Drs Yap, Hughes and Michael

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 Drs Yap, Hughes and Michael's practice on 6 May 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and managed, although actions taken in relation to risks were not always well documented.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, 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.
- Patients were able to make an appointment with a named GP and urgent appointments were 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 the senior partners. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider should:

- Ensure robust records are maintained in relation to the governance of the practice including risks, audit actions and staff meetings to ensure actions required are not missed.
- Ensure legionella risk assessments have been completed for the premises and actions identified implemented.

Summary of findings

- Ensure doctor's bags are routinely checked to ensure items contained within them are within their expiry date and fit for use.
- Ensure systems are in place for ensuring findings from audits are discussed and where appropriate implemented.

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 understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and managed but actions undertaken were not always well recorded to demonstrate that they were complete.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. Although clinical audits were undertaken it was not always clear that the findings were well implemented to deliver service improvement. Staff understood their responsibilities in relation to consent and decision-making requirements. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals. Staff worked with multidisciplinary teams to support the needs of patients with complex needs.

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 many aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients were generally satisfied with the appointment system and could obtain and urgent appointment on the same day. The practice had good facilities and was well equipped to treat patients and

Summary of findings

meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. 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. The practice had a number of policies and procedures to govern activity and held regular governance meetings to monitor and improve quality and identify risk, although these were not always well documented. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff were supported in their professional development and attended staff meetings and events.

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. 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. For example, the practice was participating in a local improvement scheme with the CCG to target support to patients over 75 and held reduce the need for admissions. As part of the scheme patients in this population group receive same day access, had a designated named GP and had access to annual health reviews which included memory test to help identify early stage dementia. Multi-disciplinary team meetings took place with to support patients with end of life care needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Dedicated clinics were held for the management of patients with long term conditions such as diabetes, chronic obstructive pulmonary disease and hypertension. Patients received as a minimum annual health reviews with the nurse practitioner who had received additional training in specific chronic disease management or GPs. Those with complex health needs with a at risk of hospital admission were identified as a priority. The patients had access to a named GP and access to same day appointments. The practice 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 systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. The practice also met regularly with the health visitor who ran a weekly clinic from the practice to discuss the needs of vulnerable children. Immunisation rates were relatively high for all standard childhood immunisations. A range of services were available at the practice for this population group including antenatal and well baby clinics. Appointments were available outside of school hours and appointments available same day for young children and babies.

Summary of findings

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. For example the practice offered extended opening hours with early morning and evening appointments and telephone consultations. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group including health checks, travel health, family planning and sexual health services.

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 people with a learning disability. The practice also saw travellers as temporary residents and offered walk in appointments for those who preferred them. Longer appointments were available for patients who needed them.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. 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.

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). Patients experiencing poor mental health received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. Those at risk of depression were assessed and supported as appropriate. Counselling services and substance misuse clinics were available at the practice.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was performing in line with local and national averages. There were 128 responses and a response rate of 38%.

- 61% find it easy to get through to this surgery by phone compared with a CCG average of 62% and a national average of 74%.
- 87% find the receptionists at this surgery helpful compared with a CCG average of 83% and a national average of 87%.
- 72% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 58% and a national average of 61%.
- 92% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 82% and a national average of 85%.
- 88% say the last appointment they got was convenient compared with a CCG average of 90% and a national average of 92%.
- 76% describe their experience of making an appointment as good compared with a CCG average of 67% and a national average of 74%.
- 59% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 62% and a national average of 65%.
- 50% feel they do not normally have to wait too long to be seen compared with a CCG average of 54% 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 39 comment cards which were positive about the standard of care received although some patients raised booking appointments and waiting times as an issue which was consistent with the national GP patient survey findings. Feedback was particularly positive about the care provided by the GPs at the practice.

Areas for improvement

Action the service SHOULD take to improve

- Ensure robust records are maintained in relation to the governance of the practice including risks, audit actions and staff meetings to ensure actions required are not missed.
- Ensure legionella risk assessments have been completed for the premises and actions identified implemented.
- Ensure doctor's bags are routinely checked to ensure items contained within them are within their expiry date and fit for use.
- Ensure systems are in place for ensuring findings from audits are discussed and where appropriate implemented.

