Your Health Partnership - Oakham Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Your Health Partnership – Oakham Surgery on 20 July and 23 August 2017. The practice is part of partnership called Your Health Partnership (YHP), a five practice group (and one branch site) operating with centralised management and governance. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- The service operated 'Doctor First' appointment system and most patients said they found it easy to make an appointment. However, some working patients also stated that the appointment system did not work as well for them. The practice was in the process making changes to improve the appointment system following feedback from patients and staff.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice was a partnership of five locations (and one branch site) and the management and leadership structure was clear and available to staff. Staff felt supported by management.

Summary of findings

- We saw evidence that the practice proactively sought feedback from staff and patients, which it acted on. For example, patients with multiple long term conditions were managed in a single appointment and this was developed though feedback from nursing staff.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The areas where the provider should make improvement are:

- Continue to monitor the new appointment system to ensure it meets the needs of all patients.

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.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful 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 to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

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 above average compared to the local CCG and national averages. For example, the practice achievement for diabetes related indicators was 92%. This was above the CCG average of 88% and the national average of 90%.
- Staff were aware of current evidence based guidance.
- There was an annual audit plan and clinical audits and analysis of significant events demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment. There was effective supervision and mentoring of nursing staff.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

- The practice was generally above average for its satisfaction scores in comparison to the local CCG for consultation with GPs was above the CCG and national averages for consultation with nurses. However the practice was slightly below the national average on consultations with GPs.
- Survey information we reviewed showed that 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 accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. The practice engaged with the local CCG and offered extended services to meet the needs of their patients.
- The practice was part of a partnership and could offer various community services such as ophthalmology, gynaecology and dermatology. A consultant from the local hospital held clinics for complex patients with rheumatology. Patients had access to a physiotherapist.
- The service employed a pharmacist who could provide advice on medicines queries.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Most patients we spoke with told us that they were able to access care and treatment at the practice at a time that suited them. However, some patients who worked said that the practice had changed its process and all requests for appointments were triaged by a GP and this did not always suit them. The practice had reviewed this through staff and patient feedback and was in the process of implementing a system to suit all patients.
- Home visits were available for older patients following a telephone consultation with a GP.
- There were facilities to aid communication, which included a hearing loop and the practice had access to interpretation services.
- The practice had carried out an access audit and had made reasonable adjustments to remove barriers for those patients who had a difficulty with their mobility.

Summary of findings

- The practice had received 17 complaints in the last 12 months. The samples we reviewed demonstrated that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

- The practice was part of a corporate partnership and had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. The practice had involved staff to develop its values and staff were aware of those values.
- There was a clear leadership structure both within the corporate partnership and at the practice level. Staff felt supported by management and partners. The practice had policies and procedures to govern activity and held regular governance meetings.
- Many of the governance functions were centralised within the partnership with lead staff members. For example, there was a centralised governance team which had a wide remit, from managing complaints to the maintenance of surgery premises and equipment. There was a centralised patient services team that reviewed QOF achievement. All the partners had clearly defined key areas of responsibility.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour. We saw examples to demonstrate that the practice complied with these requirements.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels. The nursing team were recognised for their work to improve service for patients with multiple long term conditions.

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.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice offered influenza, pneumococcal and shingles vaccinations to patients.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Multidisciplinary team meetings were held on a monthly basis, where patients were selected and reviewed along with palliative care patients.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence.

People with long term conditions

Good

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

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- The practice was part of a corporate partnership and delivered specialised clinics in diabetes, heart disease, chronic obstructive pulmonary disease, asthma, anticoagulation as well as other specialist community services ophthalmology, gynaecology and dermatology.
- Patients had access to a physiotherapist and an in-house pharmacist was available to call patients to answer medication queries or provide advice.
- The practice achievement for diabetes related indicators was 92%. This was above the CCG average of 88% and the national

average of 90%. A diabetes specialist consultant held clinics for more complex cases. This was as part of the Diabetes Inpatient Care and Education (DICE) programme, a CCG funded area of enhanced care.

