Highley Medical Centre

Quality Report

Bridgnorth Road
Highley
Bridgnorth
WV16 6HG
Tel: 01746 861572
Website: www.highleymedicalcentre.co.uk

Date of inspection visit: 17 May 2016
Date of publication: 01/07/2016

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Highley Medical Centre on 17 May 2016. Overall the practice is rated as good.

Our key findings were as follows:

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- 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. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

However, there were also areas of practice where the provider should make improvements:

- Continue to review the system for identifying and supporting patients who are carers and take action to ensure that any improvements identified are embedded.
- Consider the reintroduction of NHS Health checks as nursing staff recruitment now complete.
- Improve the documentation of the learning derived from complaints.

Summary of findings

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.

- There was an effective system in place for reporting and recording significant events, improvement was needed in documenting the learning from events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safeguarded from the risk of abuse.
- Risk assessments such as fire checks, legionella records were complete.
- There was a robust medication review system.
- Policies and procedures to support staff with current best practice had been reviewed on a regular basis.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- The GP had completed clinical audits and used findings as an opportunity to drive improvement.

Are services caring?

Good

The practice is rated as good for providing caring services.

- 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.

Summary of findings

- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The results from the January 2016 GP national patient survey demonstrated positive feedback in relation to the patients' experiences at the practice.
- The practice offered additional services for carers, although the overall number of carers was under review to ensure its accuracy.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. More detail could be added to document the practices learning and policy changes made in response to complaints.

Are services well-led?

Good

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.

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. .

- There were 815 patients over the age of 65 (list size 2,914). Uptake of the flu vaccination for this age group between 2015/16 was 534 out of 815 patients (66%).
- The practice GP completed the Care Home's Advanced Scheme II (CHAS2) care plans. This is a local initiative supported by the Shropshire Clinical Commissioning Group (CCG) that allows and empowers the practice to dedicate more time and resources looking after their frail patients. All the patients had a care plan and 100% of these had been reviewed within six months.
- The practice offered proactive, personalised care to meet the needs of the older people in its population. They were responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice employed a part-time care coordinator who reviewed care plans, reviewed hospital admissions and provided further support coordinating with other organisations such as district nurses, physiotherapists and charity and other voluntary organisations.

People with long term conditions

Good

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

- Patients at the highest risk of unplanned hospital admissions were identified and care plans had been implemented to meet their health and care needs.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check that their health and medicines needs were being met. For people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Nursing staff had lead roles in chronic disease management and had undertaken additional training.

Summary of findings

- A practice nurse with specialist diabetic nurse training supported diabetes patients with dietary advice, referred patients to a structured education program, foot screening service and retinal screening service when they were first diagnosed.

Families, children and young people

Good

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice uptake of flu vaccinations in pregnant women in 2015/16 was15 out of 22 patients. The practice had recorded five non responders, one patient had contraindications and one self-referred to a midwife.
- The practice's uptake for the cervical screening programme was 75% which was slightly lower but comparable with the CCG average of 83% and national average of 82%.
- The practice was young person-friendly and provided pregnancy testing and chlamydia testing for all aged 15-24.

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 offered appointments outside of core working hours on a Thursday between 6.30pm and 7.15pm.
- The practice provided online services to enable patients to book appointments, order repeat medicines and access some parts of their health records online.
- Health promotion and screening services reflected the health needs of this group.
- The practice had recently recruited another practice nurse to meet the needs of patients.

Summary of findings

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 known vulnerable adults, those who were housebound and patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- The practice held a register of the practices' frail and vulnerable patients and had identified patients who may be at risk of unplanned hospital admissions.
- The practice facilitated patients at a local drug and alcohol rehabilitation centre to register as temporary residents. The care co-ordinator supported patients and signposted to other allied health and social care professionals, voluntary agencies and charitable agencies when required.

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.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Performance for poor mental health indicators was slightly lower than the national averages. For example, 80% of patients with enduring mental health had a recent comprehensive care plan in place compared with the CCG average of 89% and national average of 88%. Clinical exception reporting was higher at 16.67%, when compared with the CCG average of 12% and national average of 13%;

however, this represented one patient. (Clinical exception rates allow practices not to be penalised, where, for example, patients do not attend for a review, or where a medicine cannot be prescribed due to side effects).