Drs Yap, Hughes and Michael

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a second CQC inspector, GP, practice nurse and an expert by experience (a person who has experience of using this particular type of service, or caring for somebody who has).

Background to Drs Yap, Hughes and Michael

Drs Yap, Hughes and Michael's practice (also known as Maypole Health Centre) is part of the NHS Birmingham South and Central 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.

Drs Yap, Hughes and Michael is registered with the Care Quality Commission to provide primary medical services. The practice has a general medical service (GMS) contract with NHS England. Under the GMS contract the practice is required to provide essential services to patients who are ill and includes chronic disease management and end of life care.

The practice is located in a purpose built health centre which it shares with one other practice. Based on data available from Public Health England, deprivation in the area served is below the national average. The practice has a registered list size of approximately 4,200 patients.

The practice is open 8.30am to 6pm on Monday, Tuesday Wednesday and Friday. On a Thursday the practice is open 8.30am to 1pm. When the practice is closed during the day (between 8am and 8.30am Monday to Friday and between 1pm and 6.30pm on a Thursday) and in the out of hours period (6.30pm to 8am) patients receive primary medical services through other providers (Southdoc Services Ltd and Primecare). The practice provides extended opening hours on four evenings each week between 6.30pm and 7.30pm and one morning each week between 7.30am and 8am.

The practice has three GP partners (two male and one female). Other practice staff consist of an advanced nurse practitioner, a healthcare assistant a practice manager and a team of administrative / reception staff. The practice is also a training practice for doctors who are training to be qualified GPs.

The practice has not previously been inspected by CQC.

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.

Detailed findings

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on the 6 May 2015. During our visit we spoke with a range of staff (including GPs, a practice nurse, the practice manager and receptionists) and spoke with nine patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff we spoke with knew how to raise incidents and near misses with senior staff and were confident in doing so. Complaints received by the practice were also treated as a significant events. For example, an informal complaint about the length of wait a patient experienced led to a notice being placed in reception to remind patients to report their arrival at reception.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared with staff at weekly meetings and more widely through the local commissioning network to make sure action was taken to improve safety in the practice. For example, a patient was given two flu vaccinations and as a result a second member of staff was made available during baby clinics to ensure checks were fully completed prior to administering the vaccination.

National patient safety alerts were disseminated by the practice manager to relevant staff to review. Staff told us that relevant safety alerts would be discussed at the weekly practice meeting. We were given examples of alerts that had required action relating to medicines, equipment and information on Ebola.

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 were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Safeguarding policies were accessible to all staff. Information on who to contact in relation to safeguarding concerns was also available. Staff we spoke with demonstrated they understood their responsibilities in relation to safeguarding and all had received training relevant to their role. Alerts on the patient record system ensured staff were aware of any patients who might be vulnerable. Regular meetings were held with the health visitor to discuss children at risk. The GPs told us they were not usually able to attended safeguarding meetings but would always contact and provide reports where necessary for other agencies and were able to demonstrate they had done this.
- Information was displayed informing patients who were undergoing an examination that they could request a chaperone. 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 was a health and safety policy available with a named health and safety representative. There were procedures in place for monitoring and managing risks to patient and staff safety however, these were not always well documented to demonstrate actions required were completed. For example, the practice had up to date fire risk assessments in place but the actions required in the risk assessment had not been updated. However, the practice manager was able to evidence what actions had been undertaken. Fire equipment and alarms where checked regularly and fire drills carried out. The practice manager told us they undertook reviews of the premises but did not formally document this. 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. However we did not see risk assessments in place in respect of legionella.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. Records were seen to confirm this.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be visibly clean and tidy and saw cleaning schedules in place detailing what needed to be cleaned. Staff had access to appropriate hand washing facilities and personal protective equipment to help minimise the risk of cross infection. The practice nurse was the infection control clinical lead who was responsible for updating the infection control policy and providing advice. They told us they kept up to date through local practice nurse networks. There was an infection control policy in place

and supporting documents to provide support to staff for example on the use of personal protective equipment, sharps handling and cleaning of bodily fluids. An infection control audit was undertaken in April 2015 as part of a wider audit, actions had yet to be reviewed.