- The nursing team were involved in the development of a clinic called 'year of care' which incorporated review of patients with multiple long term conditions within one appointment. The nursing team were recognised for their work in the CCGs inaugural primary care awards.
- There was on-going development and support for nursing staff, for example, for diabetes.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- The provider had a centralised home visiting team that reviewed housebound patients with long term conditions.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

- From the sample of documented examples we reviewed, we found there were systems 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 accident and emergency (A&E) attendances.
- The practice operated a 'Doctor First' appointment system where all patients speak on the phone with a GP. The GP may ask the patient to come into the surgery if they felt it necessary. Same day appointments were available for families following a telephone call by the GP and appointments were available so that school children could be seen outside of school hours. The premises were suitable for children and babies.
- Public Health England data we looked at showed that immunisation rates were slightly below the target of 90% for three of the four sub-indicators for standard childhood immunisations. However, the practice was able to demonstrate from their own records that they were meeting the 90% target for relevant childhood immunisations.

Summary of findings

- The practice enrolled all babies into the child health surveillance programme so that they could be reviewed by the health visiting team. The practice invited all new mothers and babies for postnatal checks.
- The practice's uptake for the cervical screening programme was 85%, which was above the CCG average of 80% and the national average of 81%.

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 these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. This included extended hours service on Thursday evenings until 8pm for working patients who could not attend during normal opening hours. The practice was part of a partnership six sites and patients were able to access extended hours service provided by other sites. On Saturdays another site that was part of the partnership, offered appointments between 8.30am and 11.15pm and two pre-bookable appointments were available for patients registered at this practice. A Sunday morning GP call back service was also available (remote access by GP).
- The practice had reviewed its appointment system and had made changes to ensure it met the needs of all patients, including working age people.
- The practice offered online services such as making appointments and ordering repeat prescriptions, as well as a full range of health promotion and screening that reflected the needs for this age group.

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 operated an effective recall system and individual care plans were developed to help ensure a tailored approach to care. For example, data provided by the practice showed 35 patients registered at the practice with a learning disability, 73 with mental health as well as 89 patients living with dementia. Data we looked at showed that patients received timely reviews.

Summary of findings

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff we spoke with knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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.
- The practice's computer system alerted GPs if a patient was a carer. The practice had identified 132 patients as carers (1% of the practice list). The practice had a designated carers champion who had attended training organised by the CCG. The role of the carers champion was to inform, co-ordinate and signpost carers as well as to keep the practice team updated on any new guidance. The practice had a notice board dedicated to carers where written information was displayed informing carers of support services available.

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 carried out advance care planning for patients living with dementia.
- 87% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months. This was above the local CCG average of 84% and the national average of 84%.
- 95% of those patients with mental health conditions had their alcohol consumption recorded in the previous 12 months. This was above the CCG average of 93% and the national average of 89%.
- The practice regularly worked with multidisciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.

Summary of findings

- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff we spoke with had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2017. The results showed the practice was performing in line with local and national averages. Of the 269 survey forms that were distributed, 108 were returned. This represented 1% of the practice's patient list.

- 73% of patients described the overall experience of this GP practice as good compared with the CCG average of 77% and the national average of 85%.
- 66% of patients described their experience of making an appointment as good compared with the CCG average of 63% and the national average of 73%.
- 64% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 65% and the national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 25 comment cards which were all positive about the standard of care received. Four comment cards stated that they did not find the new process for making appointments helpful although they were happy with the level of care received. Some patients stated that the reasons they did not find the appointment system helpful was because they worked and they found it difficult to plan leave as they were only offered a face to face appointment following a telephone consultation.

We spoke with six patients including one member of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately and provided support when required. One patient we spoke with told us that the process for making appointments did not always suit them and others who worked. The PPG member we spoke with told us that the current appointment system where all calls were answered at a call centre (located at another practice within the partnership) was implemented a couple of years ago and it worked well for most patients. However, some patients did not like the change and had taken longer to become familiar with it. The practice had reviewed the appointment system and was in the process of launching a new appointment system to meet needs of all people following feedback from patients and staff.

Areas for improvement

Action the service SHOULD take to improve

- Continue to monitor the new appointment system to ensure it meets the needs of all patients.

Your Health Partnership - Oakham Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Your Health Partnership - Oakham Surgery

Your Health Partnership – Oakham Surgery is a partnership of five GP practices including Oakham Surgery and one branch surgery. Oakham Surgery provides NHS services to the local community in Oldbury, West Midlands. The practice has an approximate patient population of 11.600 and is part of the NHS Sandwell and West Birmingham Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

The service is registered with the Care Quality Commission to provide primary medical services. Services to patients are provided under a General Medical Services (GMS) contract used when services are agreed locally with a practice which may include additional services beyond the standard contract. The practice has expanded its contracted obligations to provide enhanced services to patients. An enhanced service is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients.