- Staff had a good understanding of how to support patients with mental health needs and dementia. For example the percentage of patients with dementia care plans on their dementia register was 23 out of 28 patients (85%). Of the remaining five patients the practice found two electronic clinical coding issues that were rectified, one patient chose to decline, one patient was seen in April 2016 and a new patient who required review.

Summary of findings

What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included comments made to us from patients and information from:

- The national GP patient survey published in January 2016. The survey invited 248 patients to submit their views on the practice, a total of 108 forms were returned. This gave a return rate of 44%.
- The practice worked with the patient participation group (PPG) and the practice manager attended each meeting.
- We invited patients to complete Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 17 completed cards.

In the national GP survey, patient satisfaction was positive in areas relating to interaction with nurses, reception, opening hours and overall experience. Satisfaction levels were less positive in the areas of making an appointment and interaction with GPs.

The feedback we received from patients about the practice care and treatment was positive. Themes of positive feedback included:

- The helpful, caring, compassionate and professional nature of staff and the new practice environment.
- Overall good or excellent experience of the practice.

Four less positive comments received included: at times it could be difficult to get appointments, one comment was they had found a receptionist to be rude and two on the length of time waiting in the waiting room to see a GP. This was fed back to the practice management and it was clear they wanted to focus on improving patients experience and would take action on the feedback given by patients.

Highley Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Highley Medical Centre

Highley Medical Centre is registered with the Care Quality Commission as a partnership provider, which includes a GP and practice manager. The provider holds a General Medical Services contract with NHS England. At the time of our inspection 2, 914 patients were registered at the practice. The practice, in line with the local Clinical Commissioning Group (CCG), have a higher proportion of patients aged 65 years and over when compared with the practice average across England. For example, the percentage of patients aged 65 and above at the practice is 28%; the local CCG practice average is 24% and the national practice average, 17%.

Highley Medical Centre is located in a purpose built building. The practice treatment areas and consulting rooms are on the ground floor. As well as providing the contracted range of primary medical services, the practice provides additional services including:

- Minor surgery
- Venepuncture (blood sample taking)

The practice is open each weekday from 8.30am to 6.30pm with the exception of Wednesday when the practice is open between 8.30am and 12pm. Extended hours are provided on Thursday evenings between 6.30pm and 7.15pm. The practice has opted out of providing cover to patients outside of normal working hours. These out-of-hours services are provided by Shropdoc. The on call duty GP provides cover for Wednesday afternoons, the contact details of which are provided on the practice telephone system.

Staffing at the practice includes a full time male lead GP and a female locum GP, who currently provides two sessions per week. There is a managing partner/practice manager, an assistant practice manager, two practice nurses, senior receptionist, three receptionists, a care co-ordinator and cleaner. There are 11 permanent staff in total, working a mixture of full and part times hours.

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

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?

Detailed findings

- 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 our inspection we reviewed the information we held about the practice. We also reviewed intelligence including nationally published data from sources including Public Health England and the national GP Patient Survey. We informed NHS England and NHS Shropshire Clinical Commissioning Group that we would be inspecting the practice and received no information of concern.

During the inspection we spoke with members of staff including GPs, a practice nurse, care co-ordinator, the managing partner/practice manger, reception and administrative staff. We also spoke with a member of the patient participation group (PPG). (PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services).

- We observed how patients were being cared for and talked with carers and/or family members.
- We reviewed an anonymised sample of 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.

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.

Good

Are services safe?

Our findings

Safe track record

The practice operated an effective system to report and record significant events.

- Staff knew their individual responsibility, and the process, for reporting significant events.
- Significant events had been thoroughly investigated. When required action had been taken to minimise reoccurrence and learning had been shared within the practice team.
- Significant events were discussed at practice meetings.
- All occurrences were reviewed and trend discussion/ analysis took place and when needed changes were made to promote a safe culture.
- Improvement was needed in documenting the learning from events.