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). However we did note that there was no formal system for checking doctor's bags and identified one medicine that was past its expiry date, the practice were informed so that it could be removed. The practice worked closely with the CCG pharmacist to ensure prescribing was in line with best practice. Antibiotic prescribing data made available to us showed that the practice prescribing was similar to other practices within the CCG. Prescription pads were securely stored and there were systems in place to monitor their use.
- Recruitment checks were carried out and the two 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 checks through the Disclosure and Barring Service. Protocols were also in place for checks on locum staff.
- Arrangements were in place to ensure there were enough staff on duty to maintain the smooth running of the practice and keep patients safe. There was a stable workforce in place and arrangements to provide cover when staff were absent through leave or sickness.

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 defibrillator available on the premises and oxygen 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 fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and alternative arrangements should the building be inaccessible.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. (NICE are an 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.) Clinical staff told us they received NICE guidance via email and would discuss these at the twice weekly clinical meetings for example changes in the management of patients with atrial fibrillation (a heart condition).

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The latest published data available for 2013/2014 showed that the practice had achieved 100% of the total number of points available, [BA1] with[NL2] 3.6% exception reporting (lower than both the CCG and national averages). Exception reporting is used 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 at 100% which was better than both the CCG and national average by 10%.
- The percentage of patients with hypertension having regular blood pressure tests was at 86% which was better than the CCG and national averages by 3%.
- Performance for mental health related indicators was 100% which was better than the CCG average by 9% and the national average by 10%.
- The percentage of patients with dementia diagnosis who a received a face to face review in the preceding 12 months was above the CCG average by 5% and national average by 4%.

Clinical audits were carried out but did not always demonstrate improvement to care and treatment and people's outcomes. We saw three clinical audits that had been completed in the last 12 months. The audits identified where improvements had been made and where there was room for further improvement. For example the management of urinary tract infections had been re-audited against guidance but it was not evident that the findings had been well implemented to deliver improvement. Clinical staff told us that the findings from the audits were discussed at the twice weekly clinical meetings, although this was not well documented.

Effective staffing

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

- Most staff had been employed at the practice for several years which enabled patients to receive continuity of care.
- All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).
- The nurse practitioner held additional diplomas and training in asthma, chronic pulmonary disease, family planning and sexual health and could demonstrate evidence of regular updates.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to and were supported to undertake appropriate training to meet these learning needs and to cover the scope of their work. All staff we spoke with had received an appraisal but some of these were over 12 months.
- Staff received training that included: safeguarding and basic life support. Staff had access to and were making use of e-learning training modules and in-house training.

Good

Are services effective?

(for example, treatment is effective)

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 test results, letters from the local hospital including discharge summaries and out-of-hours GP services. All relevant information was shared with other services in a timely way, for example when people were referred to other services. Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan on-going care and treatment. We saw evidence that multi-disciplinary team meetings took place with district nurses, health visitors and community matrons usually on a three monthly basis. This enabled patient needs and any care plans to be reviewed and updated. The practice ran a substance misuse clinic for drugs and alcohol in conjunction with Crime Reduction Initiatives.

Consent to care and treatment

Patients' consent to care and treatment was sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Information relating to mental capacity was displayed in clinical areas to support staff. Clinical staff knew how to access independent mental capacity advocates (IMCAs). IMCAs work with and support people who lack capacity, and represent their views to those who are working out their best interests. We also saw evidence of information relating to lasting power of attorney (a legal document in which authority is given to someone chosen by the patient to make decisions on their behalf if they should lack mental capacity to do so in the future). This ensured staff were aware of patient's wishes.

Although the practice did not undertake surgical procedures we saw examples of the consent forms which were used for joint injections and implants. Information was provided on risk and benefits of such procedures.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients with end of life care needs, carers, those at risk of developing a long-term condition and for substance misuse. Patients who needed additional support were signposted to relevant services as appropriate. For example health trainers who provided advice and support on leading healthier lifestyles.

Other services available at the practice included a smoking cessation services which patients could attend without an appointment. The practice had also participated in Sexual Health in Practice (SHIP) training. This is a service commissioned by public health in the local area to provide educational support to general practices so that they can better deliver sexual health services.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 83%, which was comparable to the CCG average of 82% and 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 also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Practice data showed that 96.3% of eligible patients had received breast cancer screening.