Based on data available from Public Health England, the levels of deprivation (deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial) in the area served by Oakham Surgery are greater than the national average, ranked at four out of 10, with 10 being the least deprived.

The clinical team includes five GPs (two female and three male), two practice nurses and one advanced nurse practitioner (ANP). There were also two healthcare assistants (HCAs). The practice was part of a partnership of six sites and many of the functions were centralised. For example, there was a centralised governance team which was based at the surgery.

The practice had achieved training practice status helpingqualified doctors, complete the final stages of their GP Training. The practice also engaged in the training of medical undergraduate students.

The practice is open from 8am to 6.30pm Monday to Friday. Extended hours appointments are offered on a Thursday from 6.30pm to 8pm. The practice was part of a partnership with six local sites and patients were given option to attend for appointments during extended hours at those sites. Saturday opening was offered between 8.30am to 10.30am at another site that was part of the partnership and two appointments for patients from Oakham Surgery are allocated. There is also an option for telephone consultation on Sunday Mornings.

The practice has opted out of providing out-of-hours services to their own patients. This service is provided by the external out of hours service provider.

Detailed findings

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the CCG to share what they knew. We carried out an announced visit on 20 July and 23 August 2017. During our visit we:

- Spoke with a range of staff including nursing staff, GPs and administration staff including the governance team.
- Observed how patients were being cared for in the reception area and talked to patients who used the service.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- People experiencing poor mental health (including people living with dementia).

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 and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform their line manager of any incidents and there was a recording form available on the practice's computer system. The practice was part of a partnership with four other surgeries. When an incident was reported the line manager organised discussion of the incident at the daily 'huddle' meeting at the practice where learning was identified. If it was a clinical incident it was also discussed at the monthly Clinical Quality and Operational Group (COAG) meeting where clinical leads from all the sites met. All incidents were then shared with the central governance and compliance team who recorded the learning and shared it with the CCG where relevant.
- The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). We saw an example where a patient was sent an apology letter following an incident where the practice had made an error. We saw evidence that this was discussed in team meetings and learning had been identified and implemented
- Some of the administration functions were centralised including receipt and actioning of alerts. Patient safety alerts such as those from the Medicines and Healthcare products Regulatory Agency (MHRA) were received by the governance and compliance team who then notified the relevant lead in the partnership. For example, if alerts related to medicine then it was forwarded to the prescribing lead for the partnership. The lead then determined further action and where relevant the centralised patient services team were asked to take action and was then discussed at the COAG meeting with all clinical leads. For example, following receipt of a recent MHRA medicine alert, the centralised patient services team carried out a search on the patient record system for the corporate partnership. Relevant patients identified were sent letters by the patient services team and we saw an example of this. All relevant alerts were uploaded on to the corporate partnership website (extranet) so that it was available to all staff.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff and clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding and staff were aware. Minutes of meetings we sampled showed that safeguarding was a standing agenda item for discussion.
- The practice was in the process of updating its safeguarding policy in response to the changes in safeguarding procedures in the CCG and the Local Authority (LA). Previously, any communication from the local safeguarding team was received by relevant GPs at the practice. However, the practice had recently centralised this process with the governance and compliance team taking over the responsibility. The governance and compliance team now received safeguarding concerns through a centralised email address. Following review they cascaded the concerns to relevant leads at each site. We saw examples where relevant concerns were discussed at the daily 'huddle' meetings where it was a standing agenda item.
- Staff we spoke with demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. Some nurses were trained to level three child safeguarding and all others were trained to level two. All administration staff were trained to level one.
- The practice offered chaperones when required. Nurses acted as chaperones, except on one weekly occasion when the practice offered extended opening hours and nurses were not available. Administration staff fulfilled this role and we saw evidence that they were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a

person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- One of the practice nurses was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being issued to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. For example, we saw evidence that the practice's performance for antibiotic prescribing was below the CCG set target. The practice prescribing of high risk broad spectrum antibiotics was also below the CCG target.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use.
- We looked at patients on disease-modifying anti-rheumatic drugs (DMARDS), lithium and anticoagulant medicine and saw that regular monitoring of blood tests was in place.
- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment carried out by an external contractor in June 2016 and we saw that actions identified had been completed. For example, designated fire marshals were identified as an action and we saw this was now in place. We saw evidence that regular fire drills were carried out and there was a fire evacuation plan in place.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments 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).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a centralised process with a workforce manager that reviewed demand and matched resources to this. We were shown an example of the workforce planning spreadsheet used to manage staffing and were told that each site would receive feedback if there were changes to staffing after review.