We reviewed records, meeting minutes and spoke with staff about the measures in place to promote safety. Staff knew the processes and shared recent examples of wider practice learning from incidents. For example, a patient queried their prescribed diabetes medicine; it was the same medicine but had been prescribed as the generic rather than brand name. The risk was that the patient may have taken both medicines. The GP requested that staff review patient records and they found that three other patients had been prescribed both the brand and generic medicine. Patients were contacted and assessed to ensure they were taking the medicines appropriately. The risk once identified was rectified on the practice's electronic systems and the learning from this shared with staff. Since this event the practice had also introduced a software system which alerted GPs to risks such as generic and brand medicines.

The practice had a process in place to act on alerts that may affect patient safety, for example from the Medicines and Healthcare products Regulatory Agency (MHRA). These were discussed with the lead GP who demonstrated clear knowledge on the most recent alerts.

A culture to encourage duty of candour was evident through the significant event reporting process. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Overview of safety systems and processes

The practice had a number of systems in place to minimise risks to patient safety.

- The practice had policies in place for safeguarding both children and vulnerable adults that were available to all staff. All staff had received role appropriate training to nationally recognised standards. The lead GP was identified as the safeguarding lead within the practice. The staff we spoke with knew their individual responsibility to raise any concerns they had and were aware of the appropriate process to do this. Staff were made aware of both children and vulnerable adults with safeguarding concerns by computerised alerts on their records.
- Chaperones were available when needed. All staff who acted as chaperones had received appropriate training, had a disclosure and barring services (DBS) check and knew their responsibilities when performing chaperone duties. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. The availability of chaperones was displayed in the practice waiting room.
- The practice was visibly clean and tidy and clinical areas had appropriate facilities to promote the implementation of current Infection Prevention and Control (IPC) guidance. IPC audits of the whole service had been undertaken, this included staff immunity to healthcare associated infections, premises suitability and staff training/knowledge.
- The practice followed their own procedures, which reflected nationally recognised guidance and legislative requirements for the storage of medicines. This included a number of regular checks to ensure medicines were fit for use. The practice nurses used Patient Group Directions (PGDs) to allow them to administer medicines in line with legislation. Blank prescriptions were securely stored and there were systems in place to monitor their use. Staff ensured there were adequate stocks of medicines for example in the use of children's

immunisations and travel vaccines to ensure the expiry dates and rotation of medicine stocks held was monitored. The GPs did not routinely hold medicines in their bags.

- Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines' audits, with the support of the local CCG medicine management teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. We saw no evidence of any incidence of unsafe care or treatment for patients who took these medicines. For example an audit was conducted in 2015 to ensure that only a particular strength of a disease modifying medicine was prescribed. Twelve patients were identified and 100% were on the recommended dosage. Further audits of this high risk medicine were to be planned for on an annual basis.
- We reviewed three personnel files and found 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. The practice had medical indemnity insurance arrangements in place for relevant staff.

Monitoring risks to patients

Risks to patients were in general well assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills.
- The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs.
- Regular infection control audits were held and staff were immunised against appropriate vaccine preventable illnesses.

Arrangements to deal with emergencies and major incidents

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

- All staff had received recent annual update training in basic life support.
- The practice had emergency equipment accessible within the building. This included an automated external defibrillator (AED), (which provides an electric shock to stabilise a life threatening heart rhythm), oxygen and pulse oximeters (to measure the level of oxygen in a patient's bloodstream).
- Emergency medicines were held to treat a range of sudden illness that may occur within a general practice. All medicines were in date and one replacement medicine had been ordered from the pharmacy. Medicines were stored securely and staff knew their location. The practice emergency medicines checks completed by staff included expiry date monitoring.
- An up to date business continuity plan detailed the practice response to unplanned events such as loss of power or water system failure.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- Changes to guidelines were shared and discussed at practice learning and training events/ meetings, clinical meetings as well as frail and vulnerable and palliative care multi-disciplinary team meetings.
- The practice monitored that these guidelines were followed through risk assessments and random sample checks of patient records.