Childhood immunisation rates were slightly above CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 85% to 100% and five year olds from 91% to 96%. Flu vaccination rates for the over 65s were 83%, and at risk groups 66%. These were also above the national averages.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74 and those over 75 years. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

[BA1]This was on the risk register due to allegations of fraudulent practice in relation to QOF, with a referral made to NHS Protect. Presumably you were satisfied with these QOF figures?

[NL2]Not followed up by NHS protect as there was insufficient information. The cocerns were raised anonymously and nothing came out of the inspection to suggest otherwise. QOF is to be looked at in latest round.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and helpful to patients both attending at the reception desk and on the telephone. Patients were treated with dignity and respect. Screens 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. 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 39 patient CQC comment cards we received were positive about the service experienced. Patients said they had confidence in the service and staff were helpful, caring and treated them with dignity and respectWe also spoke with nine patients including two members of the patient participation group (PPG) as part of our inspection. (A PPG is a group of patients registered with a practice who work with the practice 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.

Results from the national GP patient survey 2014/2015 showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with doctors and average for nurses. For example:

- 94% said the GP was good at listening to them compared to the CCG average of 88% and national average of 89%.
- 95% said the GP gave them enough time compared to the CCG average of 86% and national average of 87%.
- 99% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%
- 97% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 85%.
- 90% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 89% and national average of 90%.
- 87% said they found the receptionists at the practice helpful compared to the CCG average of 83% and national average of 87%.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the friends and family test which was introduced into general practice in December 2014. The Friends and Family test asks patients if they would recommend the practice to others. The latest results available showed 91% of patients would recommend the practice to others.

Care planning and involvement in decisions about care and treatment

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 was also positive and aligned with these views.

Results from the national GP patient survey we reviewed 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:

- 93% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 86%.
- 94% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 88% and national average of 89%

Staff told us that translation services were available for patients who did not have English as a first language but had not often needed to use them.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. A practice counsellor was also available on site to support

Good

Are services caring?

patients who would benefit from this. Patients with long term conditions were assessed for depression using recognised assessment tools and were referred as appropriate for support and counselling.

The practice maintained a register for patients who were carers and staff were alerted through the patient record system of this. This enabled the practice to offer support and notify carers in relation to services available to them for example, flu vaccinations. The practice had a carers support pack and information was available on the practice website detailing what avenues of support were available. Information was displayed in the waiting area inviting carers to identify themselves.

Families that had suffered bereavement were followed up and offered counselling services. The practice was in the process of developing a formal letter and bereavement pack for patients with advice and support during this period.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had an awareness of the population it served and described it as relatively stable. The practice worked with the local CCG and clinical networks to address local priorities including the promotion and uptake of NHS health checks and reviewing accident and emergency attendances in children.

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example;

- The practice offered extended opening hours on four evenings each week between 6.30pm and 7.30pm and one morning each week between 7.30am and 8am for those with working and other commitments who were unable to attend during the day.
- There were longer appointments available for patients who might need them. These were usually requested by the GP. Patients we spoke with also told us they did not feel rushed during their appointments.
- Home visits were available for older patients and those who would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions. Specific appointments were allocated for this purpose.
- There were disabled facilities, hearing loop and translation services available if needed, although patients were not alerted to the availability of the hearing loop.
- The practice was accessible to patients with babies and young children. There was sufficient room for buggies and baby changing facilities available.
- The practice was participating in a local improvement scheme to support to the over 75 years and reduce the need for hospital admissions. As part of the scheme patients in this age group received access to same day appointments and annual health reviews. Those admitted were invited for a review or receive a home visit.
- Care plans and multi-disciplinary team working took place for those with complex care needs.
- The care of patients discharged from hospital was reviewed to ensure appropriate care was being given.
- The practice were aware of a high demand for appointments and had sought to review this and have increase the availability of telephone appointments and monitor the rates of non-attendance.