Arrangements to deal with emergencies and major incidents

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

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

Good

Are services safe?

- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book was available.
- Emergency medicines were securely stored and easily accessible to staff. All staff knew of their location. All the medicines we checked were in date.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. All calls for appointments were answered at a call centre at another site but could be re-directed to other sites. The partner GPs had laptops which provided remote access to the patient system and so could print out details of clinics in the event they were unable to access the system onsite. We were told that other sites could be used to see patients and were told about a recent incident where this had occurred.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. The daily 'huddle' meetings and the monthly clinical quality and operations group (CQOG) meetings were used to discuss any updates and guidance between clinicians. Minutes of meetings we looked at confirmed this.
- Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits. For example, an audit was based on new NICE guidance on the monitoring of new anticoagulants.
- The centralised CQOG group met monthly and was responsible for ensuring adherence to and dissemination of guidance such as NICE. Minutes of meetings we looked at confirmed this.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 97% of the total number of points available compared with the clinical commissioning group (CCG) average of 95% and national average of 95%. The overall exception reporting at 6% was similar to the local CCG and national average of 6%. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/16 showed:

- Performance for diabetes related indicators was slightly higher compared to the CCG and national averages. The practice achievement for diabetes related indicators was 92%. This was above the CCG average of 88% and the national average of 90%. A diabetes specialist consultant held clinics for more complex cases. This was as part of the Diabetes Inpatient Care and Education (DICE) programme, a CCG funded area of enhanced care.
- Performance for mental health related indicators was higher compared to the CCG and national averages. For example, the practice achievement for mental health indicators was 99% which was above the CCG average of 92% and the national average of 93%.

There was evidence of quality improvement including clinical audit:

- The service had developed yearly audit plans. Audit plans for 2016 and 2017 were made available to us. The current audit plan detailed seven audits that had been carried out. We saw details of an audit that looked at a blood thinning agent that required monitoring of kidney function. The audit showed that the practice achieved 94% of the required standard. A re-audit showed a similarly high achievement target. The practice aimed to repeat this audit on an annual basis to ensure standards were maintained. Other completed audits included a review of patients on a specific medicine following an MHRA alert. Findings were used to ensure safety of patients. Minutes of CQOG meetings we looked at showed that findings of audits were shared with all partners to improve service.

Information about patients' outcomes was used to make improvements such as:

The practice performance was monitored through the monthly CQAG meeting where performance for each practice within the partnership was reviewed. They included monitoring of patient outcomes through monitoring of QOF achievements such as cervical screening, cancer, asthma among others. If patient outcomes were not being achieved, they were highlighted to the lead GP and further guidance and support offered.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

Good

Are services effective?

(for example, treatment is effective)

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice was able to demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. The practice nurses attended clinical update sessions regularly for influenza, diabetes and asthma. The lead nurse for the partnership was an advanced nurse practitioner and supervised other nurses. There was a nurse forum where all lead nurses that were part of the partnership meet regularly to discuss updates and training needs. Minutes of meetings we looked at confirmed this.
- The practice engaged in core skills training of nurses and healthcare assistants (HCAs). The purpose was to upskill staff and expand their role.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which included a competency assessment. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months. Revalidation is the process by which clinicians are required to demonstrate on a regular basis that they are up to date and fit to practise.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results. Evidence we looked at showed that all results were being processed on a daily basis and there was a buddy system if someone was away. There was a process in place to share information with other external agencies such as out of hours and hospitals.
- From the sample of documented examples we reviewed, we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

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

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

- The practice operated an effective recall system and individual care plans were developed to help ensure a tailored approach to care. For example, data provided by the practice showed 35 patients registered at the practice with a learning disability, 73 with mental health as well as 89 patients living with dementia. Data we looked at showed that these patients were being reviewed at appropriate intervals.

Consent to care and treatment

Staff sought patients' consent to care and treatment 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.
- The practice used written consent for minor surgeries.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

Good

Are services effective?

