained to help patients become more aware of the ways to book an appointment.

The practice had changed its appointment system after auditing the rate of missed appointments (DNAs). The practice now offered most appointments on the day but working patients could book late appointments two weeks in advance on Mondays. The practice also had a seven day advance appointment with a GP all day Mondays and Fridays, in the morning on Tuesdays and Thursdays and afternoons on Wednesdays. The practice had also introduced a walk in clinic held every day run by the Advanced Nurse Practitioner and a 'duty' doctor. This was for patients who wanted to see a GP but could not book an

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appointment on the day because all on the day appointments had been booked up. If patients arrived before 11am to register and did not mind waiting they were generally seen.

In regards to continuity of care, one of the GP partners explained that there had been recent changes and long term absence of some of the GPs at the practice. This impacted on continuity of care for patients. However, the practice had recently recruited a new GP partner and the practice was hoping to see improvements in its ratings for continuity of care. Furthermore, the practice had a dedicated whiteboard in the reception area with names of patients who only wanted to see a particular GP. This ensured staff booked appointments with their chosen GP as long as patients did not mind waiting longer.

We spoke with five patients including a member of the PPG. We also received 37 comments cards. All the patients we spoke with were positive about the GPs and the consultations. However, two patients did state that at times they found it difficult to get an appointment or get through to the practice on the phone. In regards to continuity of care, patients told us that as long as they did not have a preference for a GP they were able to get an appointment quickly. All the comments cards were positive about the service and three cards commented on the difficulty accessing the practice for an appointment but were positive overall.

Listening and learning from concerns and complaints

The practice had a 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. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system in the reception area. Most patients we spoke with were not aware of the process to follow if they wished to make a complaint. However, they said that they did not have any reasons to make a complaint and would speak with a member of staff if they ever needed to complain.

We saw that the practice had a complaints folder. We saw that the practice had received nine complaints in the last 12 months and found any learning outcomes were clearly marked. Staff members we spoke with confirmed that complaints were discussed in team meetings and minutes of meetings looked at confirmed this.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice mission was to provide high quality care without discrimination to any patient group. To screen effectively for disease as well as implement measures to reduce the risk of illness. Although we saw evidence that efforts were being made to fulfil its mission, not all staff members were aware of the practice vision.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control although and although this was not supported by a policy all staff we spoke with were aware of the lead. A senior partner was the lead for safeguarding. Staff members we spoke with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. For example, one staff member told us that they had been given extra roles and responsibilities and were supported with training to enhance their skills. A nurse had been supported to attend a diabetic course as long as they then held a clinic.

The practice manager was responsible for the day to day running of the practice and there was a business manager responsible for the financial aspects of the practice.

There were arrangements for identifying, recording and managing most risks, issues and implementing mitigating actions. A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. We saw evidence of two clinical audits that were carried saw that improvements in patient care were demonstrated through them. Evidence from other data sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. For example, the practice responded to findings from the GP national survey and feedback from its own patient group regarding access to appointments. We saw that various strategies were being tried to ensure better access to appointments.

Leadership, openness and transparency

The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness and honesty. This was evident in the way incidents and complaints were analysed and through involving and sharing learning with the wider staff.

Staff members we spoke with told us that regular team meetings were held. They told us that sometimes these meetings were used for training such as safeguarding or other role specific training. We were told that there was an open culture within the practice. Staff had the opportunity to raise any issues at team meetings, were confident in doing so and felt supported if they did. For example, a staff member told us that they had a meeting in regards to the practice joining another GP surgery to become a partnership. The staff member added that it was nice to be involved and the management explained why they wanted to become a partnership.

Staff said they felt respected, valued and supported, particularly by the partners in the practice. Most staff had been employed at the practice for many years. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. For example, staff members were split into groups at practice meetings every quarter to discuss and analyse incidents. They were then asked to present their analysis to the rest of the team members and for everyone to contribute so that any further learning could be implemented.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. We spoke with a member of the PPG who confirmed that the practice took on board their suggestions. They stated that they met on a regular basis,

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carried out patient surveys and helped to hand out leaflets to patients informing them of the forthcoming for flu jab dates. They also stated that they spoke with patients to inform them of the changes to appointment system such as the walk in clinic that had been introduced.

The practice had a comments box but we were told that they did not receive many comments. However, we saw many thank you cards that the practice had received from patients displayed in the reception area.

Innovation

The practice trained new doctors and there was a strong focus on continuous learning and improvement at all levels within the practice. The practice was recognised as being research ready and undertook studies approved by the Primary Care Research Network and Royal College of General Practitioners.