Access to the service

The practice was open 8.30am to 6pm on Monday, Tuesday Wednesday and Friday. On a Thursday the practice was open 8.30am to 1pm. Appointments were available between 8.30am to 11.20pm daily and 3.20am and 5.40pm on Monday, Tuesday Wednesday and Friday. When the practice was closed during the day (between 8am and 8.30am Monday to Friday and between 1pm and 6.30pm on a Thursday) and in the out of hours period (6.30pm to 8am) patients received primary medical services through another provider.

Appointments could be pre-booked up to two weeks in advance. Urgent appointments were available on the day. Telephone consultations were available daily between 11.30am to 12.30pm. The practice also saw walk-in-patients who would be seen at the end of surgery.

Results from the national GP patient survey 2014/2015 showed that patients' satisfaction with how they could access care and treatment was comparable to local and slightly below national averages in most areas. Patients we spoke to on the day were able to get appointments when they needed them. For example:

- 69% of patients were satisfied with the practice's opening hours compared to the CCG average of 72% and national average of 76%.
- 61% of patients said they could get through easily to the surgery by phone compared to the CCG average of 62% and national average of 74%.
- 76% of patients described their experience of making an appointment as good compared to the CCG average of 67% and national average of 74%.
- 59% of patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 62% and national average of 65%.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a system in place for handling complaints and concerns and there was a designated responsible person who handled all complaints in the practice. We looked at complaints received in the last 12 months and found these had been handled appropriately.

We saw that information was available to help patients understand the complaints system. A notice was displayed in the waiting area referring patients to reception where a patient information leaflet could be obtained detailing the practices complaints procedure. The complaints leaflet (dated October 2014) detailed the process to follow and expected timescales for responding to a complaint. Information on where to escalate concerns if the patient was dissatisfied with the response received was included however one of the contacts provided was incorrect and referred to an organisation that no longer existed. One patient we spoke with told us that they had once tried to raise an informal complaint but had felt dismissed. The senior partners assured us that this would be discussed with staff to ensure any informal complaints were sensitively handled and we received an update following the inspection on this.

Complaints were reviewed at the weekly clinical meetings. Complaints were discussed with staff to ensure any learning identified was shared.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and to promote good outcomes for patients. During the practice presentation the senior partner explained how it was their aim to treat patients with kindness, compassion, dignity and respect and empathy. Our observations and discussions with staff were aligned to this vision. During the inspection staff demonstrated a desire to provide a good and caring service.

The practice had identified areas for development including more frequent palliative care meetings and the development of bereavement packs.

Governance arrangements

The practice had an overarching governance framework which supported service delivery The structures and procedures in place and ensured that:

- There was a clear staffing and leadership structure within the practice. Staff were aware of their own roles and responsibilities. They felt supported and knew who do go to if they needed support. There were named members of staff in lead roles for example, for the management of long term conditions. Staff we spoke with told us about development opportunities that they have had and how they had been supported to progress in their role.
- Practice specific policies were implemented and were available to all staff on a shared drive on their computers. Most policies seen were up to date.
- The practice understood how it was performing. QOF data was monitored by the practice manager and discussed as necessary at clinical meetings.
- Twice weekly clinical and management meetings provided the main forum for monitoring quality. These were not always well documented to ensure any actions required relating to risks and audits were not missed.

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. 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. Staff were aware there was a whistleblowing policy but told us that they had no cause to use it.

Staff told us that regular team meetings were held. They had the opportunity to raise any issues at these meetings and felt confident in doing so and supported if they did. Formal staff meetings were also held between two and three times a year. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

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), through the national GP survey, friends and family test and complaints received. There was an active PPG which met on a regular basis (usually three monthly). Issues discussed with the PPG included improving access and the management of patients who did not attend their appointments. Minutes of meetings seen showed information about what was going on in the practice was also shared for example, raising awareness of flu campaigns and of the allocation of a named GP to patients.

The practice had also gathered feedback from staff through meetings, appraisals and general discussions. Staff told us they felt involved and engaged to improve how the practice was run and how their suggestions had been implemented for example, in the provision of new services.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice nurse told us that they regularly attended practice nurse network group meetings which enabled them to keep up to date. The practice was also a training practice for doctors who were training to be qualified GPs. We spoke to this member of staff who told us they felt well supported and had access to a senior partner for advice and support when needed.

Acupuncture was also offered at the practice on the NHS as an alternative to medicine in pain control for those who wished to receive it.