(for example, treatment is effective)

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. The practice was part of a partnership and could offer various community services such as ophthalmology, gynaecology and dermatology. A consultant from the local hospital held clinics for complex patients with rheumatology.
- A physiotherapist held regular clinics and patients could speak with reception staff for an appointment. Patients were first telephoned by the physiotherapist before being referred to community services or being offered advice. The service employed in-house pharmacists who could call patients and answer medication queries or provide advice.

The practice's uptake for the cervical screening programme was 85%, which was above the CCG average of 80% and the national average of 81%. There were systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. Performance was monitored by a centralised team and discussed at the partners meeting.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. For example,

- 58% of patients were screened for bowel cancer in the last 30 months which was above the CCG average of 45% and comparable to the national average of 58%
- 77% of females aged 50-70 years were screened for breast cancer in the last 6 months which was above the CCG average of 67% and the national average of 74%.
- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were below CCG/national averages. For example, rates for the vaccines given to under two year olds ranged from 86% to 95% and five year olds from 74% to 99%. However, the provider was able to demonstrate from their own records that they were meeting the 90% target for relevant childhood immunisations.

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

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that 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.
- All staff had completed face to face confidentiality training delivered by an external contractor.
- We were told that all staff had completed equality and diversity training and staff records we looked at confirmed this.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

All of the 25 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with six patients including one members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately and provided support when patients needed help.

Results from the national GP patient survey were mixed. The practice was generally above average for its satisfaction scores in comparison to the local CCG but slightly below the national average on consultations with GPs. The practice was above local CCG and national average for consultation with nurses. For example:

- 85% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 81% and the national average of 89%.
- 83% of patients said the GP gave them enough time compared to the CCG average of 81% and the national average of 86%.
- 90% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and the national average of 95%
- 77% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 80% and the national average of 86%.
- 94% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 87% and the national average of 91%.
- 93% of patients said the nurse gave them enough time compared with the CCG average of 87% and the national average of 92%.
- 99% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 95% and the national average of 97%.
- 90% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 85% and the national average of 91%.
- 87% of patients said they found the receptionists at the practice helpful compared with the CCG average of 82% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

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

- 84% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 82% and the national average of 86%.
- 80% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 76% and the national average of 82%.

Good

Are services caring?

- 93% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 86% and the national average of 90%.
- 89% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 82% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. However, we were told that most patients registered with the practice were able to speak English and the practice did not need to use the service as much as other practices within the partnership.
- The Choose and Book service (NHS e-Referral) was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). We spoke with an administration staff member based at the practice who told us that a key part of their role was to transcribe the audio referral dictated into a handheld devise where the recording was captured and managed on a central computer and was available for relevant staff. This was a centralised process and the staff member told us told us that they prioritised urgent referrals.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 132 patients as carers (1% of the practice list). The practice had a designated carers champion who had attended training. The role of the carers champion was to inform, co-ordinate and signpost carers as well as to keep the practice team updated on any new guidance. We saw written information was available on one of the notice boards dedicated to carers to direct them various avenues of support services available.

In the event of bereavement the GPs called relatives and offered support. As soon at the practice was informed of bereavement, patients details were added to a list to ensure all clinicians were aware. They would also be discussed in the daily 'huddle' meetings and the centralised patient services team cancelled any outstanding appointments for the patient so that the families did not receive any letters.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on a Thursday evening until 8pm, this was ideal for working patients who could not attend during normal opening hours. The practice was part of a partnership of six sites and patients were able to access extended hours service provided by other sites. On Saturday mornings another site offered appointments between 8.30am and 10.30am. We were told that two pre-bookable appointments were available for patients registered at this practice. A Sunday morning GP call back service was also available (remote access by GP). This was available to one patient per site, we were told that the uptake was low and there was capacity to increase this further.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. There was a centralised home visiting team that had been established recently. The team consisted of an advanced nurse practitioner and a healthcare assistant but the decision to offer a home visit was made by a GP following telephone consultation. GPs were also available for home visits if it was felt that the patient would benefit.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- All calls for appointment requests were answered by staff located at another site. These staff allocated a GP for a call back to the patient. The GP determined if any patients needed to have a face to face consultation following the telephone call. We looked at the appointment system and saw that there was capacity on the day if patients needed an appointment with the doctor.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately. Patients could be referred to other clinics for vaccines available privately.
- The practice offered influenza, pneumococcal and shingles vaccinations to patients.
- There were facilities to aid communication, which included a hearing loop, and interpretation services were available.
- We saw that the practice had carried out an access audit and had made reasonable adjustments to remove barriers for those patients who had a difficulty with their mobility. For example, a ramp had been built at the rear of the practice building to enable improved access.
- The practice enrolled all babies into the child health surveillance programme so that they could be reviewed by the health visiting team. All new mothers and their babies were invited to postnatal checks (at eight weeks).