Management, monitoring and improving outcomes for people

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

- The practice achieved 94% of the total number of points available; this was comparable with the national average of 94.8% and clinical commissioning group (CCG) average of 96.9%. The overall clinical exception reporting for the practice was 5% which was 4 percentage points below the local CCG average and 4.2% below the national average. (Clinical exception rates allow practices not to be penalised, where, for example, patients do not attend for a review, or where a medicine cannot be prescribed due to side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed:

- Performance for poor mental health indicators was slightly lower than the national averages. For example, 80% of patients with severe poor mental health had a recent comprehensive care plan in place compared with the CCG average of 89% and national average of 88%. Clinical exception reporting was higher at 16.67%, when compared with the CCG average of 12% and national average of 13%; however, this represented one patient. Clinical exception rates allow practices not to be penalised, where, for example, patients do not attend for a review, or where a medicine cannot be prescribed due to side effects.
- Performance for diabetes related indicators was similar to local and national averages. For example, 79% of patients with diabetes had received a recent blood test to indicate their longer term diabetic control was below the highest accepted level, compared with the CCG average of 80% and national average of 78%. Clinical exception reporting was 3.2%, compared with the CCG average of 11% and national average of 12%. This represented six patients out of 186.
- The practice patients aged 70 to79 who were eligible to have the Shingles vaccine had been actively informed. The number eligible was 81 patients, 46 were vaccinated, 13 declined and 22 were contacted via letter and by phone calls, but had not responded.

The practice participated in a number of schemes designed to improve care and outcomes for patients:

- A practice nurse with specialist diabetic nurse training supported diabetic patients with dietary advice, referred patients to a structured education program, foot screening service and retinal screening service when they were first diagnosed.
- The practice participated in the avoiding unplanned admission enhanced service. Two per cent of patients, many with complex health or social needs, had individualised care plans in place to assess their health, care and social needs. Patients were discussed with other professionals when required and if a patient was admitted to hospital their care needs were reassessed on discharge.
- The practice ran a weekly search on all patients on the practices' avoiding unplanned admissions (AUA) register to find out if they had been admitted to hospital. In patients who had been admitted the practice established when they were discharged home or due to be discharged, and the care co-coordinator at the practice contacted them for an initial post hospital discharge review, to ensure their needs could be met.

The practice performance between 2014/15 for the number of emergency admissions for 19 ambulatory care sensitive

Good

Are services effective?

(for example, treatment is effective)

conditions per 1,000 of the population was 14.83 which was comparable with the CCG average of 13.75 and national average of 14.6. Ambulatory care sensitive (ACS) conditions are chronic conditions for which it is possible to prevent acute episodes and reduce the need for hospital admission through active management, such as vaccination; better self-management, disease management or case management; or lifestyle interventions.

The practice was working with the primary support medicines management team on the practice performance on prescribing medicines. They were in receipt of a report based on their prescribing data between 2015/2016 from NHS Shropshire Clinical Commissioning Group, Prescribing Quality and Optimisation Scheme (PQOS). The practice engaged with the medicines management team who supported them in ensuring best practice in medicine optimisation and prescribing and in the monitoring and auditing for example, in antibiotic prescribing levels within the practice.

There had been a number of two cycle clinical audits undertaken, we looked at three completed between 2011 and 2013. For example, we saw that there had been a review of the take up of the Measles Mumps and Rubella childhood immunisation and on dietary vitamin B12 levels in patients on a specific long term diabetes medicine. Both audits demonstrated an improvement in the set standards. The most recent audit, 2015/2016, was aimed at improving the prescribing of a particular group of anti-inflammatory medicines and of ensuring they were on a medicine to protect the stomach. The findings clearly showed there had been improvements made and patients were involved in the decisions and informed of the medicine changes.

Effective staffing

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

- A GP partner left the practice in 2014/15 and the practice had been unable to recruit to the position. Since the GP partner left the practice has provided the same GP services and used locum GPs to support the lead GP. The practice had also established strong collaborative links with a neighbouring practice to support its patients, for example with some family planning services, such as the insertion of contraceptive coils.
- The practice had an induction programme for all newly appointed staff. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The locum GP induction pack was reviewed which provided clear, relevant and extensive information.
- The learning needs of staff were identified through appraisals, and staff told us they felt supported.
- 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.