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Extended hours appointments were offered on Thursdays from 6.30pm to 8pm. Pre-bookable appointments with nurses were available up to six weeks in advance.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 78% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 75% and the national average of 76%.
- 69% of patients said they could get through easily to the practice by phone compared to the CCG average of 60% and the national average of 61%.
- 82% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 76% and the national average of 84%.
- 81% of patients said their last appointment was convenient compared with the CCG average of 72% and the national average of 81%.
- 66% of patients described their experience of making an appointment as good compared with the CCG average of 63% and the national average of 73%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 59% of patients said they do not normally have to wait too long to be seen compared with the CCG average of 46% and the national average of 56%.

The practice operated a 'Doctor First' appointment system where all patients speak on the phone to a GP who will ask the patient to come into the surgery if they feel necessary. Patients told us that the appointment system generally worked well and they always received a call from the GP on the day and if needed received a face to face appointment also on the same day. However, two of patients told us that the system of call backs did not always work well for patients who worked. Although most patients told us that they received a call back within an hour of their request they were not given a time slot which made it difficult for working patients to plan leave as face to face appointments were only offered following telephone consultations. The practice was aware of this following feedback from patients and staff and was in the process of launching a system to suit all patients.

The practice had a system to assess whether a home visit was clinically necessary as all calls were triaged by a GP and home visit was carried out by a centralised team consisting of an advanced nurse practitioner (ANP) and a HCA. A GP was also available to carry out home visits if it was felt necessary following the telephone triage. 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.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The complaints process was centralised for the partnership where the outlet supervisor/practice manager at the practice acknowledged the complaint in three working days. The centralised governance and compliance team then took over the responsibilities for the investigation and implementation of the learning. We saw evidence that complaints were discussed at the COAG meeting.
- We saw that information was available to help patients understand the complaints system included a patient's information leaflet and posters in the reception area.

We looked at complaints received between April 2016 and 2017 and saw that 17 written and verbal complaints had been documented with actions taken. Examples we reviewed demonstrated that where the practice was at fault an apology letter was sent to the patient and learning was discussed and implemented to improve service.

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 service had a clear vision to deliver high quality care and promote good outcomes for patients. The service engaged with its staff in the summer of 2016 to pull together their thoughts and ideas about the type of organisation they wanted the service to be. Through a series of further engagement and workshops, the service's values were launched in April 2017. The values selected by staff were 'inspiring, caring and one team'. We saw these values were promoted and available to staff. For example, internal communication such as newsletters used the values as a letterhead. Staff members were presented with pens and coasters with the values of the service and staff members we spoke with were aware of and understood the values.

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 and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. The service was part of a partnership of six sites. Many of the functions were centralised with lead staff members. For example, there was a lead nurse responsible for overseeing and supervising nurses. The lead nurse was also responsible for reviewing the practice performance such as for QOF. If the practice was underperforming in an area the lead nurse would look at the speciality of the nurses within the partnership and arrange extra clinics to improve performance. The GP partners had lead roles for management of specific chronic diseases based on interest and expertise. There was a centralised governance team with that had a wide remit such as management of complaints to the management of the surgery premises and equipment. There was a centralised patient services team that reviewed relevant clinical outcomes.
- We were told that the centralised processes helped the service to better manage risk as staff worked between sites that were part of the partnership and there was potential where things could be missed.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example the CQAG met regularly as well as the centralised governance team to manage risks.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. We saw evidence of a dashboard that was used to monitor and review individual practices that were part of the partnership. Minutes of meetings we looked at demonstrated that staff at different levels were involved in discussions about the performance of the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. We saw evidence of annual audit plans that were in place.
- We saw evidence from minutes of meetings that were structured in a way to allow for lessons to be learned and shared following significant events and complaints. We saw evidence that incidents and complaints were a standing item for discussion at the partners meetings, governance team meetings, administration team meetings as well as nurses' team meetings.

Leadership and culture

On the day of inspection the service was able to demonstrate that an appropriate structure was in place to run the practice effectively and to ensure high quality care. Each partner had an area of responsibility based on interest and expertise. For example, there were leads for safeguarding, diabetes management and other chronic disease management.