Working with colleagues and other services

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. When patients required referrals for urgent tests or consultations at hospitals, the practice monitored the referral to ensure the patient was offered a timely appointment.
- The practice team met with other professionals to discuss the care of patients that involved other allied health and social care professionals. This included patients approaching the end of their lives and those at increased risk of unplanned admission to hospital. Minuted meetings took place on a monthly basis.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- < >taff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Staff were aware of the importance of involving patients and those close to them in important decisions about when and when not to receive treatment.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

The practice offered a range of services in house to promote health and provided regular reviews for patients with long-term conditions:

- NHS Health Checks were offered to patients between 40 and 74 years of age to detect emerging health conditions such as high blood pressure/cholesterol, diabetes and lifestyle health concerns.
- The practice offered a comprehensive range of travel vaccinations.
- Immunisations for seasonal flu and other conditions were provided to those in certain age groups and patients at increased risk due to medical conditions.
- New patients were offered a health assessment with a member of the nursing team, with follow up by a GP when required.
- The practice's uptake for the cervical screening programme was 75.25% which was slightly lower than the CCG average of 82.66% and national average of 81.8%.

Data from 2014, published by Public Health England, National Cancer Intelligence Network Data showed that the number of patients who engaged with national screening programmes when compared with local and national averages:

- 79.1% of eligible females aged 50-70 had attended screening to detect breast cancer .This was slightly higher than the CCG average of 77.0% and higher than the national average of 72.2%.
- 57.1% of eligible patients aged 60-69 were screened for symptoms that could be suggestive of bowel cancer. This was comparable with the national average of 58.3%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

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

We received 17 completed cards, of which most were positive about the caring and compassionate nature of staff, with one comment noting a receptionist had been rude. Patients told us they were treated with care, dignity, respect and understanding.

We reviewed the most recent data available for the practice on patient satisfaction. This included comments made to us from patients and information from the national GP patient survey published in January 2016. The survey invited 248 patients to submit their views on the practice, a total of 108 forms were returned. This gave a return rate of 44%.

The results from the GP national patient survey demonstrated the most recent feedback in relation to the experience of their last GP appointment. For example:

- 77% said that the GP was good at giving them enough time compared to the Clinical Commissioning Group (CCG) average of 92%, and national averages of 87%.
- 84% had confidence in the last GP they saw or spoke with compared to the CCG average of 97% and national averages of 95%.
- 76% said that the last GP they saw was good at listening to them compared with the CCG average of 92% and national average of 89%.

The practice had discussed these findings with their Patient Participation Group entitled, Highley Patient Group. A number of suggestions were made and an action plan derived with the practice.

The results in the national patient survey regarding nurses showed slightly higher than average satisfaction when compared locally and nationally:

- 95% said that the nurse was good at giving them enough time compared to the CCG average of 94% and national average of 92%.
- 95% said the practice nurse was good at listening to them with compared to the CCG average of 94% and national average of 91%.

Care planning and involvement in decisions about care and treatment

Individual patient feedback we received from patients about involvement in their own care and treatment was positive, all patients felt involved in their own care and treatment.

The GP patient survey information we reviewed showed patient responses to questions about their involvement in planning and making decisions about their care and treatment with GPs in comparison to national and local CCG averages. The GP patient survey published in January 2016 showed;

- 78% said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 76% said the last GP they saw was good at explaining tests and treatments which was lower when compared with the CCG average of 90% and national averages of 86%.
- 95% said the last nurse they saw was good at involving them about decisions about their care which was higher than the national average of 85%.
- 87% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 92% and national average of 90%.

Patient/carer support to cope emotionally with care and treatment

Patients and carers gave positive accounts of when they had received support to cope with care and treatment.

The practice's computer system alerted staff if a patient was also a carer. The practice had identified the care co-ordinator to the role of ensuring that the carers register was an accurate representation. The practice care co-ordinator and performance manager were working

Good

Are services caring?

towards improving the carers register, as of May 2016 there were 52 carers on the register. Known carers had been offered an annual health check and seasonal flu vaccination.

If a patient experienced bereavement, practice staff told us that they were supported by a GP with access and signposting to other services as necessary.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified.

- The practice offered extended hours evening appointments until 7.15pm on a Thursday.
- Online services for ordering repeat prescriptions and appointments were available.
- Same day appointments were available for children and those with serious medical conditions.
- They also offered telephone consultations with the GP.
- There were longer appointments available for patients with a learning disability.
- Emergency admissions to hospital were reviewed and patients were contacted to review their care needs if required.
- There were disabled facilities, a hearing loop and translation services available.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice provided a minor surgery clinic.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- The practice provided information to patients such as the community car scheme service which was run on a volunteer basis mainly for appointments at the practice.
- The practice hosted additional services to enable eligible practice patients to be seen by visiting clinical staff at the practice for screening, such as a diabetic foot screening service and abdominal aortic aneurysm (AAA) screening (AAA is an enlarged area in the lower part of the aorta, the major blood vessel that supplies blood to the body).The practice hosted AAA screening, for aortic aneurism.
- Designated clinics were held in house for 65 year old males.
- The practice worked closely with other local practices to provide access to services with limited clinics such as midwifery and health visitor services.

Access to the service

The practice was open Monday to Friday 8.30am to 6pm with the exception of Wednesday when the practice opened from 8.30am to 12pm. Extended hours were provided on Thursday evenings to 7.15pm. During the practice open times the telephone lines and the reception desk were staffed and remained open. The practice offered pre-bookable appointments and telephone access appointments for all patients who required an urgent (same day) appointment. The practice did not provide an out-of-hours service to its own patients but had alternative arrangements for patients to be seen when the practice was closed through Shropdoc, the out-of-hours service provider. The practice telephones switched to the out-of-hours service each weekday evening and during weekends and bank holidays. The on call duty doctor provided GP services on Wednesday afternoons.

Patients could book appointments in person, by telephone and on line access. The availability of appointments was a mix of book on the day or routine book ahead. We saw that the practice had availability of routine appointments with GPs and nurses within a week.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made by contacting the appropriate emergency service to meet their needs. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Results from the national GP patient survey published in January 2016 showed positive patient satisfaction when compared to local and national averages:

- 95% of patients found it easy to contact the practice by telephone compared to the CCG average of 86% and national average of 73%.
- 89% of patients said the last appointment they made was convenient compared to the CCG average of 94% and national average of 92%.
- 81% of patients felt they did not have to wait too long to be seen compared to the CCG average of 62% and national average of 58%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 87% of patients described their experience of making an appointment as good compared to the CCG average of 82% and national average of 73%.

The practice had worked closely with the patient participation group (PPG). (PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services).

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.

Information was available to help patients understand the complaints system and the complaints process was displayed on notice boards, website and a practice leaflet.

The practice had received six complaints in the last 12 months. We tracked three complaints and saw they had been acknowledged, investigated and responded to in line with the practice complaints policy. The practice analysed complaints for trends, to which they were none. Complaints were discussed with staff and at practice meetings. We found that more detail could be added to document the practices learning and policy changes made in response to complaints. However, it was clear that learning took place and when appropriate the practice issued an apology and explained how systems had been changed to limit the risk of reoccurrence.

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 promote good outcomes for patients.

- Staff knew and understood the practice values.
- The practice had a strategy and supporting business plan which reflected the changing primary care priorities and this was regularly monitored. For example, the practice hoped to recruit a healthcare assistant in the near future.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- Practice specific policies were implemented, monitored and reviewed and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous performance management and interrogation of their systems to internally audit and monitor quality and to make improvements was undertaken.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

The lead GP, managing partner/practice manager and assistant practice manager were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.

Staff told us that they felt supported and able to make suggestions to how the practice provided services. The practice had identified staff for key leadership roles within the practice.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Staff encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had an active patient participation group (PPG) who worked with staff to improve services. (PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services). We spoke with one member of the PPG. They informed us they met with the practice on a regular basis and felt valued by the practice team. The main priorities for joint working between the practice and PPG had been:

- Recruitment and retention of GPs
- Discussion on the Five Year Forward plan, this plan sets out NHS England's strategy for the NHS for the next five years.
- Assisting the practice in its eligible population group's awareness of the flu vaccination programme.