Evidence we looked at demonstrated that the service prioritised safe, high quality and compassionate care. Staff told us that management teams and partners were approachable and always took the time to listen. We saw evidence where staff feedback was used to improve service for patients.

The service was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about

Are services well-led?

Good

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

notifiable safety incidents. The partners encouraged a culture of openness and honesty. We reviewed significant events and complaints documented by the service and saw examples where the practice gave affected people reasonable support, truthful information and written apologies when things went wrong with care and treatment. We saw evidence that the practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- The practice held a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings and minutes of meeting we looked at demonstrated this.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. There was a staff forum and there was evidence that action was taken following feedback. For example, the partnership set up an electronic portal to engage with staff and collect feedback to develop the service's mission and values. Following feedback the service celebrated its success and the launch of its values by meeting in a restaurant outside of working hours. The partnership used an internal newsletter to update and communicate new developments.
- The service was a partnership and many of the functions were centralised. Evidence we looked at showed that meetings took place regularly to manage service effectively. For example, the partners met regularly to discuss running of the service and finalise any changes. They also discussed safeguarding, significant events and other clinical issues. The Clinical Quality and Operations Group (CQOG) met regularly as well as the central governance team and the nursing team (across the partnership). Minutes were comprehensive and were available for practice staff to view.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- The practice engaged with staff and patient groups. For example, to develop its core values it engaged with both patients and staff. The practice sought feedback from patients on the appointment system. As a result of the feedback, the practice had become aware that the current appointment system was not ideal for all patients and was in the process of launching a new appointment system that would be more suitable for most patients.
- The partnership had a staff forum to engage with staff and provide opportunity to voice any concerns. The staff forum wanted a better understanding of the NHS structure and clarifications to some of the jargons and abbreviations used so that staff were better informed. We saw that the newsletter from the executive partner on May 2017 had responded to this request from the staff forum.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice piloted a scheme titled 'year of care' to effectively manage patients with multiple long term conditions in one appointment. Due to an ageing population and increase in chronic disease prevalence, patients with multiple long term conditions were becoming the norm which required review to appropriately manage them. Nurses normally reviewed these individually at separate intervals requiring the patient to attend numerous appointments. This was not seen as efficient for the practice or convenient for the patients. At times patients were seen by nurses for review when a healthcare assistant would have been more appropriate which also did not effectively use the appropriate skill mix. As a result the service created a clinic called 'year of care' which incorporated review of each condition within one appointment. It also prepared and created a scheduled plan for the patient for the following 12 months.

To demonstrate impact of the approach the practice had carried out an audit using a cohort of 49 patients who had a diagnosis of diabetes and Chronic Obstructive Pulmonary Disease (COPD). The audit findings showed that a total of 70 minutes would have been required per patient to review both conditions using the old method (a total of 57 clinical

Are services well-led?

Good

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

hours for all 49 patients). Using the new method, this was reduced to 24.5 clinical hours (57% reduction in clinical time required per patient). This was trialled at another corporate site and had now been implemented at all sites.

This pilot was driven by the nursing team and they were recognised as team of the year partly due to this work in the inaugural CCG awards for primary care in June 2017. We found that the nursing team worked well as a team and covered for each other between sites. There was good engagement from the nursing team whose feedback was used to improve service.

The practice offered qualified doctors training to become GPs and one of the trainees was awarded trainee of the year. One of the doctors was recognised as the GP of the year. The practice also offered placements for nurses and physicians assistants. In total, the partnership was nominated for five awards.

The practice had developed a clinical support team that were due to be operational by September 2017. The team would consist of a GP, nurse, a healthcare assistant and a pharmacist and was formed in response to feedback from patients and staff. The support team's role would be to process many of the administration duties such as processing of hospital communications, processing of results and for any medicine queries where they do not need to be reviewed at a formal consultation. This was to ensure effective use of GP time and to ensure patients with appropriate clinical needs were reviewed by appropriate staff. This was being launched at the same time as the new appointment system and would be integral to the success of the appointment system.

From September 2017 the partnership planned to hold a single contract with the CCG for all sites. As part of this, the practice planned to launch a new model of care (we saw letters were going out to each patient explaining this) where patients could access any of the sites for care allowing flexibility. For example, patients who lived in one area but worked near another site could access care at that site.